Great Western Hospitals NHS Foundation Trust

TRUST BOARD

Thursday 8 May 2025, 9.30am to 1.00pm

By MS Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Will Smart, Caroline Coles	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 • 13 March 2025 (draft)	8 – 18	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	19	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	20 – 23	LC	-	-
6.	**Staff Story – Staff Support** Jenni Fry, Community Midwife and Dr Jon Freeman, Clinical Lead – Consultant Clinical Psychologist	24 – 29	JF/JF	Receive	9.40
7.	**Chair's Report** Liam Coleman, Chair • Register of Board Declarations of Interest • Fit & Proper Person Test 2024/25	30 – 38	LC	Note	10.15
8.	**Chief Executive's Report** Cara Charles-Barks, Chief Executive Jon Westbrook, Managing Director	39 – 48	CCB/ JW	Note	10.25
9.	**BSW Hospitals Group Partnership Agreement and Joint Committee Terms of Reference** Cara Charles-Barks, Chief Executive	49 – 138	CCB	Approve	10.40

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		PAGES	BY	ACTION	TIME
10.	**Integrated Performance Report**			Assurance	10.50
	• Performance, Population & Place Committee Board Assurance Report (March & April) – Bernie Morley, Non-Executive Director & Committee Chair	139 – 144	BM		
	• Quality & Safety Committee Board Assurance Report (March & April) – Claudia Paoloni, Non-Executive Director & Committee Chair	145 – 150	CP		
	• People & Culture Committee Board Assuance Report (April) – Julian Duxfield, Non-Executive Director & Committee Chair	151 – 153	JD		
	• Finance, Infrastructure & Digital Committee Board Assurance Report (March & April) – Faried Chopdat, Non-Executive Director & Committee Chair	154 – 157	FC		
	• Integrated Performance Report	158 – 209	All		
BREAK (10 minutes) at 11.30 to 11.40					
11.	**Mental Health Governance Committee Board Assurance Report (April)** Liam Coleman, Chair and Committee Member	210 – 211	LC	Assurance	11.40
12.	**Trust-wide Quarterly Learning from Deaths Report Q4** Steve Haig, Chief Medical Officer *(received at Quality & Safety Committee 17 April 2025)*	212 – 217	SH	Assurance	11.45
13.	**Emergency Preparedness, Resilience & Response Annual Assurance Report** Benny Goodman, Chief Operating Officer *(received at Performance, Population & Place Committee 26 March 2025)*	218 – 235	BG	Assurance	12.00
14.	**Trust Staff Survey Results 2024** Jude Gray, Chief People Officer Angela Morris, Senior People Partner *(received at People & Culture Committee 29 April 2025)*	236 – 285	JG/AM	Approve	12.10
15.	**Perinatal Services Six Month Summary (Q3 & Q4)** Luisa Goddard, Chief Nurse Lisa Marshall, Director of Midwifery & Neonatal Services and Kat Simpson, Head of Midwifery & Neonatal Services	286 – 298	LG/LM/ KS	Receive	12.30
16.	**Delegation of authority for approval of Annual Accounts 2024/25** Simon Wade, Chief Financial Officer	299 – 300	SW	Approve	12.45
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.**					
17.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	None	CC	Approve	12.50
18.	**Annual Self Certification – CoS7** Simon Wade, Chief Financial Officer	301 – 304	SW	Approve	
19.	**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	-	-

		PAGES	BY	ACTION	TIME
20.	**Date and Time of next meeting** Thursday 10 July 2025 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-
21.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	13.00

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF TRUST BOARD HELD IN PUBLIC
13 MARCH 2025 AT 9.30AM
VIA MS TEAMS

Present:

Claudia Paoloni (CP)	Non-Executive Director/Senior Independent Director (Chair)
Lizzie Abderrahim (EKA)	Non-Executive Director
Cara Charles-Barks (CCB)	Chief Executive (part meeting for item 24/150)
Faried Chopdat (FC)	Deputy Chair/Non-Executive Director (part meeting for item 24/150)
Jon Burwell (JB)	Acting Chief Digital Officer
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
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Jon Westbrook (JW)	Interim Managing Director

In attendance:

Caroline Coles (CC)	Company Secretary
Deborah Rawlings (DR)	Board Secretary
Johanna Bogle	Deputy Chief Financial Officer (for Simon Wade)
Tania Currie	Head of Patient Experience & Engagement (agenda item 254/24)
Tim Allen	Admiral Nurse (agenda item 254/24)
Sharon Woma	Head of EDI & Health Inequalities (agenda item 260/24)

Apologies

Liam Coleman (LC)	Chair
Julian Duxfield (JD)	Non-Executive Director
Claire Lehman (CL)	Associate Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director
Simon Wade (SW)	Chief Financial Officer

Number of members of the Public: There were 5 members of public in attendance (Chris Shepherd, Governor; Stephen Baldwin, Governor, Sarah Marshall, Governor, Ashish Channawar, Governor, and Natalie Titcombe, Lead Governor)

Matters Open to the Public and Press

Minute	Description	Action
248/24	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. It was noted that both the Trust Chair and Chief Executive were called away to an NHSE meeting at very short notice hence apologies for the meeting (part for Chief Executive). Apologies were received as above.	
249/24	**Declarations of Interest** There were no declarations of interest.	
250/24	**Group Joint Chair Role** The Board received and considered a paper which had set out the proposal to appoint a Joint Chair to support the BSW Hospitals Group development leadership.	

Minute	Description	Action

It was noted that the BSW ICB Chair had indicated support for the recruitment of a Joint Chair to enable a strong response to the significant system challenges faced by the BSW. NHS England's Regional team also supported recruitment of a Joint Chair and establishment of Joint Committee arrangements.

It was recommended that the Councils of Governors establish a Joint Nominations Committee with responsibility for undertaking the selection process for the Joint Chair and recommending a preferred candidate.

The Board considered the two options within the paper for further development by the Joint Nominations Committee as follows:

- Option 1 : Open external recruitment process, assume internal candidates shortlisted.
- Option 2 : Interim appointment, pending completion of external open recruitment process. Role ringfenced to current Chairs of Trusts. Applications and interview process. Propose 6-8 months role.

Cara Charles-Barks, Chief Executive outlined a case for discussion by the Board in which she supported an open recruitment process, however recognised that the NHS was in a period of significant transition and transformation ahead for the NHS and therefore there was a need for stability and continuity over the next 12 to 18 months to help navigate the Group during this period of change.

It was noted that the development of the terms of reference for the Joint Committee would also include the role and expected commitment of a Deputy Chair. Clarification was provided that this commitment would be confirmed as the arrangements for the Joint Committee were formalised.

Following robust discussion, there was unanimous support of Option 2 with the interim appointment to be adjusted to a period of 12 to 18 months.

Caroline Coles, Company Secretary reminded the Board of a line in the Trust's Constitution which referred to other board members working in another trust and that this would require 75% of board approval. It was agreed that the Board had no objection for a Chair being a Chair in another trust.

RESOLUTION:

The Board

a) agreed to support the development of a Job Description and Person Specification for a Joint Chair in support of the Nominations & Remunerations Committee of the Council of Governors recommendation to the Council of Governors;

b) agreed to recommend to the Council of Governors option 2 for an interim appointment to be adjusted to a period of 12 to 18 months to maintain stability, pending completion of an external open recruitment process; and,

c) ***approves the Chair being a Chair in another trust as outlined in the Trust's Constitution.***

251/24 **Minutes of the previous meeting (public)**

The minutes of the Board meeting held in public on 9 January 2025 were adopted and agreed as a correct record, subject to the following amendment:

Minute	Description	Action
	Minute No. 225/24 – Board Assurance Report – Our Performance Second bullet point, deletion of the words "reported an increase" and replaced with "deteriorated".	
252/24	**Outstanding actions of the Board (public)** The Board received and considered the outstanding action list.	
253/24	**Questions from the public to the Board relating to the work of the Trust** There were no questions from the public to the Board.	
254/24	**Care Reflection – Dementia Care – Ralph's Story** *Tania Currie, Head of Patient Experience & Engagement and Tim Allen, Admiral Nurse joined the meeting to present this item.* A care reflection story was received on the inpatient treatment experience at GWH by a patient with dementia and also the impact on the family. Small changes which could have improved their overall experience was shared and the key theme that had emerged related to the lack of communication and involvement of carers who knew the patient best and were able to support care and advise our staff. Tim Allen shared examples of improvement work that was ongoing across the Trust to increase staff awareness and to ensure standards of care were raised for patients suffering with dementia and their families. Lizzie Abderrahim, Non-Executive Director reflected on the Trust's Dementia Strategy that had been received at a recent Mental Health Governance Committee and commented that the story received by the Board had stressed the need for a person-centred care and the effectiveness of dementia training and the dementia champions' programme. In response, Tania Currie outlined the improvement work that had been undertaken around carers and the continuous efforts being made to raise awareness and training for staff to ensure that carers were involved in the patient's care. Tim Allen also outlined the aims of the dementia champions network and sessions for staff to expand the person-centred care principles within the organisation. The Board was informed that work was ongoing to address the number of late night moves, which had been highlighted in the story, as a need to improve patient flow and prioritise continuity of care. The Board thanked Tania and Tim for their presentation and acknowledged the significant work still needed to improve the experience of both dementia patients and their carers. The Board **noted** the care reflection story.	
255/24	**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 February 2025 in which the Governors participated. It was noted that this was the last Board meeting for our Associate Non-Executive Directors, Claire Lehman and Rommel Ravanan, as their term of office would come to an end on 31 March 2025. This was also the last formal Board meeting of Lizzie Abderrahim, Non-Executive Director whose term of office also comes to an end on 30 April 2025. The Board wished to thank Claire, Rommel and Lizzie for their contribution to their roles during their times in office at the Trust.	

Minute	Description	Action

An effectiveness questionnaire survey was to be sent out shortly for committee members and regular attendees to complete.

The Board **noted** the report.

256/24 **Chief Executive's Report**

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

NHS Chief Executive

The Board noted that the Chief Executive of NHS England had announced her decision to step down from her position at the end of the financial year, and that since the report had been written, resignations had also been received for other prominent positions in NHSE. This was coupled with the announcement that NHSE England was to be abolished and that there was to be a period of significant transformation and change ahead.

Staff Survey

The Staff Survey results were being published on 13 March 2025 and that there had been an outstanding response rate from Trust staff in excess of 70%. Very high level results had reported an average score in most elements. Those areas that had scored below the national mean were around discrimination and violence against staff and slightly lower morale.

Group development

The first Board to Board development day had been held in January 2025 which included a session of group governance development. A task and finish group had been established to develop terms of reference for the Joint Committee and the transitional support had now been selected to start with the Group in March 2025 to plan the group design phase.

Leadership Team: Managing Directors

The recruitment process for the three Managing Directors was underway and that interviews were now planned to be held in early April.

System working engagement series with Councils of Governors

Supported by the Group's legal advisors, a series of local Governor discussion sessions had been held which focused on system working and group leadership and development.

Corporate Service Collaboration

Opportunities were being identified to work at scale and align processes in readiness for the arrival of transitional support to help with more detailed design and implementation.

Shared Electronic Patient Record (EPR)

The Group was now in the 'Engage' stage which was to run through to March 2026. This included the build, testing and training for the shared EPR and would receive oversight by the EPR Joint Committee.

Changes to divisional structures

As many community services would be moving to a new provider from 1 April 2025, a review of the structure of clinical divisions at GWH was to be undertaken. It had been agreed to keep three clinical divisions but rebalanced in line with criteria. From 1 April, the Integrated Care and Community division would no longer exist and a new Specialist Services division would be created. The communication process with the affected teams had commenced. It was requested that changes to the divisional structures be circulated to the Non-Executive Directors of the Board for information.

Action: Chief Officer of Improvement & Partnerships

Minute	Description	Action

Care Quality Commission
Following an inspection last year, the Care Quality Commission had announced that GWH had maintained a 'Good' rating for medical care. The CQC had acknowledged staff concerns about patients being cared for outside of specialty areas and that this would be addressed in the ward reconfiguration process.

HIV testing
The Great Western Hospitals NHS Foundation Trust was the first Trust in the South West to offer opt-out testing which would enable the early onset of treatment. It was noted that in the last year, the team had diagnosed 15 new HIV patients, four of which had been tested through routine testing at the hospital. The Board commended the Sexual Health Team who had successfully set up this programme.

Angina clinics
The cardiology outpatient team had launched one of the first dedicated angina clinics in the UK in February to improve the heart care for people with the condition and to offer a truly holistic service.

Children's Emergency Unit training
The team on the Children's Emergency Unit had introduced a new manikin with Down's Syndrome to support staff training and to enable staff to recognise the important differences in care required for children with special needs.

STAR of the Month
Radiographer, Musab Bashir has been commended as Star of the Month for his commitment to compassionate and excellent care for patients in the radiology department.

The Board **noted** the report.

257/24 **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 January 2025 (December 2024 for Cancer).

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

Our Performance
Benny Goodman, Chief Operating Officer reported that the RTT performance and target for 52-week wait had continued to improve, however challenges remained to reach a zero target by the year end. Key challenges that continued to affect the 65-week waits related to orthopaedics, plastics and corneal grafts (ophthalmology). Services that were starting to experience a significant increase in demand were highlighted to the Board and that robust plans were to be developed to mitigate against this for the longer term.

Performance data for ambulance handover delays continued to show a deterioration due to the significant operational challenges faced by the organisation and that this was the fourth consecutive month during which the breakthrough objective was not met. Performance had also been significantly affected by ward closures due to infection, prevention and control which was a compounding factor in terms of the number of bed moves, increased length of stay and delays in discharge.

Surge and escalation protocols in response to ambulance offload delays were to be reviewed for February to ensure that all temporary escalation spaces were used proportionately and safely to reduce ambulance offload delays over 75 minutes. The Trust would continue to work with System partners on priorities to drive improvement.

Minute	Description	Action

An urgent care and flow transformation programme for 2025/26 was to be initiated in Spring 2025 following recommendations received from the Emergency Care Intensive Support Team (ECIST) and a report was to be received by the Trust Management Committee at its March meeting on the priorities and rationale for resource commitment to the next phase of transformation. A programme board would be initiated to deliver the programme and in doing so support achievement of the Trust strategic objectives for outstanding patient care and reduced emergency waits.

It was noted that there had been one 104-week wait breach and the Board were provided with assurance that learning and actions had been applied.

The Board noted that due to the ongoing challenges around Plastics and consultant vacancies at Oxford, the financial impact of using a private third-party provider would remain and that a plan to address these issues would continue to be sought in discussion with the ICB.

Our Care

Luisa Goddard, Chief Nurse reported that the total number of harms had continued to report significant reduction over the last year. However, over the last quarter there had been little change in the total overall harms during the last quarter which was a reflection of significant operational pressures on the organisation during this period.

Falls remained the current breakthrough objective with the aim to reduce total falls by 20%, reduce the number of patients who had experienced moderate harm and above by 20% and reduce the number of patients who had fallen more than once by 20%. Luisa Goddard, Chief Nurse added that whilst these had been a decrease in the number of falls reported for March so far, there had been four cases of falls with harm of those patients who had fallen more than once during the reporting period. The number of patients who were presenting at the Emergency Department with falls had also increased.

It was acknowledged that the trajectory of 20% had not yet been met and focus remained on the improvement projects on enhanced care in relation to total falls and multiple falls. A review of the A3 methodology had been undertaken with the addition of weekly meetings of a divisional trust-wide panel to review all falls and identified immediate learning to be shared. Improvement actions around deconditioning continued, working collaboratively with AHP colleagues to ensure that patients were getting up and dressed and mobile every single day.

The number of hospital-acquired pressure harms had continued to reduce and reflected greater ownership and awareness in clinical teams around pressure harm. However, there had been a slight rise in harm reported for February due to significant operational pressures experienced in ED and MAU and staffing challenges during the norovirus outbreak at GWH.

C. diff numbers for the Trust have continued to remain below its target trajectory. MSSA numbers have increased to four in month and showed an upward trend and work continued around additional training on skin prep and hand hygiene to drive improvement.

High number of influenza had been experienced during this quarter; however there was minimal transmission within the hospital. A significant outbreak of Norovirus had been experienced, which was in line with the national picture. A root cause analysis had been undertaken for shared learning.

The number of Family and Friends Test (FFT) positive responses for January had remained similar in month at 90.9% which was above the target, together with an increase in positive responses for ED.

Minute	Description	Action

Our People

Jude Gray, Chief People Officer reported that the Staff Survey 2024 results had shown that there had been no significant changes in the overall results and that a sustained result had been achieved against the staff survey question "Staff recommendation as a Place to Work". An improved position in the disparity ratio had been reported which was due to a reduction in BME staff reporting discrimination, although this did remain above the national average.

Voluntary turnover and retention rates remained stable during 2024. The funding for a dedicated People Promise role was due to end in March and that work would be moving into business as usual through People Partners in the divisions from April 2025.

The pillar metric around staff turnover was to be replaced in 2025/26 by Trust sickness absence rates to increase focus around the steady rise in staff sickness levels. Further focus was to be applied to the management of short-term absence following a review of the Absence Management (Sickness) Policy.

Jude Gray, Chief People Officer provided an overview of the deep dive into the granular details of the data around the three pillar metrics over the previous four years which related to voluntary staff turnover, 'Recommending as a place to work' and discrimination disparity and the areas of focus for 2025/26 and that this data had provided areas of focus within divisions to drive improvement.

Following a review of staff survey performance, the Trust A3 had been updated and 'Teamwork' had been identified as an area of opportunity to drive performance against the pillar metric of 'Recommending as a place to work' and therefore the breakthrough objective had been moved to question 7C ('I receive the respect I deserve from my colleagues at work') to drive further improvement in 2024/25. It was reported that there had been no significant change in the last 12 months but the data showed a more positive picture over a 4-year trend line. A further deep dive into the granular detail had shown areas of focus within divisions using the Improving Together approach for both short and long-term sickness.

Use of Resources

Johanna Bogle, Deputy Chief Financial Officer reported on the breakthrough objective for productivity. The financial breakthrough objective was to remain within the Trust's overall deficit plan by month for 2024/25, having improved the underlying financial deficit position by the financial year and through delivery of recurrent CIP.

The Board was reminded that the pillar metric was to meet the full year control total deficit of £10.2m to demonstrate the Trust's credibility in setting a financial plan and it was noted that at Month 10, the Trust had a year-to-date adjusted deficit position of £9.6m, which represented a £1.8m adverse variance to plan which triangulated with the delivery of efficiency programmes.

Johanna Bogle, Deputy Chief Financial Officer reported that the full year deficit was expected to be £8.8m, which was £1.4m better than plan and as a result of some non-recurrent benefit around public dividend capital charges.

It was noted that further grip and control was to continue around the underlying recurrent position and increased focus on the non-pay run rate. Actions were also to continue to be progressed in relation to the improvement of requisitioning controls and developing the training offer.

The Board acknowledged the considerable work undertaken to achieve a positive position at year end and demonstrated the strength of the Finance Team in collaboration with all teams to strategically achieve the plan.

Minute	Description	Action

Board Assurance Reports

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meeting on 17 February 2025 and the following was highlighted:

- Cancer diagnosis performance continued to show an improved position. The under-delivery of the Plastics Service provided at GWH via a SLA with Oxford continued to remain a significant risk with breaches due this issue.
- Diagnostics performance remained strong and work continued to drive this improvement.
- Referral to Treatment (RTT) figures continued to reduce but was still off target for the year to date.
- A review of patient flow was to be undertaken using some of the recommendations from the Internal Audit Report on Admissions and ECIST (Emergency Care Intensive Support Team) and how this also impacted on ambulance handovers.

The Board **noted** the report.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (QSC) at its meeting on 17 February 2025 and the following was highlighted:

- The digital move to 'Badgernet' had now been completed.
- Compliance on all 10 standards was expected to achieve the Maternity Incentive Scheme (CNST) Year 6.
- Progress with the national clinical audits remained on track, with a participation rate of 99%.
- Compliance with NICE guidelines had improved significantly and that data validation had resulted in improved quality of data.

The Board **noted** the report.

Our People

People & Culture Committee Chair Overview

The Board received an overview of the detailed discussions held at the People & Culture Committee (PCC) at its meeting on 25 February 2025 and the following was highlighted:

- The EDI and Health Inequalities Strategy 2025-2028 had been developed to align with objectives with the Trust Strategy and priorities. This would be approved by Board prior to publication.
- The workforce recovery trajectory remained above target. The significant workforce reductions required in 2025/26 would receive oversight at PCC.
- It was agreed that work should commence on the development of a more coherent leadership strategy with focus of resources on interventions.
- Medical revalidation, appraisal, and job planning continued to be embedded across the Trust, with two cycles of job planning complete and 2024/25 almost complete.
- Proposals were endorsed to improve the measurement of the impact of equality, diversity and inclusion initiatives to respond to more dynamic feedback.

The Board **noted** the report.

Use of Resources

Minute	Description	Action

Finance, Infrastructure & Digital Committee Chair Overview
The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meeting on 24 February 2025 and the following was highlighted:

- The BSW finance position as at Month 10 was a YTD adverse variance of £16.3m and this position was after the recognition of the pro rata share of £30m deficit funding. Positions were deteriorating at RUH and SFT, with GWH reducing its deficit and the ICB improving. Mitigating actions had been identified to address these challenges.
- An extraordinary meeting of the Finance, Investment & Digital Committee and Performance, Population & Place Committee was to be held on 17 March 2025 to receive the draft plan for submission to BSW ICB on 19 March to be included as part of the system plan return on 27 March.

The Board reflected on the recent announcements that ICBs had been ordered to cut costs by 50% and that NHS England was to be abolished and management of the NHS brought back to the Department of Health & Social Care, and how this would impact on NHS organisations.

The Board **noted** the report.

258/24 **Charitable Funds Committee Board Assurance Report**
The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) at its meeting on 12 February 2025 and highlighted the following:

- The revised Brighter Futures strategic plan for 2025-2028, based on the GWH strategy, had been received and would be presented to the Corporate Trustees for approval at the next appropriate meeting.
- Progress was being made on the rationalisation plan for charitable funds at GWH with external support to develop a more strategic approach to the use of funds.
- The transfer of Adult and Children's Community Services charitable funds from the Trust and Wiltshire Health &Care to HCRG would require an agreement between the Trust and HCRG as to the process for the holding of and approval for the allocation of these charitable funds. Claire Thompson, Chief Officer of Improvement & Partnerships confirmed that a partnership agreement had been circulated to Trustees for approval and sign off.
- A number of funding proposals was agreed around the Defence Medical Welfare Service and staff reward and recognition.

The Board **noted** the report.

259/24 **Audit, Risk & Assurance Committee Board Assurance Report**
The Board received an overview of the detailed discussions held at the Audit, Risk & Assurance Committee (ARAC) at its meeting on 6 March 2025 and highlighted the following:

- Progress of the External Audit Plan for 2024/25 from Deloitte was received and that there had been an improvement in the outcomes in comparison to prior years with further implementation and progress on implementing controls.
- The Internal Audit Programme for 2024/25 continued to progress well. Some audits were yet to be completed to inform the internal audit assurance rating for the year.
- The final report on the Internal Audit on Data Quality (NCTR) was received and was rated as partial assurance with improvements required. ARAC had escalated the full report to the Performance, Population & Place Committee for review and oversight as it impacted the data received by that committee and the ownership and completion of data from an operational perspective.

Minute	Description	Action

- The Internal Audit Plan for 2025/26 was considered and further follow up with the Executives was requested on two areas to ensure that internal audit time would be focused on the most challenging areas for the Trust. The plan would then be approved separately outside of the ARAC meeting in advance of the year.

The Board **noted** the report.

260/24 **EDI-HI 3 Year Strategic Plan**

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

The Board received and considered the EDI-HI three year strategic plan and developed in line with the Trust's overall strategy and aligned with the overall Trust objectives.

It was noted that this high-level strategic plan had set out a bold and ambitious approach to driving change and would also capitalise on emerging technology and pending data improvements. The plan responds to a number of key EDI/HI frameworks including WRES, WDES, EDS and system and regional plans and would support the Trust to meet its legal obligations set out in the Public Sector Equality Duty.

Lizzie Abderrahim, Non-Executive Director commented on the focus to improve health inequalities using the limited resources of a small patient engagement team and stressed the need to work alongside and support the work of network partner organisations to drive improvement. The Board reflected on the ongoing actions to better understand the data around health inequalities and cocreation, and the work to further embed the health inequality dialogue and cultural shift required in the Trust using refreshed Improving Together training mechanisms. It was also noted that work was underway with Healthwatch to strengthen health inequalities with the local population.

The Board considered that the plan should also include tangible actions and metrics to measure the outcomes of implementing the strategy. Jude Gray, Chief People Officer responded that the strategic plan was to set out the vision for the Trust for the next three years and that EDI pillar metric had outlined the key priorities of the Improving Together approach. Sharon Woma also outlined redesigned frameworks to improve the EDI metrics to provide evidence around the delivery of EDI actions and the impact evaluation of all the initiatives in place. Following Board discussion, it was agreed that an additional paragraph would be added to the strategy around the oversight of the implementation of the strategy.

RESOLUTION:

The Board approves the EDI-HI 3 Year Strategic Plan for publication, subject to the addition of a paragraph around the oversight of the implementation of the strategy.

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.

261/24 **Ratification of Decisions made via Board Circular**

None.

262/24 **Urgent Public Business (if any)**

Caroline Coles, Company Secretary referenced an email of 12 March 2025 which had circulated a revised page from the Trust's local strategic direction document, which was formally approved last month at the public Board session. An action was taken to revise

Minute	Description	Action
	page 5, which outlined our group and system, so that it more clearly articulated the benefits of us working collectively together as BSW Hospitals Group. It was noted that the revision had been reviewed and approved by both the Chief Executive and Chair and that it would be included into the final version of the document which was set to be launched internally in March.	
263/24	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 8 May 2025 at the DoubleTree by Hilton Hotel, Swindon.	
264/24	**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 12.10hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – May 2025				
ARAC – Audit, Risk and Assurance Committee, CFC – Charitable Funds Committee, FIDC – Finance, Infrastructure & Digital Committee, PPPC – Performance, Population and Place Committee, PCC – People & Culture Committee, QSC – Quality & Safety Committee, RemCom – Remuneration Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
13 March 2024	256/24	**Chief Executive's Report – Changes to divisional structures** Changes to divisional structures to be circulated to the Non-Executive Directors of the Board for information.	Chief Officer of Improvement & Partnerships	Email sent to Non-Executive Directors on 21 March 2025.

Future Actions				
None				

Great Western Hospitals NHS Foundation Trust

Report Title	**Questions for the Board**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Liam Coleman, Trust Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

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 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 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:

Process and outcome in respect of the process of obtaining and gaining response to questions to the Board

Report

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

The Board is invited to consider the questions raised, the response given and agree if any further action is required.

Strategic Alignment – select one or more		✓ Outstanding care		☐ Valued teams		☐ Better together		☐ Sustainable future

Link to CQC Domain – select one or more	Safe	☐	Caring	☐	Effective	☐	Responsive	☐	Well-led	✓

Risk + Oversight		Risk Score
Key risks – risk number & description (Link to BAF / Risk Register)		
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Deputy Chief Officer of Improvements and Partnerships	
Next Steps	Consideration by the Council of Governors	

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

Explanation of above analysis:

Quality Impact and risk assessments were done for the moves and mitigations were put in place where concerns were identified.

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to review the responses to the questions and to consider whether any further action is required.

Accountable Lead Signature	Liam Coleman, Trust Chair
Date	**28/04/2025**

Questions to the Board				
Topic	**Questioner**	**Question**	**Responder**	**Board Response**
Trust's policies and procedures for relocating wards with particular reference to the moves in November 2024.	Member of the public via Sam Pearce-Kearney, Appointed Governor	The question was around the Trust's policies and procedures for relocating wards. Specifically, around:- • What kind of training is provided to staff involved in ward moves, both clinical and non-clinical? How are staff informed and prepared for the move? • What specific checklists or protocols are in place to ensure a smooth and safe transition during ward moves? How far in advance are ward moves planned? How are patient safety and continuity of care prioritised during this process? • What mechanisms are in place to oversee and monitor ward moves? How are potential risks and challenges identified and mitigated? • Based on the recent ward moves that occurred during the	Emily Beardshall, Deputy Director Improvement & Partnership	Ahead of ward changes there was a mobilisation plan put in place that included induction of staff, both clinical and non-clinical into the ward environments. There were additional staff rostered to work during the move days to help smooth the transition. There was a comprehensive staff engagement plan that supported staff to express a preference for where they would move to working and to review the skill-mix and training needs of staff. Where specialist skills were required, this was reviewed as part of the relocation of staff e.g. urology nursing skills. However, it is not uncommon for staff to need to be mobile around the organisation and as far as possible processes are standard across the organisation to support mobility of staff and the prioritisation of patient care. The changes went through a full business case process and were reviewed, iterated, and agreed by Trust Management Committee – the final decision to proceed was made in May 2024 with the move taking place in November 2024. There was a checklist process in place for the 4-week period where moves were taking place with gateways that reviewed the operational status of the organisation and agreed whether we could progress to the next stage of the move. There was an underpinning principle of minimising patient moves and bed

		week commencing 18 November, what key lessons have been learned? How will these lessons be applied to future ward relocation processes to improve efficiency and patient experience?		capacity was flexed over a 3-4 week period to support smooth transition. All normal patient safety measures continued throughout the move with additional clinical and non-clinical staff being in place to support transition. Quality Impact and risk assessments were done for the moves and mitigations were put in place where concerns were identified. During the move period the multidisciplinary project group met daily to review the status of the transition and to take any actions needed to support the change. There were regular walk arounds undertaken by senior clinical and non-clinical leaders to assess areas of further need and any staff concerns or observations. The project group continues to meet fortnightly to review the changes and to support full benefits realisation. Risks and challenges are flagged to the project group through the normal management and reporting routes. We are currently undertaking a lesson learnt process with questionnaires having been distributed to staff involved. We will summarise key lessons learnt as part of the project closure.

Report Title	**Staff Story**				
Meeting	**Trust Board**				
Date	**08/05/2025**	**Part 1 - Public**	✓	**Part 2 - Private**	☐
Accountable Lead	Jude Gray – Chief People officer				
Report Author	Jennifer Fry, Community Midwife				
Appendices					

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 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 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 is a staff story, from a community midwife who was involved in a traumatic experience at work last year, following which the staff member engaged in appropriate support pathways (i.e. Trauma Risk Management (TRiM) and clinical psychology support) enabling her to return to work after a period of significant distress and sickness associated with the incident. The story will share her personal experiences regarding this.

Strategic Alignment – select one or more		☐ Outstanding care		✓ Valued teams		☐ Better together		☐ Sustainable future

Link to CQC Domain – select one or more	Safe	✓	Caring	✓	Effective	✓	Responsive	✓	Well-led	✓

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

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

Explanation of above analysis:

Recommendation / Action Required

The Board/Committee/Group is requested to:

To listen and support the learning from the staff story

Accountable Lead Signature	Claire Warner DCPO on behalf of Jude Gray, CPO
Date	**30/04/2025**

NHS
Great Western Hospitals
NHS Foundation Trust

My Staff Story

Jenni Fry, Community Midwife | May 2025

Together we are Great

Incident

- Attended planned, low risk, home birth with one other Community Midwife in the early evening of 3rd June
- During delivery, complications arose leading to an emergency situation with the baby where Ambulance, Critical Care and Air Ambulance were required
- Due to location of homebirth, we were working alone as a pair, with no contact with the hospital due to poor phone signal
- Baby was transferred to GWH however passed away in the early hours of the following morning

Impact on Me

Great Western Hospitals NHS Foundation Trust

- Unable to return to work until October due to suffering from severe anxiety regarding pregnancy, new borns and home births; being unable to look at GWH uniform or items related to the hospital and didn't want to attend the hospital or workplace; being convinced I would cause harm when delivering care to others
- I was unhappy at home leading to impact on relationships with husband and children
- Felt sense of guilt when having periods of family time
- Suffered from nightmares and flashbacks
- Had to relive the situation over a period of months due to time taken to fully review the incident with reviews ongoing for some months

Response from GWH

NHS
Great Western Hospitals
NHS Foundation Trust

- Initial response from Direct Line Management and Community Team was fantastic, with support and check-ins from a wide variety of the Community and Maternity team
- TRIM meeting within 24 hours resulted in referral to psychological support via Occupational Health and Wellbeing
- Psychological support sessions resulted in decrease in symptoms and a want to return to work at the start of October
- On return to work there was a phased return plan, however on week two this unable to be followed due to low staff numbers leading to me being expected to lone work at a community hub
- Following additional support from psychologist and management, I was able to fully return from the start of November with on-calls starting in December

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 : Summary Board Safety Visits Appendix 2 : Register of Board Declarations of Interest				

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 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

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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:

Due process followed.

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
- Non-Executive Directors Update & Governance changes
- Strengthening Board Oversight
- Trust Chair - Key Meeting Dates
- Declarations of Interest

Strategic Alignment – select one or more		✓ Outstanding care		✓ Valued teams		✓ Better together		✓ Sustainable future

Link to CQC Domain – select one or more	Safe	☐	Caring	☐	Effective	☐	Responsive	☐	Well-led	✓

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested:-

(a) to note the updates;

(b) to approve the disbandment of the Mental Health Governance Committee and note that the remit will be incorporated into the Quality & Safety Committee;

(c) to approve the proposed Board of Directors Register of Interests as at 31 March 2025 for submission on the Trust's website; and,

(d) to note the named NEDs for the NED champion/guardian roles for Wellbeing and Maternity Board Safety.

Accountable Lead Signature	Liam Coleman, Chair
Date	**28/04/2025**

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 March to April 2025.

1. Council of Governors

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

March 2025		
Date	**Event**	**Purpose**
5 Mar	People's Experience and Quality Working Group	To identify key issues in relation to service users and staff experience and the quality of the work of the Trust. The Group received updates on patient experience and HR.
10 Mar	Learning from Deaths Quarterly Meeting	Governor representative
18 Mar	Extraordinary CoG	Appointment of Joint Chair
28 Mar	Lead governors met with Chair and Company Secretary	Regular meeting to update and discuss any topical issues
24 Mar	Informal governor meeting	Governors met with Lizzie Abderrahim, NED
7 Apr	Nomination and Remuneration Committee	Considered and approved the recruitment process for two new NEDs and ANEDs
16 Apr	Council of Governors	Meeting of the whole group quarterly to gain assurance, on behalf of the membership and the public, on the organisation's performance, with a particular focus on service quality. The Council received updates on the Trust strategy launch, System plan, Community Services transfer and Quality Accounts priorities.

2. Non-Executive Directors

2.1 The recruitment process for 2 new NEDs and 2 new ANEDs was approved by the governor's Nomination & Remuneration Committee on 7 April 2025. The recruitment process started w/c 14 April 2025 with anticipated interviews in June 2025.

2.2 Due to the departure of Lizzie Abderrahim, Non-Executive Director there are two NED champion roles to fill. The following NEDs have expressed an interest for the two roles:-

- Wellbeing Guardian – Julian Duxfield
- Maternity Board Safety Champion – Claudia Paoloni noting that this will be on an interim basis until the new NEDs are on board.

2.3 A further review of the membership of Board committees will be undertaken once the new NEDs have commenced.

2.3 In light of the development of the Group model the trusts are looking to standardise their committee structures and therefore with the departure of Lizzie as Chair of Mental Health Governance Committee it is proposed to disband this committee and incorporate its remit into the Quality & Safety Committee (Q&SC).

The Chief Nurse has reviewed the overall governance of mental health and has strengthened the operational group below the Board committee and has recommended a quarterly report on mental health to the Q&SC. This is in alignment with the other two trusts.

The Board is requested to approve the proposal to disband the Mental Health Governance Committee and note that the remit with be incorporated into the Quality & Safety Committee.

3. Strengthening Board Oversight & Development

3.1 Safety Visits - There were four Board safety visit during the period covered by this report as follows:-

Date	Area	Board Member
6 March 2025	Woodpecker	Steve Haig, Interim Chief Medical Officer Bernie Morley, Non-Executive Director
24 March 2025	Ophthalmology	Steve Haig, Interim Chief Medical Officer Helen Spice, Non-Executive Director
3 April 2025	Ampney	Benny Goodman, Chief Operating Officer Will Smart, Non-Executive Director
15 April 2025	MAU/SDEC	Luisa Goddard, Chief Nurse Bernie Morley, Non-Executive Director

3.2 Appendix 1 summarises the Board safety visits during October to December 2024.

4. Trust Chair Key Meetings during March & April 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
NEDs' Meeting	Monthly meeting
Finance, Infrastructure & Digital Committee	To attend as an observer
Performance, Population & Place Committee	To attend as an observer
Remuneration Committee	To chair meeting
Nominations & Remuneration Committee	To discuss NED recruitment
Council of Governors	To chair meeting
Weekly Chairs & Group CEO Meeting	Network meeting
BSW Chairs' meeting	Regular meeting
EPR Joint Committee	System meeting
Wiltshire Health & Care Members Board	System meeting
HWB Champions Forum	Regular meeting
HWB Oversight Committee	To attend as member
Thinking Differently Meeting	BSW Hospitals Group meeting
Managing Director interviews	To attend interview panel
Chief Medical Officer interviews	To attend interview panel
Acting Managing Director appraisal	Annual appraisal process
NHSE Leadership Event	National meeting
A Vision for Swindon	Event in London
GWH and Wiltshire & Swindon MPs	To brief MPs on Trust issues

5. Register of Board Declarations of Interest

This is an annual reminder to members of the Board of their obligation to register any relevant and material interests as soon as they arise or within 7 clear days of becoming aware of the existence of the interest and to also make amendments to their registered interests as appropriate. It is also a reminder of the requirement to declare interests at meetings when matters in which there is an interest are being considered and the requirement to withdraw from the meeting during their consideration.

Appendix 2 is a copy of the Register of Interests of the Board of Directors as at 31 March 2025 for review, which best practice suggests should be undertaken on at least an annual basis.

The Board is requested to approve the Board of Directors Register of Interests as at 31 March 2025 for submission on to the Trust's website.

6. Fit & Proper Person Test 2024/25

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

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

I can confirm to the Board that all necessary individual annual checks have been completed, and the evidence reviewed confirms that all serving members of the Board are fit and proper.

The requirements for the annual 2024/25 FPPT assessment have therefore been fully satisfied, and an overall summary will be submitted to the regional NHSE team confirming compliance with the framework by the deadline of 30 June 2025.

Appendix 1 : Summary of Board Safety Visits October to December 2024

The Board Safety visits provide an opportunity for an inclusive and positive culture of continuous learning, as outlined in the Care Quality Commission 'Well Led' statements. They are an opportunity for leaders to be inclusive, understanding the context of the care delivered. They provide an opportunity for front line staff to Speak Up as well as leaders to see, first hand, some of the challenges faced by front line teams and the changes made to support innovation and improvement.

Table one provides a summary of the wards/departments where visits have taken place from October to December 2024.

Table one – visit summary

Name of site	Date of Walk Around
Daisy Ward/Day Surgery	30/10/2024
Saturn Ward	14/11/2024
Urgent Treatment Centre	13/12/2024
Medical Day Unit	17/12/2024

Summary of feedback planned visits

A comparison of positive and negative themes has highlighted that 'pathways of care (patient flow)' is the greatest negative theme overall and also the highest area of positive comments.

Communication, Staffing and Space all remain a regular theme.

Learning points.

Learning points were also identified during the visits but there was no overall theme identified across all visits. Some of the learning points identified include:

- National Health Service England (NHSE) visit gave feedback about the areas set up for escalation patients
- Incidents and SWIFTS being actively discussed on daily huddles.

Triangulation with Patient Safety Incident Response Framework (PSIRF) priorities

The information obtained at the safety visits has been triangulated against the Trusts five PSIRF priorities (figure three). This has highlighted 'Optimising Care Pathways and Transfers of Care' and 'Optimising Communication' as the main themes.

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

Future Planned Visits

Future planed visits will follow the same format for the remainder of the year. They provide an opportunity for individuals and teams to guide the conversation and raise any points related to patient safety (positive or negative) with the visiting team. The current list of areas to be visited this year has been reviewed by the Divisional Directors of Nursing and Deputy Chief Nurse and agreed.

Governance and review

The visits have now been running well for several years, using an agreed Standard Operating Procedure (SOP) to ensure consistency of approach and guide each visit. The governance of the visits is well established, including the pre visit organisation, visit ethos and after visit action(s). To help the teams use the data gathered from each visit, the visits notes are now shared along with the individual ward/department themes. The visit review template has been revised and will be used guide the visits for 2025.

An initial look back with one of the teams has identified that the reviews are well received. Further discussions with other teams through 2024 was not achievable and therefore a different process of review for 2025 will be explored.

Summary

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

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

Declarations of Interest Trust Board of Director - 31 March 2025

	First Name	Last Name	Position Title	Interests to declare	Description of interest / Action taken	Type of interest: Clinical Private Practice	Strategic Decision Making	Outside Employment / Directorships	Gifts and Hospitality	Loyalty	Shareholdings	Membership of Committees / Charites / Networks etc	Personal connections
6	**Voting Board Members**												
7	Elizabeth	Abderrahim	Non Executive Director May 2019 to 30 April 2025	Y	Appointed as a Specialist Member of the First Tier Tribunal assigned to the Health, Social Care and Education Chamber [Mental Health] with responsibility for determining appeals under the Mental Health Act Appointed as the Independent Chair of NHS Wales Joint Commissioning Committee's [JCC] Individual Patient Funding Request Panel			X					
8	Liam	Coleman	Trust Chair from February 2019 to 31 January 2025 Role of Chair from September 2024 at Board of L&Q , joining 1 June 2024	Y	Non Executive Director / Chair of Audit Committee - The Financial Conduct Authority Board member on behalf of GWH NHS Foundation Trust - Wiltshire Health Care LLP - Members Board London & Quadrant Housing Trust Group - Chair (as a NED)			X			X		
9	Faried	Chopdat	Non Executive Director from April 2021 to 31 March 2024	Y	Non Executive Director Grant Thornton UK Equarios Ltd - Director Blossom CIC - Non-Executive Director			X				X	
10	Julian	Duxfield	Non Executive Director from April 2023 to 31 December 2023	N									
11	Luisa	Goddard	Chief Nurse	N									
12	Benny	Goodman	David (Benny) Goodman	Y	Director of Cornbow Properties Ltd			X					
13	Judith	Gray	HR Director from July 2019	Y	Trustee for ICP Support. ICP is a charity which supports women and their families who develop intrahepatic cholestasis of pregnancy Son is a Senior Manager for our external auditors, Deloitte Husband, Head of Strategy, Civica health & Care							X	X
14	Stephen	Haig	Acting Chief Medical Officer	Y	Freelance contract with BBC studios for script advice to the writers of Casualty			X					
15	Claire	Lehman	Non Executive Director from April 2023 to 31 March 2025 Associate Non Executive Director from April 2024 to 31 March 2027	Y	NED Dorset County Hospital, clinical lead for BSW ICS Exceptional Funding and Clinical Policy Working Group NED at SWAST Advocay for People with Parkinson's Disease, including but not limited to Cure parkinsons, NHS PArkinsons Group, Local Parkinsons UKg roups			X		X		X	

	C	D	E	F	G	J	K	L	M	N	O	P	Q
16	Bernie	Morley	Non Executive Director from April 2023 to 31 March 2026 Bernard Morley Limited (Consultancy)	Y	Chairman of research committee, Bath Institute of Rheumatic Diseases Trustee of University of Bath Student Union			X				X	
17	Claudia	Paoloni	Non-Executive Director from April 2021 to 31 March 2025	Y	Director/Shareholder of Calm Water Ltd Director/Shareholder MPower Mental Health Ltd Director of Lecrahurst Ltd HCSA Executive Committee - Vice-President Husband CFO E Energy Group PLC			X					X
18	Rommel	Ravanan	Associate Non Executive Director from April 2023 to 31 March 2025	Y	Employed by NHSBT as Associate Medical Director for R&D and Innovation Consultant Nephrologist at North Bristol Trust British Transplantation Society (registered charity) Treasurer			X					
19	Will	Smart	Non Executive Director from April 2023 to 31 March 2026	Y	Council Member, Health and Social Care Council, Tech UK. Alcidion Group LTD - Non Executive Director Caretech Partners LTD - Director Strategic Advisor to T-Pro		X	X				X	
20	Helen	Spice	Non Executive Director from April 2021 to 31 March 2024	Y	Make a Wish Foundation -Non Executive Director Trustee Mental Health and Employment Partnership Ltd, Non-Executive Director Non-Executive Director Barts Health NHS Trust			X					
21	Claire	Thompson	Director of Improvement and Partnerships from 19 April 2021	Y	Member of the local governing body of Writhlington School, Bath in a multi-academy trust				x			X	
22	Simon	Wade	Director of Finance & Strategy from November 2020	Y	Wiltshire Health & Care LLP Non-Executive							X	
23	Jon	Westbrook	Acting Chief Executive	N									

Report Title	**CEO report**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Cara Charles-Barks, Chief Executive				
Appendices					

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 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

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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 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. Group Development
3. Shared Electronic Patient Record
4. Operational update
5. Quality improvements
6. Systems and strategy
7. Workforce, wellbeing and recognition

Strategic Alignment – select one or more		✓ Outstanding care		✓ Valued teams		✓ Better together		✓ Sustainable future

Link to CQC Domain – select one or more	Safe	✓	Caring	✓	Effective	✓	Responsive	✓	Well-led	✓

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

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

Explanation of above analysis:

The report details our new Patient communication toolkit which aims to improve the support staff provide to patients who may have additional communication needs, including those who have experienced a stroke or a brain injury, or who do not speak fluent English.

The report mentions the Staff Excellence Awards, which contains a specific category on Championing Health Equalities.

This category celebrates staff who have called out inequalities in healthcare experienced by staff, patients, or families. This could include:

- Championing equality and inclusion
- Challenging discrimination and prejudice
- Encouraging equal opportunities
- Ensuring inclusivity in their department

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	**01/05/2025**

1. National/system

1.1 Laying the Foundations for Reform

Sir James Mackey, the new interim NHS England Chief Executive wrote to Trust and ICB Chairs and Chief Executives on 1 April 2025 setting out priorities for the coming weeks and months. The letter covers an update on 2025/26 planning, next steps on reducing non-patient-facing roles and planned work on the financial regime and NHS operating model.

The government's mandate published in January to reform the NHS lays the foundation for longer-term reform as part of its health mission, focusing on bringing care closer to communities, prioritising prevention over treatment, embracing digital transformation, and embedding financial discipline within the system.

Through the 10 Year Health Plan, the government will focus on three strategic shifts, moving care from:

- hospital to community
- sickness to prevention
- analogue to digital

These shifts will help to:

- cut waiting times for care
- reduce the amount of time spent in ill health
- tackle health inequalities
- reduce the lives lost to the biggest killers - cancer, cardiovascular disease and suicide
- make the NHS sustainable in the long term.

Among those changes:

We are required to reduce the cost of the current operating model of the NHS

- 50% reduction in NHSE and DHSE staffing by Q3 – Central oversight of the NHS (which has been the remit of NHS England since 2012) will now be reduced in size and move back into the Department of Health in the following 2 years.
- 50% reduction in ICB running and programme costs by start of Q3
- 50% reduction in corporate cost growth in providers
- Plans to reduce costs and streamline governance and non-clinical activities.

I appreciate that these are challenging messages, the reason for these changes are that the NHS and BSW are in deficit and need to make changes to move to a more financially sustainable model. There are also clear requirements regarding service offering and delivery of core performance and quality metrics.

I appreciate that this is a challenging time for all of our teams. For providers such as ourselves, there is a significant change in the oversight regime and the expectation regarding delivery, along with a changed consequence regime for non-delivery.

I understand that these times of transition and uncertainty are by nature unsettling. I also want to reassure you that we are already doing good work in terms of the change that's needed for our future NHS. for example leaders of corporate services are taking control of what will be best for us and our patients in terms of future service design. Planning has also been underway for a number of months now responding to the asks of the national guidance issued in January and consistent with creating a bright and sustainable future for the NHS.

As a group we have a great opportunity to learn together, to tackle inequalities in access to services, to work together to remove barriers to good health and provide improved health outcomes for all our communities. Together I believe we can be at the forefront of the transformation that's needed in the NHS, but most importantly we will achieve this by working together.

1.2 Updated NHS Standard Contract and Payment Scheme 2025/26

NHS England recently published the 2025/26 NHS Standard Contract which is mandated for use by commissioners for all contract for healthcare services other than primary care. Following the consultation on the 2025/26 NHS Payment Scheme, NHS England are now consulting on further changes to the 2025/26 Contract. The consultation was scheduled to close on Monday 28 April 2025.

1.3 Board Member Appraisal Guidance

NHS England published new Board member appraisal framework on 1 April 2025 which sets out expectations and recommendations in the completion of board member appraisals to ensure a consistent and standard approach to appraisal.

2. Group Development

March and April saw progress in resourcing and governance supporting the establishment of BSW Hospitals Group.

2.1 Leadership Team: Managing Directors and Group Chief Transformation and Innovation Officer (Interim)

The recruitment process for our three Managing Director roles saw stakeholder panels and final interviews held in early April. Later in April, Jonathan Hinchcliffe started with us as interim Group Chief Transformation and Innovation Officer. Jonathan brings a wealth of digital experience as well as years of working in a hospital group at Manchester University Hospitals.

2.2 Transitional Support Partner

Following a detailed procurement exercise, we have selected an experienced partner, Teneo, to support us in our Group set-up, design and implementation over the next eighteen months. The Teneo team is led by Lucy Thorp and started working with us in late March. Initially, focus will be on detailed planning for our Group design phase – including work on our operating model, leadership structure, corporate services programme and governance and accountability framework.

2.3 Partnership Agreement and Joint Committee Establishment

The working party leading development of our BSW Hospitals Group Partnership Agreement and Terms of Reference (TOR) for a group Joint Committee held further sessions in March, supported by colleagues from our legal advisors Browne Jacobson. Trust Board review of the draft Partnership Agreement, incorporating TORs for a special purpose Joint Committee is underway. Subject to Board approval, the first meetings will be arranged for May and June.

2.4 Board to Board Development

Following our first Board to Board development day in January, we have agreed to hold three Board to Board development sessions annually, to allow Board members from GWH, RUH and SFT to build and deepen relationships. Sessions are planned in June, October and next February.

2.5 Operating Model/ Leadership Structures/ Corporate Services

Work to establish our new operating model began in April, supported by colleagues from Teneo. Corporate services will be an important part of the new operating model. We have re-launched a comprehensive joined-up corporate services programme. A Steering Group with executive leads (Simon Wade and Melanie Whitfield), has been established to oversee the programme, confirming core assumptions and adopting a common framework in response to latest national requirements on NHS provider corporate service workforce.

2.6 Governance and Accountability Framework

Trust governance leads and company secretaries meet weekly and, with Teneo's support, are developing our Group Governance and Accountability Framework, identifying opportunities for collaboration, alignment and avoidance of duplication.

2.7 Group Engine Room

Improving Together and the engine room rhythm is well-established in the Trust; we will establish something similar for the Group to help us align teams around our biggest problems, connecting Teams across the Group. Improving Together leads, Alex Talbot, Emily Beardshall and Rhiannon Hills are helping shape our approach, aiming to establish our Group Engine Room in May.

3. Shared Electronic Patient Record (EPR)

We are now in the 'Engage' stage which runs through to March 2026. This includes the build, testing and training for EPR. The team are in the building phase, preparing to show that build for the first time from 30 June onwards at Future State Review. Future State Validation will follow in mid-July. Our EPR Joint Committee met on 21 March. The implementation team is well established and following a tender exercise, St Vincent's has recently joined us as EPR implementation partner.

Great Western Hospitals NHS Foundation Trust update

4. Operational update

4.1 Current operational pressures

Our overall waiting list has decreased over recent months and now stands at around 38,000 patients.

The number of patients waiting more than 52 weeks has fallen to 950 patients, but still remains much higher than we would like.

We continue to experience challenges with the number of patients in the hospital with no criteria to reside, along with high bed occupancy, and we are working closely with our partners to try to tackle the wider issues which contribute towards this.

Positively, we have improved our performance to see more patients with a suspected cancer diagnosis within 28 days.

4.2 A&E Survey

Last month the Integrated Care Board, working with Healthwatch and our Trust, launched the first phase of an engagement programme to better understand why people attend emergency departments rather than other health settings.

The first phase involved an online survey, which will be followed by Healthwatch volunteers speaking directly to people in the Urgent Treatment Centre and Emergency Department waiting rooms over the next few weeks.

The findings will improve our understanding of whether people have been referred by the NHS 111 service or tried to get a GP appointment before attending hospital.

5. Quality

5.1 Care Quality Commission inspections

The Care Quality Commission (CQC) carried out an unannounced inspection of our surgical wards in March.

Inspectors were extremely positive about the reception from both staff and patients, and said they felt welcomed to the organisation in every department they visited. They were pleased by how well staff engaged with the inspection, and the detail provided to them.

They were also impressed by our adaptive patient pathways for vulnerable patients.

Encouragingly, the CQC did not express any red flags or regulatory concerns, but they did raise some queries around how patients' weight is recorded on our systems, which we immediately addressed.

Separately, the CQC also carried out an unannounced inspection of our Emergency Department, Children's Emergency Unit and Urgent Treatment Centre (UTC).

Inspectors were positive about some of our patient pathways and were impressed with the clinical navigator role in UTC.

They also noticed good infection prevention and control measures were in place.

Inspectors did note how busy ambulatory majors was, and the impact this had on patient waiting times.

5.2 Patient communication toolkit

Teams now have access to a new Patient Communication Toolkit to improve the support they provide to patients with additional communication needs.

A diverse collection of pictures and icons are contained in the toolkit, covering a range of everyday topics which allow patients to tell staff about themselves, how they are feeling, and what they want and need.

The toolkit can be used by staff to support patients with additional communication needs, including those who have experienced a stroke or a brain injury, or who do not speak fluent English.

6. Systems and strategy

6.1 Our local strategic direction

We have published our new local strategic direction which will take us through the next three years.

Collaboration and partnership are at the heart of this direction, with themes of integration, co-creation, prevention and patient-centred care central to everything. Four strategic pillars pinpoint our priorities:

- **Outstanding care** – Continuous quality improvement and co-creation of services with local communities, with a focus on prevention and early intervention.
- **Valued teams** – Investing in training, resources, and wellbeing, while bringing teams together with the Improving Together approach.
- **Better together** – Collaborative and integrated working to improve quality of care and address health inequalities in local communities.
- **Sustainable future** – Maximise research, innovation and digital opportunities, spend wisely, and deliver on carbon net zero.

6.2 Finance

Financially we ended the year with a £1.4m surplus to our planned deficit which is a credit to all our teams but still represents a deficit position for the organisation and a great deal of work is needed in the coming year to bring us to a balanced financial position as a Trust. This is particularly the case as this year's position was in part achieved through one-off measures that cannot be repeated next year.

We made around £18.5m in savings last year, less than our £21.9m target but £4m more than the previous year. Around 49 per cent of the savings we delivered were the kind which can recur each year.

This year more than £32m in savings will need to be found from across the Trust, and work is underway to identify where we can save money, overseen by our Financial Recovery Sub-Committee which continues to meet fortnightly.

A group-wide corporate services transformation programme is now up and running with the first services due to present their proposals for how they will collaborate more effectively across our three Trusts over the next few weeks.

6.3 Community services

The transfer of community services to the new provider, HCRG Care Group, went safely and smoothly on 1 April following a significant amount of work from a number of teams across the Trust over the last few months.

We wish those staff who have left the Trust as part of the TUPE process to join HCRG the best of luck in their new roles in which they will doubtless continue to deliver excellent care to their patients.

6.4 Improving Together

As part of our work to roll-out our Improving Together methodology and way of working, an online Staff Improvement Forum has been created by our Transformation and Improvement Hub for staff to share positive changes or improvements they have made in their area.

6.5 Private patient service

Our private patient service, previously known as Shalbourne Private Health Care, has been renamed Great Western Hospitals Private Healthcare.

Private patient services is now integrated into various areas of the hospital and this new name better reflects the service we now provide.

The service remains a critical contributor to the Trust's finances. In 2024, the service helped reinvest more than £1 million back into NHS care.

6.6 New Sustainability App

We have launched a new app, OnHand, which will replace our sustainability app, ACT, across our Trust and the RUH and SFT.

OnHand offers ideas for sustainable activities alongside health and wellbeing actions, inclusivity and community missions – all with the aim of supporting our mission to be a Net Zero Carbon organisation by 2040.

6.7 Shared Electronic Patient Record

During July staff will have the opportunity to see first-hand what our new Shared Electronic Patient Record from Oracle Health will look like.

There will be a series of events taking place at the Trust to demonstrate the first stage of the build of the new system to date.

This stage is called Future State Review, preparing us to reach our next milestone in July – Future State Validation.

7. Workforce, wellbeing and recognition

7.1 Staff Excellence Awards

Nominations for our Staff Excellence Awards have closed.

We received 225 nominations across all of the categories.

The judging panel will now review the nominations and a shortlist will be published ahead of the awards ceremony which will take place at a venue in Swindon on 18 July.

7.2 STAR of the Month

Since the Board met we have made presentations to the following STAR of the Month winners:

Nicola Simpkins, Healthcare Support Worker on Jupiter ward, who made every patient on the ward a Valentines Day card and gave them all one alongside a small fabric heart.

Rosie Howell, Clinical Psychologist, who has been instrumental in introducing projects designed to improve the psychological wellbeing of patients with cancer and their families, including wellbeing events for those on the waiting list or undergoing active treatment.

7.3 Our behaviours

As part of our work to be a vision and values-led organisation, we have launched Let's Talk Behaviours, a staff engagement exercise to co-create a set of behaviours to support our STAR values.

We need one simple set of behaviours to support our STAR values which are meaningful to everyone, and which best show these values on a day-to-day basis, but we are aware that over time a number of different behaviours frameworks have been developed.

This work aims to create one definitive set of behaviours, which will then guide the expectations for all teams and individuals as we work together to deliver the Trust's new strategic priorities.

7.4 NHS Staff Survey

The results of the national NHS Staff Survey were published in March.

Since then the feedback we've received has been discussed at a number of forums and meetings, including Trust Management Committee.

Our response rate to the 2024 Staff Survey was the highest in the country compared to other acute and community organisations.

The views of 71 per cent of our staff – 4,200 individuals – were published and will be used to shape our improvement work over the next 12 months.

The results show improvements in several areas compared to last year, and we scored above the national benchmark in 20 areas.

Improvements were seen in continuous learning, safety and wellbeing, and recognition. Feedback on flexible working is particularly encouraging, showing that staff feel supported in being able to achieve a good work-life balance.

Areas where we did not perform as well will form our action plan for 2025/26.

7.5 Flu vaccination campaign

Our Trust achieved the highest flu vaccination uptake among all NHS Trusts in the South West this winter.

Nationally we ranked 10th, delivering over 4,100 vaccines to staff, students, volunteers, and colleagues at Serco. In total, 59 per cent of our staff received the flu vaccine, either at work or within the community.

Report Title	**BSW Hospitals Group Partnership Agreement and Joint Committee Terms of Reference**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	**Cara Charles-Barks, Chief Executive**				
Report Author	**Ben Irvine, Programme Director, BSW Hospitals Group**				
Appendices	**Appendix 1 : BSW Hospitals Group Partnership Agreement and Terms of Reference.**				

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 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 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:

Due process followed with extensive consultation.

Report

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

In accordance with the Board of Directors' decision in July 2024 to form a Group, in January 2025 Trusts nominated non-executive and executive directors to join a working party to develop Terms of Reference for our BSW Hospitals Group Joint Committee. The working party has been supported by legal advisors Browne Jacobson, who have helped other groups across the NHS develop their governance arrangements. The team has completed a Partnership Agreement, incorporating Terms of Reference for a Joint Committee.

The document was reviewed in private Boards in April. In response to those Board discussions a few updates have been made to text:

- Provision for attendance of deputies has been included, in the event of absence of a member [refer s5.4].
- The binding nature of decisions of the Joint Committee in relation to Joint Functions is clarified [refer s8.4]
- Reference is included to duties introduced by the Health and Care Act 2022 on the Trusts to have regard to the wider effects of their decisions and the expenditure limits and use of resources requirements of their system. [refer s10.3]
- In the event of the Joint Committee establishing a committee to oversee a tranche of work, that committee may include members who are not voting members of the Joint Committee [refer s17.3].
- Finally, the cycle of business for the Joint Committee will include a review after six months of operation.

The updated version of the *BSW Hospitals Group Partnership Agreement*, incorporating *Terms of Reference for a Joint Committee* is presented for Board consideration and approval.

Strategic Alignment – select one or more	☐ Outstanding care	☐ Valued teams	☐ Better together	☐ Sustainable future

Link to CQC Domain – select one or more	**Safe** ☐	**Caring** ☐	**Effective** ☐	**Responsive** ☐	**Well-led** ☐

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

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

Explanation of above analysis:

An Equality and Health Inequalities Assessment in relation to BSW Hospitals Group Development Programme was completed in July and August 2024.

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to, in accordance with Board of Directors' decision in July 2024 to form a Group it recommended that the Board of Directors:

1) *Approve the BSW Hospitals Group Partnership Agreement, agreeing:-*

   - *Five Joint Functions - set out in Schedule 3 (Page 22)*
   - *Terms of Reference of a special purpose Joint Committee – set out in Schedule 5 (Page 58)*

2) *Approve the execution of the Partnership Agreement by 9th May;*

3) *Request that the Chair and Chief Executive nominate members of the Joint Committee; and,*

4) *Establish the BSW Hospitals Group Joint Committee in May 2025.*

Accountable Lead Signature	**Cara Charles-Barks, Chief Executive**
Date	**28/04/2025**

Date **2025**

Great Western Hospitals NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Partnership Agreement
for the purpose of establishing Hospital Group Joint Working Arrangements and Appointment of a Joint Committee to Exercise Joint Functions

Version control

Date	Version	Author
18 Feb 2025	001	Browne Jacobson LLP
23 Feb 2025	001B	BSW Programme Team updates
17 Mar 2025	002	Working party updates from 3 March meeting and marked up copies of version 001B
20 Mar 2025	003	Browne Jacobson LLP
26 Mar 2025	004	Feedback incorporated from Board Members re membership, quorum and decision-making.
27 Mar 2025	005	Working party updates from 27 March included: Draft for Board consideration.
14 Apr 2025	006	Updated following review by all three Trust Boards.

Contents

This Agreement is made between the Parties on

PART A – PARTIES

The Parties to this Agreement are

(1) Great Western Hospitals NHS Foundation Trust of Marlborough Road, Swindon, SN36BB (**GWH**)
(2) Royal United Hospitals Bath NHS Foundation Trust of Combe Park, Bath, BA1 3NG (**RUH**) and
(3) Salisbury NHS Foundation Trust of Salisbury District Hospital, Odstock Road, Salisbury, Wiltshire, SP2 8BJ (**SFT**)

Each a Trust and together the Trusts

PART B – BACKGROUND

A. The Background to this Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1

B. GWH is constituted as an NHSFT in accordance with its constitution dated November 2023

C. RUH is constituted as an NHSFT in accordance with its constitution dated 2022

D. SFT is constituted as an NHSFT in accordance with its constitution dated January 2023

E. Each Trust must exercise its Functions in accordance with its respective Governance and having regard to Guidance.

F. The Trusts have worked together collaboratively since 2018 as the Acute Hospital Alliance (AHA) in Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW ICS). The Trusts have formalised this relationship through Committees in Common made up of the Chief Executive, Managing Directors and Chairs.

G. In May / June 2024 the Boards received the Case for Collaboration report which set out recommendations for the collaborative leadership, governance, and development of the Trusts as a group. In July and September 2024 the Boards formally approved eight recommendations developed in light of the Case for Collaboration report.

H. In October 2024 the Trusts implemented recommendation 1 by appointing Cara Charles-Barks as Joint Chief Executive.

I. The Trusts now wish to work together to deliver high quality care to our population more effectively and efficiently. In a climate with increasing financial constraints and demand, a group structure is seen as an appropriate way to do that and future initiatives will include, but are not limited to, the remaining recommendations set out in Schedule 9.

J. Accordingly, the Trusts intend to exercise their powers under sections 65Z5 and 65Z6 of the NHSA to establish and implement joint working and delegation arrangements as set out in this Agreement and to establish a joint committee to exercise Joint Functions.

K. The Trusts accordingly intend that the arrangements set out in this Agreement will supersede and replace their current committees in common arrangements.

L. The Trusts intend to agree to data sharing, access to records and mutual operation of all Joint Functions including human resources and joint line management arrangements to facilitate the exercise of Joint Functions.

M. The Trusts have agreed that the BSW Hospitals Group Joint Committee should exercise Joint Functions but not Reserved Functions.

PART C – OPERATIVE PROVISIONS

1 Definitions and interpretation

This Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1.

2 Purpose of this Agreement

The Trusts have entered this Agreement for the purpose of collaborating as a Group including exercising their powers under s65Z5 and s65Z6 of the NHSA to agree and establish joint working and delegation arrangements.

3 **Creating an Environment for Success**

3.1 The Trusts will:

3.1.1 Work as a Group with pace and agility.

3.1.2 Work collectively to enable provision of seamless services to the population, prioritising resources to provide maximum healthcare benefit, ensuring that patient experience and outcomes are reflected in discussions and decisions.

3.1.3 Communicate frequently, comprehensively and with transparency using multiple channels to reach all patients, staff and partners. Staff will be enabled to relay in clear and simple terms why the group matters to patients and staff.

3.1.4 Actively seek to build trust between themselves and all partners.

3.1.5 Adopt the principle of doing together once what can beneficially be done as a group, allowing the Trusts to deliver that which can only be done locally.

3.1.6 Share learning across the Group as a core behaviour.

3.1.7 Agree a timely definition of the Operating Model which provides clarity and certainty and, once agreed, provide strong and consistent support.

3.1.8 Appoint a highest quality leadership team and provide them strong and consistent support to thrive.

3.1.9 Empower the BSW Hospitals Group Joint Committee which will include the Joint Chief Executive, a Chief Nursing Officer, Chief Medical Officer, Chief Finance Officer, Chief People Officer, Chief Operating Officer, and Director of Estates and Facilities, Managing Director of each Trust, agreed joint Executive Director roles (Chief Strategy Officer and Chief Information and Technology Officer), Joint Chair and a majority of voting NEDs

3.1.10 Ensure the demands on capacity of Non-Executive Directors and Executive Directors are practical, so will review frequency, length and remit of Board committee meetings as the BSW Hospitals Group Joint Committee and other group-level fora emerge.

3.1.11 Establish an annual programme of work that provides focus, clear deliverables and quick wins.

3.1.12 Through the BSW Hospitals Group Joint Committee, be responsible for Group strategy development in accordance with the Group Strategy Framework.

4 Commencement and duration

4.1 The Agreement shall take effect from the Commencement Date and will continue in full force and effect until terminated in accordance with the terms of this Agreement and, in particular but without limitation, in accordance with Clause 19.

4.2 No termination of the Agreement by any of the Trusts shall take effect within the period of three years from the Joint Chair Commencement Date.

5 No merger, acquisition or dissolution

5.1 The Trusts shall remain independent, sovereign organisations constituted in accordance with the NHSA and their respective constitutions.

5.2 Nothing in this Agreement commits the Trusts or is intended to commit them to undertake or apply for merger, acquisition or dissolution or any other transaction whose outcome would be the establishment of a single organisation as successor to any of them.

5.3 Each of the Trusts shall continue at all times to maintain its own individual governance, registrations, licences, memberships, committees and other arrangements that it may be required to maintain or hold by Law, Direction or Guidance including:

5.3.1 Standing Orders, Standing Financial Instructions and Scheme of Delegation

5.3.2 CQC registration

5.3.3 NHS provider licence

5.3.4 ICO registration

5.3.5 NHSR Schemes membership

5.3.6 Remuneration Committee

5.3.7 Audit Committee

5.3.8 Meetings that the Trusts' Boards must each hold in accordance with Schedule 7.

6 Capacity and capability

6.1 The Trusts shall together use their best endeavours to support their leadership capacity and capability:

6.1.1 To focus not on doing more but doing the things only the Trusts can do.

6.1.2 To work in partnership between the Trusts and with others – collaborating as inter-dependent parts of the BSW Hospitals Group and BSW Integrated Care System.

6.1.3 To focus on what the Trusts can do to deliver improvements in the services they provide to the BSW population.

6.2 The Trusts shall together use their best endeavours to improve their leadership capacity and capability through:

6.2.1 The 'golden thread' of working together, learning together, improving together – cultural change.

6.2.2 Maximising the opportunity to transform and work differently that coming together as a Group gives them.

6.2.3 Listening to and delivering through front-line teams based on clear priorities, using an 'Improving Together' approach.

7 Trust Board Appointments

7.1 Voting NEDs of each Trust shall continue to be appointed by its CoG in accordance with its Constitution.

7.2 Voting EDs of each Trust shall continue to be appointed by its Remuneration Committee:

7.3 Each Trust shall (in compliance with its Constitution) continue to maintain a functioning Board comprising Voting NEDs (including the Chair) and Voting EDs whose numbers will be neither less nor more than the number of Voting NEDs and Voting EDs prescribed by its Constitution.

7.4 For the purpose of developing Group Operating Model and Governance arrangements the Trusts including their Councils of Governors shall cooperate to appoint Joint Directors where the BSW Hospitals Group Joint Committee recommends that they should do so.

8 Appointment of Joint Committee

8.1 The Trusts shall establish a special purpose Joint Committee to be known as the BSW Hospitals Group Joint Committee.

8.2 The BSW Hospitals Group Joint Committee shall be fully and equally accountable to each Trust.

8.3 The BSW Hospitals Group Joint Committee membership (including the number of members, and balance between EDs and NEDs) shall be agreed by each Trust.

8.4 The BSW Hospitals Group Joint Committee ToR shall be substantially in the form set out in Schedule 5 and shall include the provisions set out in Clause 8.5.

8.5 The provisions referred to in Clause 8.4 are:

8.5.1 All the Voting Directors of each Trust shall be eligible for appointment as voting members of the BSW Hospitals Group Joint Committee during their terms of office

8.5.2 The Trusts may agree in writing to appoint Non-Voting Directors and/or other individuals to be voting members of the BSW Hospitals Group Joint Committee

8.5.3 The Trusts and BSW Hospitals Group Joint Committee shall have Committees in accordance with Clause 12

8.5.4 The BSW Hospitals Group Joint Committee shall exercise the Joint Functions

8.5.5 The proceedings of the BSW Hospitals Group Joint Committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the BSW Hospitals Group Joint Committee.

9 Joint Exercise of Functions

9.1 Subject to Clause 9.2 the Trusts agree that:

9.1.1 They shall jointly exercise their Joint Functions

9.1.2 If the BSW Hospitals Group Joint Committee appoints a Committee in accordance with Clause 12, then the BSW Hospitals Group Joint Committee may authorise the Committee to exercise Joint Functions that the BSW Hospitals Group Joint Committee expressly subdelegates to the Committee in its ToR.

9.1.3 The BSW Hospitals Group Joint Committee may authorise one of the Trusts to contract with a third party on behalf of itself alone or the Trusts jointly and/or severally subject to compliance with the Trusts' standing orders and standing financial instructions.

9.2 Subject to Clause 8.5.5, the Trusts agree that they, the BSW Hospitals Group Joint Committee and their Committees, directors and officers shall always comply with each of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation when they are exercising Joint Functions.

10 Workforce

10.1 Each Trust shall continue to employ its own workforces

10.2 The Trusts intend that in the exercise of their joint working arrangements, members of one Trust's workforce may be line managed by duly authorised officers of one or more of the Trusts.

11 Exercise of Reserved Functions

11.1 The Trusts shall continue to exercise separately their Reserved Functions.

11.2 The Trusts agree that the BSW Hospitals Group Joint Committee shall not at any time exercise their Reserved Functions.

12 Appointment of Committees and Committees in Common

12.1 The BSW Hospitals Group Joint Committee shall have the following Committees (sub-committees to the Joint Committee):

- Electronic Patient Record (EPR) Committee
- Financial Sustainability Committee
- Group Development, Strategy & Planning Committee

12.2 For the purpose of assisting the exercise of Joint Functions the BSW Hospitals Group Joint Committee may appoint one or more Committees additional to those set out in Clause 12.1.

12.3 The voting members of a Committee of the BSW Hospitals Group Joint Committee may comprise or include individuals who are or are not voting members of the BSW Hospitals Group Joint Committee.

12.4 For the purpose of assisting the exercise of their Mandatory Reserved Functions the Trusts may appoint Committees in Common.

12.5 Without prejudice to the generality of Clause 12.4, the Boards of each of the Trusts (acting as independent, sovereign bodies) may consider and (if agreed by each Board) arrange for their like for like committees to operate together as Committees in Common.

12.6 For illustrative purposes an organogram of the Trusts' Committees structure as at the Commencement Date is set out in Schedule 6.

13 Operating Principles

13.1 The Trusts shall exercise their Functions having regard to best practice in effective collaborative and system leadership, adopting the operating principles set out in Clause 13.2, and further commitments set out in Clause 13.3.

13.2 The operating principles referred to in Clause 13.1 are:

13.2.1 Create value for the population

13.2.2 Create constancy of purpose

13.2.3 Think systematically

13.2.4 Lead with humility

13.2.5 Respect every individual

13.3 In addition, the Trusts together commit to:

13.3.1 Develop a shared purpose and vision for the population we serve

13.3.2 Ensure frequent personal contact to build understanding and trust

13.3.3 Surface and resolve conflicts, not letting them fester

13.3.4 Work collectively for the long-term

13.3.5 Behave altruistically towards partners

13.3.6 An open book approach to information to build understanding and trust.

13.3.7 Be facilitative, enabling and pace setting in their role as System leaders.

14 Benefits

14.1 The Trusts shall exercise their Functions having regard to unlocking benefits set out in Clause 14.2. The benefits of group formation and approach to measurement and evaluation of those benefits will be set out in detail in **BSW Hospitals Group Business Case** and **Return on Investment plan**, which will be developed alongside the **Group Operating Model** and **Governance and Accountability Framework**.

14.2 The benefits referred to in Clause 14.1 are:

14.2.1 Together we will make the best use of collective resources available to us to support the population we serve. Our decisions will be judged by their ability to make best use of resources for Group in BSW, working to deliver the BSW Integrated Care Partnership strategy.

14.2.2 A collective approach will enable enhanced clinical effectiveness – spreading best practice, and responding to inequity, fragile services, improving fairness across BSW.

14.2.3 A collective approach will enable service viability – it will be easier to create high quality resilient services in Group for the BSW population. We will work to avoid creation or emergence of unacceptable levels of fragility to services and individual Trusts.

14.2.4 We need to change how we operate. Individually, Trust sustainability is challenging. A group model offers Trusts opportunity to remain as stand-alone local organisations focused on needs of population within the support structure of a group.

14.2.5 A group model offers a range of benefits for staff, including increased service resilience, enhanced career development and specialization opportunities. It also offers the ability to work within a wider network of professionals, spreading learning, improving training and development provision, freeing-up capacity by reducing duplication.

15 Organisational development

The Trusts will develop and adopt a shared organisational development programme.

16 Resourcing the BSW Hospitals Group Joint Committee

The Trusts shall be jointly responsible for resourcing the BSW Hospitals Group Joint Committee.

17 Pooled Fund

17.1 The Trusts may enter arrangements for the Trusts themselves or the BSW Hospitals Group Joint Committee to establish and maintain a Pooled Fund.

17.2 Arrangements for any Pooled Fund must be on terms set out in a Pooled Fund Agreement.

18 Variation

18.1 Except as set out in Clause 18.2 or otherwise in this Agreement, any Variation of this Agreement, including the introduction of any additional terms and conditions, shall only be binding when agreed by written resolutions of each Trust's Board.

18.2 The Scheme for Trust Board Appointments set out in Schedule 8, the Governance Organogram for the Trusts' Appointment of Committees as at the Commencement Date set out in Schedule 6 and the Recommendations set out in Schedule 9 are intended to be illustrative only and may be updated by resolution of the BSW Hospitals Group Joint Committee without the requirement for Variation set out in Clause 18.1.

19 Termination

19.1 The Trusts acknowledge and confirm that, save in accordance with this Clause 19, none of them shall be entitled to terminate this Agreement.

19.2 The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement in consequence of any breach (whether material or otherwise) of any provision of this Agreement by the other.

19.3 The Trusts acknowledge and confirm that they have considered and understood the position set out at Clause 19.2 above and that the provisions of Clause 4.2 (and Clause 24 in relation to the Dispute Resolution Procedure) shall apply in the event of any breach of this Agreement.

19.4 Subject to Clause 4.2 , a Trust may only terminate this Agreement by giving Notice of Termination specifying a minimum notice period that expires on the next 31 March which is not less than six months before the third anniversary of

the Joint Chair Commencement Date if it expires on the third anniversary of the Joint Chair Commencement Date or (if it expires on a date after the third anniversary of the Joint Chair Commencement Date) twelve (12) months from the date the notice of termination is served. The notice period may be shorter where agreed in writing by the other Trusts.

20 Consequences of termination

20.1 On or pending termination of this Agreement, the Trusts will agree an Exit Plan to ensure that the services provided by any Trust are not destabilised. The Trusts shall use best endeavours to agree the Exit Plan no less than six (6) months prior to termination of this Agreement

20.2 For a reasonable period before and after termination of this Agreement the Trusts shall co-operate fully with one another and ensure that the Exit Plan provides for continuity of services and a smooth transition of Trust Boards whilst avoiding any inconvenience or risk to the health and safety of the Trusts' service users, employees or members of the public.

20.3 This Clause 20 shall continue in full force and effect on or after termination of this Agreement.

21 Data sharing and confidentiality

Each Trust undertakes that it shall not at any time during the period for which this Agreement applies, and for a period of five years after termination of this Agreement, disclose to any person any Confidential Information concerning or in connection with the other Trust or this Agreement except as permitted by Schedule 7.

22 No partnership

Except as expressly provided in this Agreement, nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between the Trusts, constitute one Trust the agent of another Trust, nor authorise a Trust to make or enter any commitments for or on behalf of another Trust.

23 Notices

23.1 A notice given under this Agreement:

23.1.1 Will be in writing in the English language

23.1.2 Will be sent to the intended recipient by email to the following address or such other address as the Party has notified for the purposes of this clause:

(a) For GWH, the Chief Executive Officer of GWH in post at the time of the notice

(b) For RUH, the Chief Executive Officer of RUH in post at the time of the notice

(c) For SFT, the Chief Executive Officer of SFT in post at the time of the notice

23.2 Any notice or other communication given to a Trust under or in connection with the Agreement shall be in writing, addressed to the authorised representatives at the Trust's principal place of business or such other address as that Trust may have specified to the other Trusts in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery, commercial courier or email.

23.3 A notice or other communication shall be deemed to have been received:

23.3.1 If delivered personally, when left at the address referred to in Clause 23.2; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Business Day after posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed; or, if sent by fax, one (1) Business Day after transmission.

23.3.2 If delivered by email, immediately on sending provided it is correctly addressed or if deemed receipt is not within business hours (meaning prior to 5.30 pm and excluding weekends and public holidays in England), then it will be deemed to have been received at 9.00 am on the next day that is not a weekend or a public holiday in England.

23.4 The provisions of this Clause 23 shall not apply to the service of any proceedings or other documents in any legal action.

24 Dispute Resolution

24.1 In accordance with Clauses 4.2 and 19 regarding termination of the Agreement, the Trusts agree to this dispute resolution process.

24.2 In a case where it has not been possible or appropriate to seek to resolve any dispute informally, a Trust shall promptly serve on the other Trusts a Notice (a 'Dispute Notice') of any dispute or claim or any potential dispute or claim in relation to this Agreement or its operation (each a 'Dispute') when it arises.

24.3 A Dispute Notice must contain a particularised account of the Dispute and the resolution sought.

24.4 In the first instance the Chair(s) shall seek to resolve any Dispute to the mutual satisfaction of each of the Trusts.

24.5 If the Dispute cannot be resolved by the Chair(s) within ten (10) Working Days of the Dispute being referred to it, the Dispute shall be referred to the ICB Chair.

24.6 The ICB Chair will consider and reach a position on the Dispute which, in the view of the ICB Chair, is the most consistent with the principles set out in this Agreement.

24.7 If a Trust does not agree with the position reached by the ICB Chair, it may within ten (10) Working Days of receiving notice of the ICB Chair position, refer the Dispute to an independent facilitator.

24.8 Where it has not been possible or appropriate to seek to resolve any dispute informally, if the Trusts consider doing so appropriate before or instead of

making a referral to the ICB under Clause 24.5, they may refer the Dispute to an independent facilitator.

24.9 If the Trusts are unable to agree on an independent facilitator or the terms of their appointment within seven (7) Working Days of any Trust serving details of a suggested independent facilitator on the others, any Trust shall then be entitled to request NHS England to appoint an appropriately experienced and reputable independent facilitator and for NHS England to agree with the terms of appointment.

24.10 The independent facilitator shall act on the following basis:

24.10.1 The independent facilitator shall decide the procedure to be followed in the determination and shall be requested to make their determination within thirty (30) Working Days of their appointment or as soon as reasonably practicable thereafter. The Trusts shall assist and provide the documentation that the independent facilitator requires for the purpose of the determination

24.10.2 The determination process shall be conducted in private and shall be confidential

24.10.3 The independent facilitator shall have its costs and disbursements met by the Trusts.

24.11 The Trusts recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Trust.

24.12 In the case of dispute between the Boards leading to consideration of termination, Clauses 3.2 and 3.3 determine the timescale and Clause 18 in respect of notification of termination.

25 Other general provisions

25.1 Each Trust shall (at its own expense) promptly execute and deliver such documents, perform such acts and do such things as the other Trust may reasonably require from time to time for the purpose of giving full effect to this Agreement.

25.2 Each Trust will bear its own costs of negotiating and entering into this Agreement.

25.3 This Agreement is personal to each of the Trusts who shall not assign, transfer, mortgage, charge, declare a trust of, or deal in any other manner with any of its rights and obligations under this Agreement without the prior written consent of the other Trusts.

25.4 This Agreement (together with the documents referred to in it) constitutes the entire agreement between the Trusts and supersedes and extinguishes all previous discussions, correspondence, negotiations, drafts, agreements, promises, assurances, warranties, representations and understandings between them, whether written or oral, relating to its subject matter.

25.5 No failure or delay by a Trust to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or

remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy. A waiver of any right or remedy under this Agreement or by law is only effective if it is in writing.

25.6 Except as expressly provided in this Agreement, the rights and remedies provided under this Agreement are in addition to, and not exclusive of, any rights or remedies provided by law.

25.7 If any provision or part-provision of this Agreement is or becomes invalid, illegal or unenforceable, it shall be deemed modified to the minimum extent necessary to make it valid, legal and enforceable. If such modification is not possible, the relevant provision or part-provision shall be deemed deleted. Any modification to or deletion of a provision or part-provision under this Clause shall not affect the validity and enforceability of the rest of this Agreement.

25.8 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

25.9 No one other than a party to this Agreement shall have any right to enforce any of its terms.

25.10 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

25.11 Each Trust irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims).

The Trusts have executed this Agreement as set out below on the date stated at the beginning of it.

PART D – SCHEDULES

Schedule 1 – Definitions and Interpretation

1 In this Agreement capitalised words and expressions shall have the meanings given to them as follows:

Word or expression	**Meaning**
Agreement	This partnership agreement (including its Schedules) which sets out arrangements for the purpose the Trusts exercising their Functions jointly
Arrangements for delegation and joint exercise of statutory functions	NHS England Guidance *Arrangements for delegation and joint exercise of statutory functions – Guidance for integrated care boards, NHS trusts and foundation trusts* dated 27 March 2023 (Publication approval reference: PRN00346)
Audit Committee	A Committee that each of the Trusts must appoint in accordance with NHS England's *Code of governance for NHS provider trusts* (2022) to ensure that it operates effectively and meets its statutory and strategic objectives, and to provide it with assurance that this is the case
CEO	A Voting ED who is the Chief Executive Officer of one or more of the Trusts
Chair	A Voting NED who is the Chair of one or more of the Trusts
Commencement Date	[DATE]
Committee	A committee or subcommittee of one of the Trusts or a subcommittee of a joint committee (including the BSW Hospitals Group Joint Committee)
CiC or Committees in Common	Arrangements between the Trusts to appoint like for like Committees with the same or equivalent terms of reference and

Word or expression	Meaning
	memberships so that they may meet simultaneously with shared agenda and minutes
Conditions for Success	the conditions for success set out in Clause 3
CoG	Council of Governors
CQC	Care Quality Commission
Constitution	The constitution of an NHSFT that has been approved by its Board of Directors and CoG and is in force at the relevant time of their respective decision-making and exercise of functions
Direction	A direction to a Trust that the Secretary of State or NHS England may issue in the exercise of their respective functions under Legislation
Director	A NED or an ED of one or more of the Trusts
ED or Executive Director	an executive director who may be Voting ED or a Non-Voting ED
Exit Plan	A plan for the transition of any affected services and required changes to the Trust Boards on the termination of this Agreement to include: (i) details of the affected services; (ii) details of service users and/or user groups affected; (iii) the joint working arrangements and jointly exercised functions that will need to continue to ensure continuity of services and how these will be transitioned into separate arrangements for each Trust; (iv) the intended timescales for the Exit Plan
Functions	All the duties and/or powers of the Trusts under the NHSA or their constitutions or any other legislation or otherwise conferred by any other source whatsoever

Word or expression	**Meaning**
Governance	A Trust's Constitution, Standing Orders and Schedule 7
Group	The Trusts jointly working together as a hospitals' group in accordance with this Agreement
Group Strategy Framework	The group strategy framework set out in Schedule 2
Guidance	Any statutory guidance of the Secretary of State or NHS England to NHS bodies comprising or including NHS trusts (for example *Arrangements for delegation and joint exercise of statutory functions*) or other non-statutory guidance that the Trusts must have regard to in accordance with their NHS provider licence
Joint Chair Commencement Date	The date of commencement in post of the Joint Chair
Joint Committee	A joint committee that the Trusts have agreed to establish under section 65Z6 of the NHSA to exercise Joint Functions in accordance with the BSW Hospitals Group Joint Committee ToR
Joint Committee ToR	ToR of the BSW Hospitals Group Joint Committee
Joint Functions	Any Functions which the Trusts agree are jointly exercisable by them in accordance with Schedule 3
Legislation	An Act of Parliament (for example the NHSA) or statutory instrument (for example the NHSM&P Regulations)
Mandatory Reserved Functions	Any Reserved Functions that the Trusts may not delegate and/or exercise jointly under Legislation or Guidance

Word or expression	Meaning
NED or Non-Executive Director	A non-executive director who may be Voting NED or a Non-Voting NED
NHSA	National Health Service Act 2006
NHSFT	NHS foundation trust within the meaning of section 30 of the NHSA
NHSR Schemes	The indemnity schemes known as the Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and Property Expenses which the Secretary of State has established under the NHSA and which are managed on her behalf by NHS Resolution
Non-Voting ED	An Executive Director who is not a Voting Director
Non-Voting NED	A Non-Executive Director who is not a Voting Director
Notice of Termination	Notice in writing from one Trust to the other Trust to terminate this Agreement in accordance with Clause 19
Pooled Fund	A fund to be made up of payments received in accordance with arrangements between the Trusts that must be set out in a Pooled Fund Agreement and out of which payments may be made in accordance with the arrangements towards expenditure incurred in the exercise of Joint Functions
Pooled Fund Agreement	An agreement in writing between the Trusts for the establishment of a Pooled Fund in accordance with section 65Z6 of the NHSA
Remuneration Committee	A Committee that each Trust must appoint whose responsibilities include functions under paragraphs 17(3), 17(4) and 18(2) of Schedule 7:

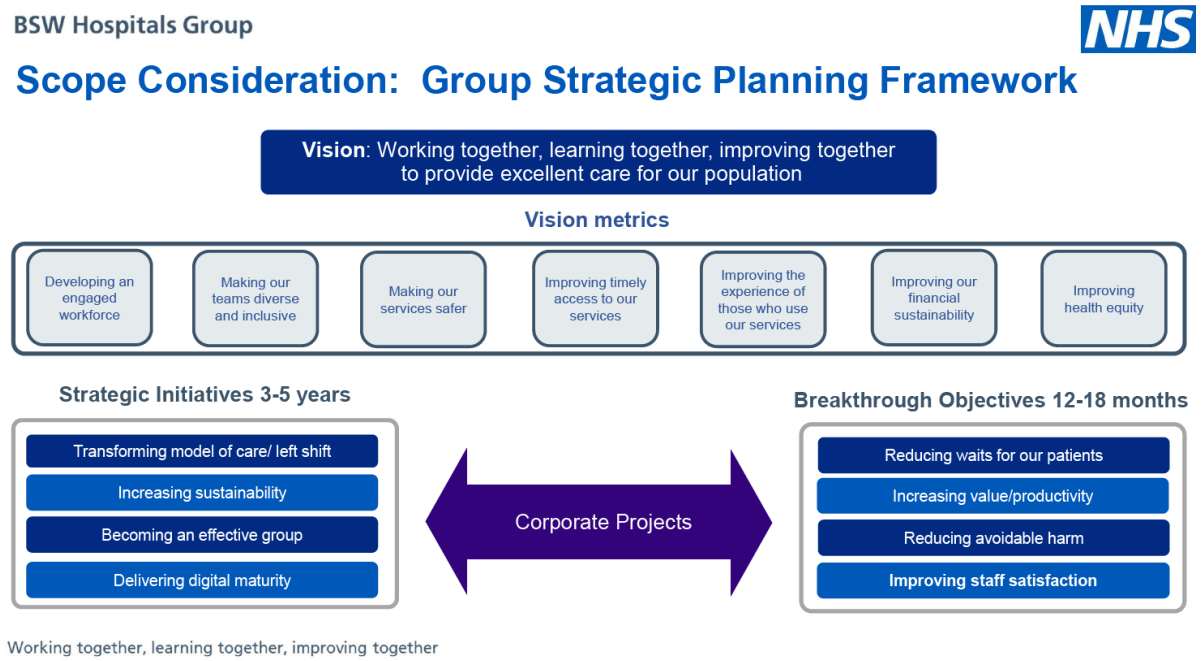
Word or expression	**Meaning**
	• (The CEO not being a member of it) to appoint the Trust's CEO and to determine the remuneration and terms of service of the CEO and other executive directors and • (The CEO being a member of it) to appoint the other executive directors
Reserved Functions	Any Functions that are not Joint Functions
Schedule 7	Schedule 7 of the NHSA unless it is intended to refer to Schedule 7 of this Agreement
Secretary of State	Secretary of State for Health and Social Care
Standing Orders	The standing orders of each of the Trust's board of directors and/or the standing orders of its CoG that the Trust is required to adopt by its Constitution for the regulation of their proceedings and business
ToR	Terms of reference
UK GDPR	Has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.
Variation	A variation of this Agreement in accordance with Clause 18
Voting Director	A Voting ED or a Voting NED
Voting ED	A Director who is an executive director of one of the Trusts within the meaning of paragraph 16 of Schedule 7 and has been appointed by the NEDs and (except for the CEO's appointment) the CEO in accordance with the NHSFT's Constitution

Word or expression	**Meaning**
Voting NED	A Director who is a non-executive director of one of the Trusts within the meaning of paragraph 16 of Schedule 7 and has been appointed by the Trust's CoG in accordance with its Constitution
Working Day	A day (other than a Saturday, Sunday or public holiday) when banks in London are open for business.

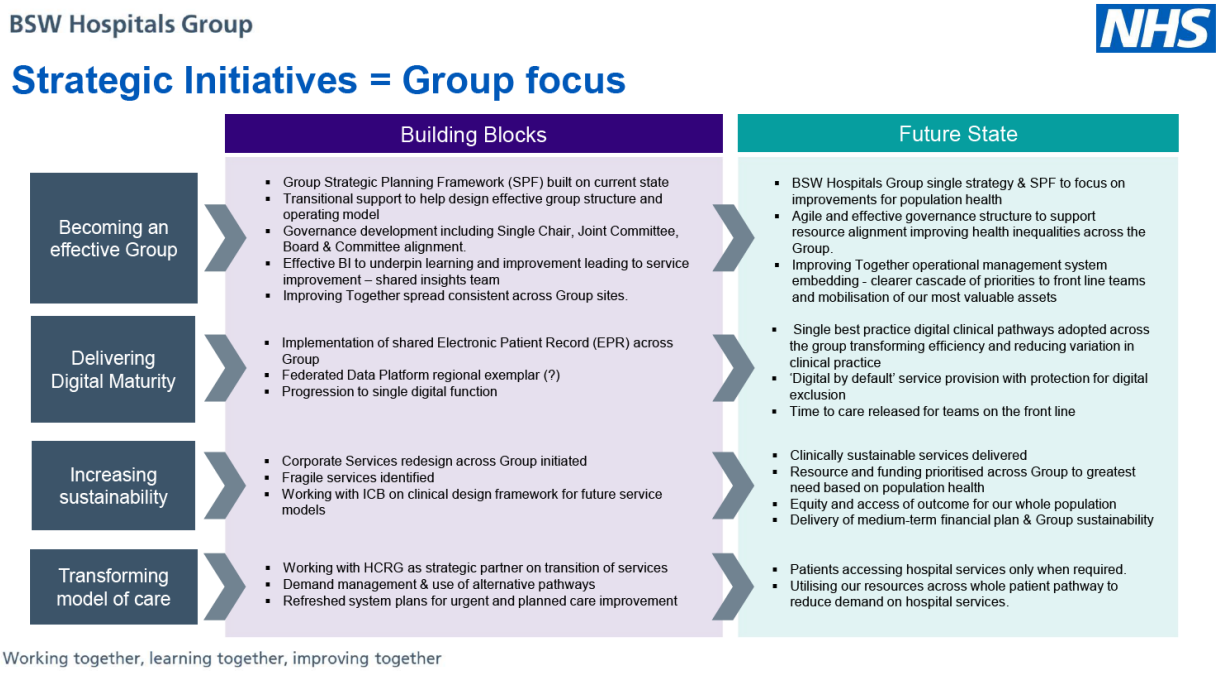
2 Any reference to the exercise by the Trusts of Joint Functions shall be interpreted to include any exercise of Joint Functions by the BSW Hospitals Group Joint Committee or a Committee of it on behalf of the Trusts.

Schedule 2 Group Strategy Framework

Part 1 - Strategic Planning Framework



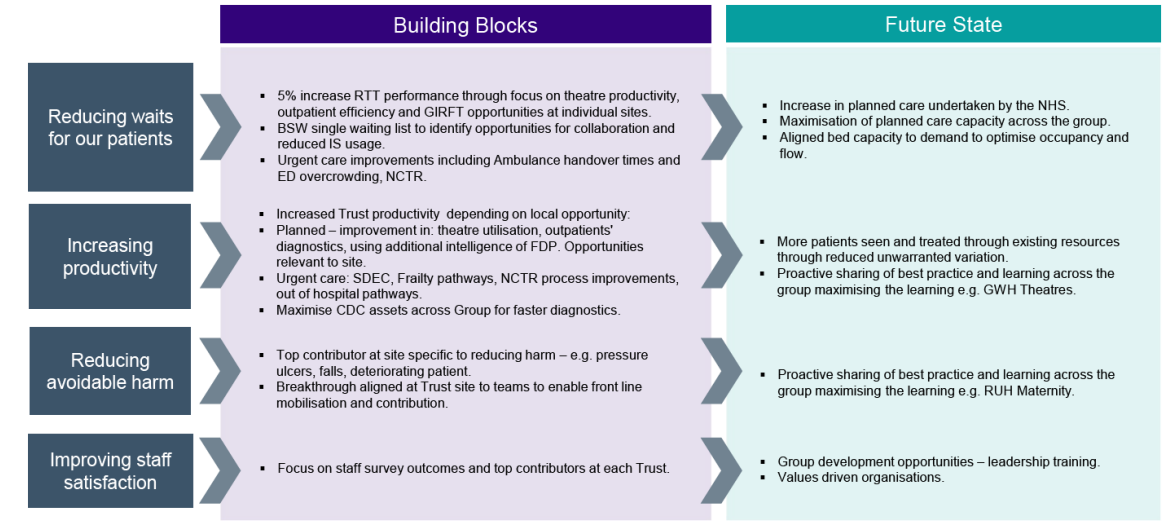
Part 2 – Group Focus



Part 3 – Trust Focus

BSW Hospitals Group

Breakthrough objectives = Trust focus



Working together, learning together, improving together

Schedule 3 – Joint Functions

1 Subject to paragraph 2:

1.1 Joint Functions are any Functions relating to any of the matters set out in paragraph 3 below.

1.2 Joint Functions may additionally include any or all Functions that NHS England has categorised as 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in Paragraph 4 below (excluding references to legislation that is applicable to or in force in Wales only) which the Trusts agree by Variation should be Joint Functions.

2 Joint Functions may not at any time include Mandatory Reserved Functions.

3 The matters referred to in paragraph 1.1 are:

3.1 Group Strategy & Planning Framework

- Development, approval and delivery of overarching Group Strategy and associated specialist development and delivery plans, including Group Clinical, Workforce, Financial Sustainability, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital Plans.
- Development, approval and delivery of Group Strategic Planning Framework and Annual Group-wide Plan.
- Oversight of delivery of Group Strategic Initiatives.
- Management of risk to delivery of Group Strategy

3.2 Transforming our Model of Care for the BSW Population we Serve - Clinical Services Organisation/ Pathways/ Design

- Development of Group **clinical services framework for the collective population we serve** with associated decision-making processes.
- **Approval** of service/pathway/treatment configuration changes across the Group.

3.3 Financial Sustainability - Use of Resources

- Setting and delivery of Group Financial Recovery and long-term Group financial sustainability.
- Capital Programme. Development and approval of capital investment programme for the Group ensuring we attract capital into BSW to address priorities.
- Capital Programme. Development and approval of capital limits for each Trust within the group to be delegated.

3.4 Group Mobilisation & Development

- Oversight of Group Mobilisation & Development. Approval of Group Operating Model, including Accountability Framework and associated Integrated Performance Reporting.

- Oversight of delivery of the Case for Collaboration and emerging agreed priorities. Includes programme oversight of 10x workstreams from case for collaboration – with details, phasing and resourcing agreed in Group annual plan.

- Group Development - Corporate Services – Define objectives, shape and structure of Group corporate services transformation. Approve resourcing of programme.

3.5 Achieving Digital Maturity

- EPR Programme – Oversight of Implementation. Approval of new Benefits Profile. Approval of proposals for new Budget.

- Group Digital transformation programme – implementation [x-refer 3.1]

4 The table referred to in paragraph 1.2 is as follows:

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 43 NHS Act 2006	(2) An NHS foundation trust may provide goods and services for any purposes related to— (a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and (b) the promotion and protection of public health. (2A) An NHS foundation trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes. (3) An NHS foundation trust may also carry on activities other than those mentioned in subsection (2) for the purpose of making additional income available in order better to carry on its principal purpose.	ANCILLARY FUNCTION	Yes
Section 44 NHS Act 2006	(6) According to the nature of its functions, an NHS foundation trust may, in the case of patients being provided with goods and services for the purposes of the health service, make accommodation or further services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS foundation trust in respect of the accommodation or services. (7) An NHS foundation trust may exercise the power conferred by subsection (6) only to the extent that its exercise does not to any significant extent interfere with the performance by the NHS foundation trust of its functions.	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 47 NHS Act 2006	(1) An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. (2) In particular it may– (a) acquire and dispose of property, (b) enter into contracts, (c) accept gifts of property (including property to be held on trust for the purposes of the NHS foundation trust or for any purposes relating to the health service), (d) employ staff. (3) Any power of the NHS foundation trust to pay remuneration and allowances to any person includes power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay). (4) "The purposes of the NHS foundation trust" means the general or any specific purposes of the trust (including the purposes of any specific hospital at or from which services are provided by the trust).	ANCILLARY FUNCTION	Yes
Section 47A NHS Act 2006 as inserted by section 64 of the Health and Care Act 2022	Joint exercise of functions An NHS foundation trust may enter into arrangements for the carrying out, on such terms as the NHS foundation trust considers appropriate, of any of its functions jointly with any other person.	CORPORATE	Yes
Section 56 NHS Act 2006	(1) An application may be made jointly by– (a) an NHS foundation trust, and (b) another NHS foundation trust or an NHS trust	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	established under section 25, to the regulator for the dissolution of the trusts and the establishment of a new NHS foundation trust. (1A) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (2) The application must– (a) be supported by the Secretary of State if one of the parties to it is an NHS trust, (b) specify the property and liabilities proposed to be transferred to the new NHS foundation trust, and (d) be accompanied by a copy of the proposed constitution of the new trust (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trusts and the establishment of the proposed new trust have been taken. (11) On the grant of the application, the proposed constitution of the NHS foundation trust has effect, but the directors of the applicants may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.		
Section 56A NHS Act 2006	56A Acquisitions (1) An application may be made jointly by— (a) an NHS foundation trust (A), and (b) another NHS foundation trust or an NHS trust established under section 25 (B), to the regulator for the acquisition by A of B.	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(2) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (3) The application must— (a) be supported by the Secretary of State if B is an NHS trust, and (b) be accompanied by a copy of the proposed constitution of A, amended on the assumption that A acquires B. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the acquisition have been taken. (4A) Where the regulator proposes to grant the application, it may by order make provision for the transfer of employees of B to A on the grant of the application. (5) On the grant of the application, the proposed constitution has effect, but where a person who is specified as a director of A in the constitution has yet to be appointed as such, the directors of A may exercise that person's functions under the constitution.		
Section 63 NHS Act 2006	An NHS foundation trust must exercise its functions effectively, efficiently and economically.	ANCILLARY FUNCTION	Yes
Section 63A NHS Act 2006	(1) In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to— (a) the health and well-being of the people of England;	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) the quality of services provided to individuals— (i) by relevant bodies, or (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.		
Section 65Z5 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint working and delegation arrangements (1) A relevant body may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the following— (a) a relevant body (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) In this section "relevant body" means— (a) NHS England, (b) an integrated care board, (c) an NHS trust established under section 25, (d) an NHS foundation trust, or (e) such other body as may be prescribed.	CORPORATE	Yes
Section 65Z6 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint committees and pooled funds (1) This section applies where a function is exercisable jointly (by virtue of section 65Z5 or otherwise) by a relevant body and any one or more of the following— (a) a relevant body; (b) a local authority (within the meaning of section 2B);	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(c) a combined authority. (2) The bodies by whom the function is exercisable jointly may— (a) arrange for the function to be exercised by a joint committee of theirs; (b) arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.		
Section 72 NHS Act 2006	(1) It is the duty of NHS bodies to co-operate with each other in exercising their functions.	ANCILLARY FUNCTION	Yes
Section 82 NHS Act 2006	In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.	ANCILLARY FUNCTION	Yes
Section 223L NHS Act 2006	(1) NHS England may set joint financial objectives for integrated care boards and their partner NHS trusts and NHS foundation trusts. (2) An integrated care board and its partner NHS trusts and NHS foundation trusts must seek to achieve any financial objectives set under this section.	CORPORATE	Yes
Section 223LA NHS Act 2006	(1) An integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that their expenditure in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year.	CORPORATE/ ANCILLARY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 223M NHS Act 2006	(1) Each integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that, in respect of each financial year— (a) local capital resource use does not exceed the limit specified in a direction by NHS England; (b) local revenue resource use does not exceed the limit specified in a direction by NHS England.	CORPORATE/ ANCILLARY	Yes
Section 242 NHS Act 2006	(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in– (a) the planning of the provision of those services, (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation of those services.	ANCILLARY FUNCTION	Yes
Section 249 NHS Act 2006	(1) In exercising their respective functions, NHS bodies (on the one hand) and the prison service (on the other) must co-operate with one another with a view to improving the way in which those functions are exercised in relation to securing and maintaining the health of prisoners.	ANCILLARY FUNCTION	Yes
Criminal Justice Act 2003, Section 325(3)	In establishing those arrangements for the purpose of assessing and managing risks posed by relevant sexual	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	and violent offenders &c, the responsible authority i.e. the chief officer of police, the local probation board for that area or (if there is no local probation board for that area) a relevant provider of probation services and the Minister of the Crown exercising functions in relation to prisons, acting jointly must act in co-operation with the persons specified in subsection (6); and it is the duty of those persons to co-operate in the establishment by the responsible authority of those arrangements, to the extent that such co-operation is compatible with the exercise by those persons of their relevant functions. NHS trusts are included among persons in sub-s (6)(h).		
Mental Health (Care and Treatment) (Scotland) Act 2003, Section 31	(1) Where it appears to a local authority that the assistance of a Health Board, a Special Health Board or a National Health Service trust– (a) is necessary to enable the authority to perform any of their duties under section 25 or 26 of this Act i.e. relating to provision of care and support services and services designed to promote well-being and independence; or (b) would help the authority to perform any of those duties, the authority may request the Health Board, Special Health Board or National Health Service trust to co-operate by providing the assistance specified in the request. (2) A Health Board, a Special Health Board or a National Health Service trust receiving a request under subsection (1) above shall, if complying with the request– (a) would be compatible with the discharge of its own	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	functions (whether under any enactment or otherwise); and (b) would not prejudice unduly the discharge by it of any of those functions, comply with the request.		
National Health Service Trust (Scrutiny of Deaths) (England) Order 2021, article 3	(1) An NHS trust in England may scrutinise the death of any person who has died in England where— (a) a senior coroner is not under a duty to investigate the death under section 1 of the Coroners and Justice Act 2009, or (b) it is unclear whether the death is one which a registered medical practitioner would be required to notify to the relevant senior coroner under the Notification of Deaths Regulations 2019.	ANCILLARY FUNCTION	Yes
Social Workers Regulations 2018, reg 7	(1) The persons specified for the purposes of section 53(1)(d) of the Act i.e the Children and Social Work Act 2017, which requires Social Work England ("the regulator") to cooperate with, among others, any person specified in regulations made by the Secretary of State are— (d) any NHS trust established under section 25 of the National Health Service Act 2006,	ANCILLARY FUNCTION	Yes
Children Act 2014, s11(2); (4)	(2) Each person and body to whom this section applies which includes NHS Trusts by ss(1) must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need. (4) Each person and body to whom this section applies must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Secretary of State.		
Children Act 2014, Section 25(5) [Applicable in Wales only]	(1) Each local authority in Wales must make arrangements to promote co-operation between– (a) the authority; (b) each of the authority's relevant partners which includes NHS Trusts by ss(4)(e); and (c) such other persons or bodies as the authority consider appropriate, being persons or bodies of any nature who exercise functions or are engaged in activities in relation to children in the authority's area. (2) The arrangements under subsections (1) and (1A) not reproduced here are to be made with a view to— (a) improving the well-being of children within the authority's area, in particular those with needs for care and support; (b) improving the quality of care and support for children provided in the authority's area (including the outcomes that are achieved from such provision); (c) protecting children who are experiencing, or are at risk of, abuse, neglect or other kinds of harm (within the meaning of the Children Act 1989). (5) The relevant partners of a local authority in Wales	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	must co-operate with the authority in the making of arrangements under this section.		
Children Act 2014, Section 25(6) [Applicable in Wales only]	(6) A local authority in Wales and any of their relevant partners may for the purposes of arrangements under this section– (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund as defined by ss(7).	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(8) [Applicable in Wales only]	(8) A local authority in Wales and each of their relevant partners must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 27(3) [Applicable in Wales only]	(3) An NHS trust to which section 25 see lines above applies must– (a) appoint an executive director, to be known as the trust's "lead executive director for children and young people's services", for the purposes of the trust's functions under that section; and (b) designate one of the trust's non-executive directors as its "lead non-executive director for children and young people's services" to have the discharge of those functions as his special care.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 28(2) [Applicable in Wales only]	(2) Each person and body to whom this section applies including an NHS trust all or most of whose hospitals, establishments and facilities are situated in Wales, by ss(1)(c) must make arrangements for ensuring that–	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.		
Children Act 2014, Section 28(4) [Applicable in Wales only]	(4) The persons and bodies referred to in subsection (1)(a) to (c) and (i) must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Assembly.	ANCILLARY FUNCTION	Yes
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s2(1) [Not in force]	(1) A relevant health organisation which includes NHS trusts by s13 that operates a mental health unit must appoint a responsible person for that unit for the purposes of this Act.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s3(1) [Not in force]	(1) The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Mental Health Units (Use of Force) Act 2018, s11(2) [Not in force]	(2) In exercising functions under this Act, responsible persons and relevant health organisations which includes NHS Trusts by s13 must have regard to guidance published by the SoS by ss(1) under this section.	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s4(3) [In force in Wales only]	(3) The following persons must, when exercising functions under this Part, have regard to any relevant guidance contained in the code on additional learning needs issued by the Welsh Ministers by ss(1)]— (h) an NHS trust;	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s20 [In force in Wales only]	(4) If a matter is referred to an NHS body which includes an NHS Trust by s99(1) under this section, the NHS body must consider whether there is a relevant treatment or service as defined by ss(6) that is likely to be of benefit in addressing the child's or young person's additional learning needs. (5) If the NHS body identifies such a treatment or service, it must— (a) secure the treatment or service for the child or young person, (b) decide whether the treatment or service should be provided to the child or young person in Welsh, and (c) if it decides that the treatment or service should be provided to the child or young person in Welsh, take all reasonable steps to secure that the treatment or service is provided in Welsh.	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s21 [In force in Wales only]	Various duties (not set out in full here) consequent on the NHS body identifying (or not identifying) a relevant treatment or service per s20	COMMISSIONING	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s64 [In force in Wales only]	(1) This section applies where a health body mentioned in subsection (2) which includes an NHS Trust, in the course of exercising its functions in relation to a child who is under compulsory school age and for whom a local authority is responsible, forms the opinion that the child has, or probably has, additional learning needs. (3) The health body must inform the child's parent of its opinion and of its duty in subsection (4). (4) After giving the parent an opportunity to discuss the health body's opinion with an officer of the body, the health body must bring it to the attention of the local authority that is responsible for the child or, if the child is looked after, to the attention of the local authority that looks after the child, if the health body is satisfied that doing so would be in the best interests of the child. (5) If the health body is of the opinion that a particular voluntary organisation is likely to be able to give the parent advice or other assistance in connection with any additional learning needs that the child may have, it must inform the parent accordingly.	REGULATORY	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s65 [In force in Wales only]	(1) Subsection (2) applies if a local authority requests a person mentioned in subsection (4) [which includes NHS Trusts] to exercise the person's functions to provide the authority with information or other help, which it requires for the purpose of exercising its functions under this Part.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(2) The person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person that decides not to comply with a request under subsection (1) must give the local authority that made the request written reasons for the decision.		
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s76 [In force in Wales only]	(1) The Education Tribunal for Wales may, in relation to an appeal under this Part,— (a) exercise its functions to require an NHS body to give evidence about the exercise of the body's functions; (b) make recommendations to an NHS body about the exercise of the body's functions. (3) An NHS body to whom a recommendation has been made by the Tribunal must make a report to the Tribunal before the end of any prescribed period beginning with the date on which the recommendation is made. ss(4) specifies the contents of the report.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(2) A regulatory body i.e. the Welsh Ministers and SCW, by s176(1) must, in the exercise of its relevant functions, seek to co-operate with a relevant authority which includes, by s177(1)(e) an NHS Trust if the regulatory body thinks such co-operation— (a) will have a positive effect on the manner in which the body exercises its functions, or (b) will assist the body in achieving its general objectives.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(3) Where a regulatory body requests the co-operation of a relevant authority under subsection (2) the authority must comply with the request unless the authority— (a) is prevented from co-operating in the manner requested by any enactment or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with its own functions, or (c) thinks that such co-operation would have an adverse effect on its functions.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(4) If a relevant authority requests the co-operation of a regulatory body, the body must comply with that request unless the body— (a) is prevented from co-operating in the manner requested by any enactment (including this Act) or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with the regulatory body's own functions, or (c) thinks that such co-operation would have an adverse effect— (i) on the body's functions, or (ii) on achieving the body's general objectives.	REGULATORY	Yes
Well-being of Future Generations (Wales) Act 2015, Parts 2 and 3	Not reproduced in full here, the Act confers various duties on public bodies to do things in pursuit of the economic, social, environmental and cultural well-being of Wales in a way that accords with the sustainable development principle and to require public bodies to report on such	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	action. "Public bodies", by section 6, includes NHS Trusts.		
Counter-terrorism and Security Act 2016, s26	(1) A specified authority which includes, by Schedule 6, and NHS Trust must, in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism.	ANCILLARY FUNCTION	Yes
Counter-terrorism and Security Act 2016, s38	(1) The partners which include NHS Trusts by Schedule 7 of a panel i.e. a panel established by a LA by s36 must, so far as appropriate and reasonably practicable, act in co-operation with— (a) the panel in the carrying out of its functions; (b) the police and local authorities in the carrying out of their functions in connection with section 36.	CORPORATE	Yes
Counter-terrorism and Security Act 2016, s38	By ss(3) the duty of a partner of a panel to act in co-operation with the panel includes the giving of information (subject to ss(4)) and extends only so far as the co-operation is compatible with the exercise of the partner's functions under any other enactment or rule of law.	CORPORATE	Yes
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 4(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act i.e. the public sector equality duty of the Equality Act 2010. See further regs 4(2) onwards and reg 6 for requirements as to publication and exemption for authorities with fewer than 150 employees	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 6(1)	(1) Where an NHS trust or an NHS foundation trust supplies a drug or appliance to a patient for the purpose of treatment, the NHS trust or the NHS foundation trust (as the case may be) must, subject to paragraphs (3) to (6), make and recover from the patient for the supply of continues as to charges to be made in respect of particular items See further reg 6 for exemptions	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 7(1)	(1) Where drugs or appliances are supplied to a patient, including during the out of hours period, for the purpose of treating that patient, by a prescriber at a walk-in centre, the NHS trust, NHS foundation trust or other person responsible for the management of the centre, must, subject to paragraphs (3) to (5), make and recover from that patient for the supply of continues as to charges to be made in respect of particular items See further reg 7 for exemptions	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 10(1)	(9) Where a claim to an exemption has been made but is not substantiated, and in consequence of the claim a charge has not been recovered, if— (b) the drugs or appliances were supplied by an NHS trust or an NHS foundation trust as mentioned in regulation 6, then that NHS trust or NHS foundation trust must recover that charge from the person concerned	COMMISSIONING	Yes
National Health Service (Charges to Overseas Visitors) Regulations 2015	The Regulations place various duties (not set out in full here) on "relevant bodies" (which includes NHS Trusts, by reg 2) to make and recover charges for the provision	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	of relevant services to overseas visitors. Further, NHS Trusts, in meeting their obligations to make and recover charges from overseas visitors, must (by reg 3A) enter certain specified information against record against the overseas visitor's consistent identifier.		
National Health Service (Optical Charges and Payments) Regulations 2013, reg 2(2)	(2) Where a charge is payable by virtue of paragraph (1) a charge for such amount for glasses and contact lenses as determined by the SoS, the NHS trust or NHS foundation trust, or other person on its behalf, that supplies or is to supply the glasses or contact lenses must– (a) on arranging to supply the glasses or contact lenses, make the charge, and (b) on supplying the glasses or contact lenses or having them available for supply, recover the charge from the person supplied or to be supplied (if the charge has not previously been paid).	COMMISSIONING	Yes
National Health Service (Optical Charges and Payments) Regulations 2013, reg 10(1)	(1) An NHS trust or NHS foundation trust which, following a sight test, issues a prescription for an optical appliance to a person who— (a) has indicated that they are an eligible person; or (b) is an eligible person by virtue of regulation 8(5), must issue to that person a voucher relating to the optical appliance prescribed. See further reg 10(2) for requirements on issuing a voucher	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218, reg 23	This provision imposes consultation duties (not set out in full here) on a "responsible person" ("R") (which may be a "service provider", a definition which by reg 23(14) includes an NHS Trust) where R has under consideration any proposal for a substantial development of the health service. This is subject to reg 23(12) which sets out the circumstances in which the functions in reg 23 are to be carried out by a responsible commissioner in the place of a service provider.	ANCILLARY FUNCTIONS	Yes
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, reg 4	(1) This regulation applies where a clinical commissioning group, NHS trust or NHS foundation trust and a local authority propose to designate a body as a Care Trust under section 77(1) of the 2006 Act, or propose to revoke such designation. (2) Where this regulation applies, the body and the local authority must, before designating or revoking the designation, as the case may be, consult jointly such persons as appear to them to be affected by the proposed designation or revocation.	REGULATORY	Yes
Care Act 2014, s6	(1) A local authority must co-operate with each of its relevant partners which, by ss(7) includes each NHS body in the authority's area, defined in turn by ss(8) as NHS trust or NHS foundation trust which provides services in the authority's area, and each relevant partner must co-operate with the authority, in the exercise of— (a) their respective functions relating to adults with needs for care and support, (b) their respective functions relating to carers, and	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).		
Social Services and Well-being (Wales) Act 2014, s17	(5) A Local Health Board or an NHS Trust providing services in the area of a local authority must, for the purposes of this section which imposes a duty on Welsh LAs to secure the provision of information, advice and assistance, provide that local authority with information about the care and support it provides in the local authority's area.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s118	(2) Where a child who is accommodated in Wales— (g) in any accommodation provided by or on behalf of an NHS Trust or by or on behalf of an NHS Foundation Trust, ceases to be so accommodated after reaching the age of 16, the person by whom or on whose behalf the child was accommodated or who carries on or manages the home or hospital (as the case may be) must inform the local authority or local authority in England within whose area the child proposes to live. subject to ss(3) which provides that the duty if the accommodation has been provided for a consecutive period of at least three months.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s120	(1) Subsection (2) applies where a child is provided with accommodation in Wales by a Local Health Board, an NHS Trust or a local authority in the exercise of education functions ("the accommodating authority")— (a) for a consecutive period of at least 3 months, or (b) with the intention, on the part of that authority, of	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	accommodating the child for such a period. (2) The accommodating authority must notify the appropriate officer as defined by ss(4) of the responsible authority as defined by ss(3)— (a) that it is accommodating the child, and (b) when it ceases to accommodate the child.		
Social Services and Well-being (Wales) Act 2014, s134	Not reproduced in full here, this section makes provision for "Safeguarding Boards" and regulations governing them. By ss(2)(d) an NHS Trust is designated as a partner of a Safeguarding Board.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s161B	(1) The Welsh Ministers may require a person falling within subsection (2) which includes an NHS Trust to provide them with— (a) any documents, records (including medical or other personal records) or other information— (i) which relate to the exercise of a social services function of a local authority, and (ii) which the Welsh Ministers consider it necessary or expedient to have for the purposes of a review under section 149A or 149B; (b) an explanation of the content of— (i) any documents, records or other information provided under paragraph (a), or (ii) any documents or records provided to an inspector conducting an inspection of premises under section 161 in connection with a review under section 149B. Subject to ss(3) which provides that a person is not required to provide documents, records or other	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	information under subsection (1) if the person is prohibited from providing them by any enactment or other rule of law.		
Social Services and Well-being (Wales) Act 2014, s162(6)	(1) A local authority must make arrangements with a view to promoting the matters specified in ss(3) to promote co-operation between— (a) the local authority, (b) each of the authority's relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority in the exercise of— (i) their functions relating to adults (ii) their other functions the exercise of which is relevant to the functions referred to in sub-paragraph (i), and (c) such other persons or bodies as the authority considers appropriate, being persons or bodies of any nature who or which exercise functions or are engaged in activities in relation to— (i) adults within the authority's area with needs for care and support, or (ii) adults within the authority's area who are carers. (6) The relevant partners of a local authority must co-operate with the authority in the making of arrangements under this section.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(7) A local authority and any of its relevant partners may for the purposes of arrangements under this section— (a) provide staff, goods, services, accommodation or other resources;	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) establish and maintain a pooled fund defined at ss(7); (c) share information with each other.		
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(9) A local authority and each of its relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority must, in exercising their functions under this section, have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s164(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes an NHS Trust in the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(2); (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes an NHS Trust provides it with information it requires for the purpose of the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.		
Social Services and Well-being (Wales) Act 2014, s164(5)	(5) A local authority and each of those persons mentioned in subsection (4) includes an NHS Trust must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s164A(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes NHS Trusts in the exercise of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164A(2), (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes NHS Trusts provides it with information it requires for the purpose of the exercise of any of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would—	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.		
Children and Families Act 2014, s28	(1) A local authority in England must co-operate with each of its local partners which includes, by ss(2)(m), an NHS Trust or NHS Foundation Trust which provides services in the authority's area, or which exercises functions in relation to children or young people for whom the authority is responsible, and each local partner must co-operate with the authority, in the exercise of the authority's functions under this Part.	ANCILLARY FUNCTIONS	Yes
Children and Families Act 2014, s31	(1) This section applies where a local authority in England requests the cooperation of any of the following persons and bodies in the exercise of a function under this Part— (g) an NHS trust or NHS foundation trust. (2) The person or body must comply with the request, unless the person or body considers that doing so would— (a) be incompatible with the duties of the person or body, or (b) otherwise have an adverse effect on the exercise of the functions of the person or body. (3) A person or body that decides not to comply with a	ANCILLARY FUNCTIONS	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	request under subsection (1) must give the authority that made the request written reasons for the decision.		
Children and Families Act 2014, s77	(4) The persons listed in subsection (1) including at ss(1)(l) NHS Trusts must have regard to the Code of Practice issued by the SoS pursuant to ss(1) in exercising their functions under this Part.	ANCILLARY FUNCTIONS	Yes
Equality Act 2010 c. 15	Refers to all functions under this Act	CORPORATE	Yes
Health Act 2009 c. 21	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All duties of an NHS Trust under this Act	REGULATORY	Yes
Local Government and Public Involvement in Health Act 2007 c. 28	All duties of an NHS Trust under this Act	REGULATORY	Yes
Health Act 2006 c. 28	Refers to entire Act.	REGULATORY	Yes
Health and Social Care (Community Health and Standards) Act 2003 c. 43	Refers to entire Act.	REGULATORY	Yes
Mental Capacity Act 2005 c. 9	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All functions of a Trust under this Act.	REGULATORY	Yes
Local Audit and Accountability Act 2014 c. 2	Refers to entire Act.	REGULATORY	Yes

Schedule 4 Mandatory Reserved Functions

1 Mandatory Reserved Functions are any Functions of the Trusts that they cannot lawfully delegate or jointly exercise or otherwise are Functions that NHS England has categorised as not 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in paragraph 2 below.

2 The table referred to in paragraph 1 is as follows:

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 27A NHS Act 2006	(1) A public benefit corporation must hold an annual meeting of its members. (2) The meeting must be open to members of the public. (3) At least one member of the board of directors of the corporation must attend the meeting and present the following documents to the members at the meeting— (a) the annual accounts, (b) any report of the auditor on them, (c) the annual report. (4) Where an amendment is made to the constitution in relation to the powers or duties of the council of governors of a public benefit corporation (or otherwise with respect to the role that the council has as part of the corporation)— (a) at least one member of the council of governors must attend the next meeting to be held under this paragraph and present the amendment, and (b) the corporation must give the members an opportunity to vote on whether they approve the amendment. (5) If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the corporation must take such steps as are necessary as a result.	CORPORATE	**No**
Section 37 NHS Act 2006	(1) An NHS foundation trust may make amendments of its constitution only if— (a) more than half of the members of the council of governors of the trust voting approve the amendments, and (b) more than half of the members of the board of directors of the trust voting approve the amendments.	CORPORATE	**No**
Section 42B (6) NHS Act 2006 as inserted by section 62 of the Health and Care Act 2022	Limits on capital expenditure (6) A trust that is the subject of an order under this section must not exceed the capital expenditure limit imposed by the order during the financial year to which it relates.	CORPORATE / REGULATORY	**No**

Section 43 NHS Act 2006	(1) The principal purpose of an NHS foundation trust is the provision of goods and services for the purposes of the health service in England.	CORPORATE	**No**
Section 43 NHS Act 2006	(3D) An NHS foundation trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.	CORPORATE	**No**
Section 46 NHS Act 2006	(1) An NHS foundation trust may borrow money for the purposes of or in connection with its functions. (4) An NHS foundation trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. (5) The investment may include investment by– (a) forming, or participating in forming, bodies corporate, (b) otherwise acquiring membership of bodies corporate. (6) An NHS foundation trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.	CORPORATE / ANCILLARY	**No**
Section 50 NHS Act 2006	An NHS foundation trust must pay to the regulator such fee as the regulator may determine in respect of its exercise of functions under— (a) section 39; (b) section 39A.	REGULATORY	**No**
Section 51A NHS Act 2006	(1) An NHS foundation trust may enter into a significant transaction only if more than half of the members of the council of governors of the trust voting approve entering into the transaction. (2) “Significant transaction” means a transaction or arrangement of such description as may be specified in the trust's constitution. (3) If an NHS foundation trust does not wish to specify any descriptions of transaction or arrangement for the purposes of subsection (2), the constitution of the trust must specify that it contains no such descriptions.	CORPORATE	**No**

Section 56B NHS Act 2006	(1) An application may be made to the regulator by an NHS foundation trust for the dissolution of the trust and the establishment of two or more new NHS foundation trusts. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant. (3) The application must, by reference to each of the proposed new trusts— (a) specify the property and liabilities proposed to be transferred to it; (b) be accompanied by a copy of its proposed constitution. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trust and the establishment of each of the proposed new trusts have been taken. (5) On the grant of the application, the proposed constitution of each of the new trusts has effect but, in the case of each of the new trusts, the proposed directors may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.	CORPORATE	**No**
Section 57A NHS Act 2006	57A Dissolution (1) An application may be made by an NHS foundation trust to the regulator for dissolution. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant.	CORPORATE	**No**
Section 61 NHS Act 2006	(1) An NHS foundation trust must take steps to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of the patients' constituency is representative of those eligible for such membership.	CORPORATE	**No**
Chapter 5A NHS Act 2006	Trusts Special Administration.	REGULATORY	**No**
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) including NHS trusts established under section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006 by ss(4)(a) to establish, or to participate in, a domestic homicide review as defined by ss(1).	ANCILLARY FUNCTION	**No**

Charities Act 2011, ss149; 152	Various provisions as to the audit/examination of the accounts of an "English NHS charity" (which would include a charitable trust, the trustees of which are an NHS Trust), including requirements as to the auditor/independent examiner and the giving of guidance by the Charities Commission	REGULATORY	**No**
Policing and Crime Act 2017, s1	(1) A collaboration agreement as defined by ss(3) may be made by— (a) one or more persons within a paragraph of subsection (2), and (b) one or more persons within another paragraph of that subsection. (2) Those persons are— (a) an ambulance trust in England, (b) a fire and rescue body in England, and (c) a police body in England. See further sections 3 and 4 regarding collaboration agreements	CORPORATE	**No**
Investigatory Powers Act 2016, Part 3	Not reproduced in full here, this part of the Act contains provision for applications by "relevant public authorities" to the Investigatory Powers Commissioner for authorisations to obtain communications, and the granting of authorisations by a designated officer in a relevant public authority in specific circumstances. "Relevant public authority" includes (by Schedule 4) ambulance trusts.	REGULATORY	**No**
Immigration Act 1999, s20A	Not reproduced in full here, this provision confers a duty on NHS Trusts to supply a "nationality document" at the direction of the SoS, if the SoS has reasonable grounds for believing is lawfully in the possession of an NHS Trust.	REGULATORY	**No**
Network and Information Systems Regulations 2018	Not reproduced in full here, the regulations make provision for the identification of "operators of essential services" (OES) (where they provide an essential service as specified in Schedule 2 of the regs and where they (a) rely on network and information systems; and (b) satisfy a threshold requirement described for that kind of essential service. NHS Trusts are specified in Schedule 2. An OES is subject to duties relating to notification of their status to a designated competent authority and take appropriate and proportionate technical and organisational measures to manage risks posed to the security of the network and information systems on which their essential service relies.	CORPORATE	**No**

Housing Act 1996, s213B	NHS Trusts are included among the public authorities specified by Homelessness (Review Procedure etc) Regulations 2018 (see reg 10 and Schedule) for the purposes of this provision: (1) This section applies if a specified public authority considers that a person in England in relation to whom the authority exercises functions is or may be homeless or threatened with homelessness. (2) The specified public authority must ask the person to agree to the authority notifying a local housing authority in England of— (a) the opinion mentioned in subsection (1), and (b) how the person may be contacted by the local housing authority. (3) If the person— (a) agrees to the specified public authority making the notification, and (b) identifies a local housing authority in England to which the person would like the notification to be made, the specified public authority must notify that local housing authority of the matters mentioned in subsection (2)(a) and (b).	REGULATORY	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 5(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must prepare and publish one or more objectives it thinks it should achieve to do any of the things mentioned in paragraphs (a) to (c) of section 149(1) of the Act. See further regs 5(2) onwards and reg 6 for requirements as to publication.	CORPORATE	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, Schedule 1(2)	Not reproduced in full here, a relevant public authority is subject to a duty to publish annual information relating to gender pay gap information relating to employees.	CORPORATE	**No**
Controlled Drugs (Supervision of Management and Use) Regulations 2013	The Regulations place various duties (not set out in full here) on "designated bodies" (which includes NHS Trusts, by reg 7) in relation to the supervision, management and use of controlled drugs	REGULATORY	**No**

Children and Families Act 2014, s23	(1) This section applies where, in the course of exercising functions in relation to a child who is under compulsory school age, a clinical commissioning group, NHS trust or NHS foundation trust form the opinion that the child has (or probably has) special educational needs or a disability. (2) The group or trust must— (a) inform the child's parent of their opinion and of their duty under subsection (3), and (b) give the child's parent an opportunity to discuss their opinion with an officer of the group or trust. (3) The group or trust must then bring their opinion to the attention of the appropriate local authority in England. (4) If the group or trust think a particular voluntary organisation is likely to be able to give the parent advice or assistance in connection with any special educational needs or disability the child may have, they must inform the parent of that.	ANCILLARY FUNCTIONS	**No**
Mental Health Act 1983	Refers to entire Act.	REGULATORY	**No**
Mental Capacity Act 2005	Refers to entire Act.	REGULATORY	**No**
Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008/1858	Refers to entire Regulations.	REGULATORY	**No**
Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008/1184	Refers to entire Regulations.	REGULATORY	**No**

Schedule 5 BSW Hospitals Group Joint Committee ToR

Terms of Reference for a special purpose joint committee (the BSW Hospitals Group Joint Committee) between Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Version control

Date	Version	Author
18 Feb 2025	001	Browne Jacobson LLP
27 Mar 2025	002	Browne Jacobson LLP
14 Apr 2025	003	Browne Jacobson LLP

1 Introduction

1.1 The BSW Hospitals Group Joint Committee is a statutory joint committee of the boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury Hospital NHS Foundation Trust (the Trusts) who have established it under section 65Z6 of the National Health Service Act 2006 to exercise Joint Functions in accordance with the Partnership Agreement entered into by the Trusts dated [DN: INSERT DATE] (the Partnership Agreement).

1.2 As set out in the Partnership Agreement, the BSW Hospitals Group Joint Committee will oversee the plan for closer collaboration, the subsequent delivery programme, and development of the proposed Group model. The shared narrative for the Group is as follows:

1.2.1 Together we will make the best use of collective resources available to us. Our decisions will be judged by their ability to make best use of resources for the population in BSW.

1.2.2 A collective approach will enable enhanced clinical effectiveness – spreading best practice, and responding to inequity, fragile services, improving fairness across BSW.

1.2.3 A collective approach will enable service viability – it will be easier to create high quality resilient services in Group. We will work to avoid creation or emergence of unacceptable levels of fragility to services and individual Trusts, including with our Place-based, network and tertiary partners.

1.2.4 We need to change how we operate. Individually, Trust sustainability is challenging. A group model offers real opportunity to remain as stand-alone local organisation focused on needs of population within the support structure of a group.

1.2.5 Risk: We will develop collective approach to risk and address differences between local and group risk appetite when they emerge.

1.3 In these terms of reference 'Joint Functions' mean all the Trusts' functions that the Trust Boards have agreed are Joint Functions in accordance with the Partnership Agreement.

2 Authority & Accountabilities

2.1 The BSW Hospitals Group Joint Committee is authorised by the Boards to exercise the Joint Functions.

2.2 The BSW Hospitals Group Joint Committee shall be fully and equally accountable to each Trust Board for the exercise of the Joint Functions and shall at all times comply with the Partnership Agreement and NHS England guidance when exercising Joint Functions.

2.3 The BSW Hospitals Group Joint Committee may authorise one of the Trusts to contract with a third party on behalf of itself alone or each Trust jointly and severally subject to compliance with the Trusts' standing orders and standing financial instructions.

2.4 The BSW Hospitals Group Joint Committee is authorised by the Boards to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.5 The BSW Hospitals Group Joint Committee shall transact all business in accordance with the policies of the Trusts on openness and conformity with the Nolan principles and values of the Public Services.

3 Reporting Arrangements

3.1 The minutes of Joint Committee meetings shall be formally recorded and submitted to each Trust's Board.

3.2 The BSW Hospitals Group Joint Committee shall provide regular update reports to each Trust's Board on the activities of the BSW Hospitals Group Joint Committee in accordance with a single reporting schedule agreed by the Trust Boards.

4 Membership

4.1 All the Voting Directors of each Trust shall be eligible for appointment as voting members (Members) of the BSW Hospitals Group Joint Committee during their terms of office.

4.2 Each Trust shall appoint the following Members, who may be Voting Director or Non-Voting Directors:

4.2.1 Chair, Vice Chair and three other Voting NEDs nominated in writing by the Trust's Chair

4.2.2 Chief Executive Officer, Managing Director and two other EDs nominated in writing by the Trust's Chair and Chief Executive Officer.

4.2.3 All joint Executive Director roles created by the Trusts.

4.3 The Trusts shall ensure that in appointing the EDs in accordance with paragraph 4.2.2 the membership of the BSW Hospitals Group Joint Committee shall include a Chief Nursing Officer, a Chief Medical Officer, a Chief Finance Officer, a Chief People Officer, a Chief Operating Officer, and a Director of Estates and Facilities. The role of these EDs shall be to bring their portfolio expertise to the decisions of the BSW Hospitals Group Joint Committee in the interests of the Group.

4.4 It is acknowledged that the role of the Members shall be to make decisions in the interests of the Group rather than to represent the views of their individual Trusts.

4.5 The Trusts may agree in writing to vary these Terms of Reference to amend the number of Members of the BSW Hospitals Group Joint Committee provided that:

4.5.1 Each Trust appoints the same number of Members

4.5.2 The Chair and Chief Executive Officer are Members

4.5.3 The Chair and other Voting NED Members outnumber the ED Members.

4.6 Additionally, the Trusts may agree in writing to vary these Terms of Reference to permit them to appoint Non-Voting Directors of the Trusts to be Members of the BSW Hospitals Group Joint Committee.

4.7 The proceedings of the BSW Hospitals Group Joint Committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a Member.

4.8 A Member's initial term of appointment to the BSW Hospitals Group Joint Committee shall be up to three years, or the end of their term of appointment as a Director of a Trust, whichever is the earlier. A Member's may be reappointed by their Trust in accordance with paragraph 4.2 for further terms.

5 Attendance

5.1 The Trust Secretary of one of the Trusts will attend as required to ensure that the BSW Hospitals Group Joint Committee business is transacted as per this Terms of Reference, the Partnership Agreement, the Trusts' Standing Orders and documents referred to in them.

5.2 With the consent of the BSW Hospitals Group Joint Committee Chair, other persons may be invited to attend and contribute to meetings of the BSW Hospitals Group Joint Committee but not take part in making decisions.

5.3 In line with the Trusts' Standing Orders, Members must attend at least half the BSW Hospitals Group Joint Committee's meetings annually. Any failure of a Member to meet this attendance requirement shall be considered as part of that individual's Annual Review and Appraisal process.

5.4 Subject to paragraph 5.3 and the prior agreement of the Chair, each Trust may nominate a deputy to attend a meeting of the BSW Hospitals Group Joint Committee in the event of a Member's absence. For Members appointed under paragraph 4.2.1 the deputy shall be a Voting NED nominated by the Chair of the relevant Trust. For Members appointed under paragraph 4.2.2 the deputy shall be an ED or senior director nominated by the Chair and Chief Executive of the relevant Trust. For Members appointed under paragraph 4.2.3 the deputy shall be an ED or senior director nominated by the Chief Executive. A deputy shall be formally nominated with the same rights and privileges as the Member for whom they are deputising.

6 Chair

6.1 The Joint Chair of the Trusts, if present, shall preside at any meeting of the BSW Hospitals Group Joint Committee or, if the Joint Chair is absent, the Deputy Chair of the BSW Hospitals Group Joint Committee shall preside. If the Deputy Chair is presiding at a meeting instead of the Chair, then references in this Terms of Reference to the Joint Chair shall be construed as the Deputy Chair.

6.2 Pending the appointment of a Joint Chair of the Trusts, the current Chairs of the Trusts shall agree between them who shall chair meetings of the BSW Hospitals Group Joint Committee (where possible rotating between them) and any reference in these terms of reference to 'Joint Chair' shall (where the context requires) be construed as the Trust Chair who presides at a meeting.

7 Quorum

7.1 No business shall be transacted at a meeting of the BSW Hospitals Group Joint Committee unless:

7.1.1 At least half the Members of the BSW Hospitals Group Joint Committee are present

7.1.2 At least half of the Members present are Voting NEDs

7.1.3 The Members present include (in addition to the Joint Chair) at least two EDs of each of the Trusts (who in the case of a joint director may be the same person) and at least two Voting NEDs of each of the Trusts (who in the case of a joint director may be the same person).

8 Decision making

8.1 The BSW Hospitals Group Joint Committee will generally operate on the basis of forming a consensus on all issues considered, taking account of the views expressed by all Members. The Joint Chair will seek to ensure that any lack of consensus is resolved amongst Members.

8.2 If the BSW Hospitals Group Joint Committee is unable to reach a consensus on an issue, the Joint Chair may put the issue to a vote. The vote will be carried if:

8.2.1 A special majority of not less than two thirds of the Members present and voting are in favour, and

8.2.2 The Members in favour include more than half of the Members from each Trust.

8.3 Each Member of the BSW Hospitals Group Joint Committee shall have one vote except in the event that prior to the appointment of the Joint Chair an individual is appointed as the Chair of two of the Trusts but not the other, in which case they shall be treated as if they were separate individuals and entitled to cast a vote on behalf of each Trust to which they are appointed.

8.4 The decisions of the BSW Hospitals Group Joint Committee (which for the avoidance of doubt extend only to decisions in respect of the Joint Functions) are binding on each of the Trusts.

9 Admission of the public to meetings

9.1 Meetings of the BSW Hospitals Group Joint Committee shall be held in in private.

9.2 But the BSW Hospitals Group Joint Committee may, by resolution, permit the public to attend a meeting to observe (whether during the whole or part of the proceedings).

10 Managing Conflicts of Interest

10.1 Each Member of the BSW Hospitals Group Joint Committee must abide by all policies of the Trust of which she or he is a director or officer in relation to conflicts of interest.

10.2 At the first meeting of the BSW Hospitals Group Joint Committee, the BSW Hospitals Group Joint Committee will select a chair ("Joint Committee Chair") from amongst the members who are Trust Chairs. A Deputy-Chair will also be selected. Once a joint chair for the Trusts is appointed, he or she shall become the BSW Hospitals Group Joint Committee Chair and the incumbent Joint Committee Chair (if not the joint chair) shall immediately hand over.

10.3 The Trusts acknowledge that sections 63A and 223L to 223N of the NHSA (as introduced by the Health and Care Act 2022) impose duties on the Trusts to have regard to the wider effects of their decisions and the expenditure limits and use of resources requirements of their system. In the light of these duties, there should be few occasions where the interests of the Trusts are not aligned and directors of each Trust must have regard to the wider impact of their decisions on the other Trusts and seek to cooperate with the other Trusts in exercising their functions.

11 Administrative Support

The Chief Executive Officer shall nominate a Trust Secretary to arrange provision of administrative support to the BSW Hospitals Group Joint Committee.

12 Annual Workplan

The BSW Hospitals Group Joint Committee will agree an Annual Workplan and cycle of business prior to the beginning of each financial year. The reporting cycle will then form part of the agenda alongside the standing agenda items.

13 Frequency of Meetings

13.1 Ordinary meetings of the BSW Hospitals Group Joint Committee shall be held not less than six times a year and shall be coordinated with the cycle of Board meeting of the Trusts.

13.2 Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed.

13.3 Extraordinary meetings may be called for a specific purpose at the discretion of the Joint Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

14 Papers Publication

All papers will be published using the available electronic Board paper system. Publication of papers will be seven working days before meetings. A progress report of outstanding/pending Joint Committee actions will be presented to each meeting of the BSW Hospitals Group Joint Committee.

15 Routines, Behaviours and Standards

15.1 The BSW Hospitals Group Joint Committee will implement the following routines and behaviours, in order to enable a safe, inclusive and trusting environment, where teams build and maintain effective relationships:

15.1.1 Develop a shared purpose and vision for the population we serve

15.1.2 Ensure frequent personal contact to build understanding and trust

15.1.3 Surface and resolve conflicts, not letting them fester

15.1.4 Work collectively for the long-term

15.1.5 Behave altruistically towards partners

15.1.6 An open book approach to information to build understanding and trust.

15.1.7 Be facilitative, enabling and pace setting in their role as System leaders.

15.2 The BSW Hospitals Group Joint Committee shall comply with the following standards:

15.2.1 NHSE Code of Governance for NHS provider trusts

15.2.2 NHSE Risk Assessment Framework

15.2.3 NHSE Annual Planning Guidance

15.2.4 The Health NHS Board – Principles of Good Governance

15.2.5 Corporate Governance – Principles of Public Life (GP01)

15.2.6 King's Fund: The Practice of Collaborative Leadership: across health and care services

15.3 The BSW Hospitals Group Joint Committee shall work to the following principles:

15.3.1 Create value for the population

15.3.2 Create constancy of purpose

15.3.3 Think systematically

15.3.4 Lead with humility

15.3.5 Respect every individual

16 Standard Agenda

16.1 Agendas will be built around the BSW Hospitals Group Joint Committee annual workplan, and most of the following will appear on each agenda, while some will appear only once or twice each year:

16.1.1 Declarations of interest,

16.1.2 Minutes of previous meeting,

16.1.3 Action list

16.1.4 Group Strategy

16.1.5 Performance, Transformation and Benefits Realisation

16.1.6 Reports of committees of the BSW Hospitals Group Joint Committee

16.1.7 Self-assessment of the BSW Hospitals Group Joint Committee's effectiveness

16.1.8 Review of the BSW Joint Hospitals Group Committee's terms of reference

16.1.9 Regular reports to the Trust Boards

16.1.10 Other items as per agreed cycle of business

17 Committees

17.1 The BSW Hospitals Group Joint Committee shall have the following committees (sub-committees to the Joint Committee):

17.1.1 The EPR Committee

17.1.2 Financial Sustainability

17.1.3 Group Development, Strategy & Planning

17.2 For the purpose of assisting the exercise of Joint Functions the BSW Hospitals Group Joint Committee may appoint one or more additional committees.

17.3 The voting members of a committee of the BSW Hospitals Group Joint Committee may may comprise or include individuals who are or are not voting Members of the BSW Hospitals Group Joint Committee.

17.4 The BSW Hospitals Group Joint Committee may authorise a committee to exercise Joint Functions that the BSW Hospitals Group Joint Committee expressly subdelegates to the committee in its ToR.

18 Amendment

These terms of reference may only be amended by variation agreed by resolution of each of the Trust Boards save that the Chair and Chief Executive of each of the Trusts may agree a non-material variation that they may reasonably consider to be necessary for the purpose of remedying any obvious error or omission in the terms of reference.

Date approved:

Date of review:

Annex to BSW Hospitals Group Joint Committee Terms of Reference

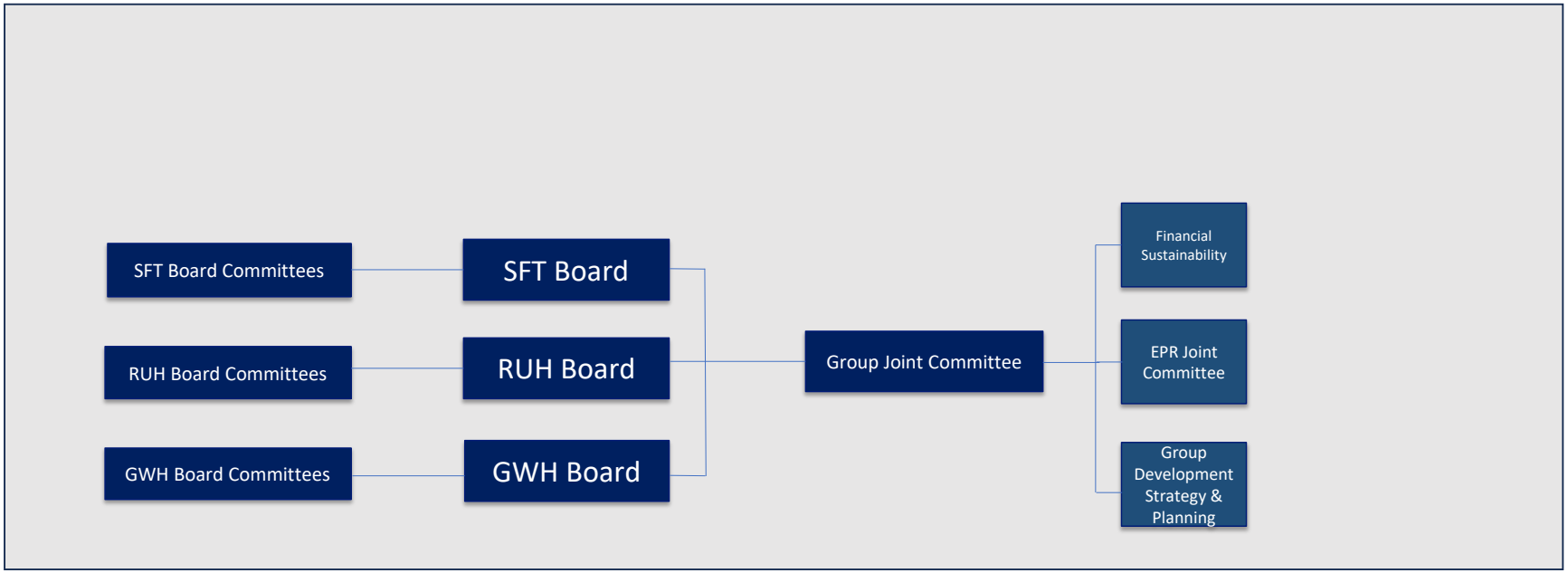
Functions Delegated by each of the Boards of GWH, RUH and SFT – Roles & responsibilities

	Role of the Joint Committee	Role of the Trust Boards
	1. Group Strategy & Planning	
Strategy		
1	Development and approval of BSW Hospitals Group Strategy. The Joint Committee determines the strategic direction, ensuring that collective BSW population interests are paramount.	Responsible for development and delivery of local operational plans aligned to and reinforcing *Group Strategy and Specialist Delivery* Plans.
2	Development and approval of *Specialist Delivery Plans* underpinning Group Strategy; Finance, People, Clinical, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital plans, in accordance with relevant system plans or strategies.	
Planning		
1	Development, approval and delivery of *Group Strategic Planning Framework* and *Annual Group-wide Plan*, reflecting planning guidance and Group Strategy. Set strategic goals and key objectives for upcoming year. Oversee budgeting process, reviewing and consolidating budgets at Group level. Oversight of delivery of *Group Strategic Initiatives.*	Development and delivery of the Trust operational plan aligned to Group objectives.
2	Approval of the overall Group Programme Budget - developing a plan that determines the financial contribution, and pooling of resources to meet financial challenges.	Delivery of the Trust operational plan, incorporating Group programme budget requirements.
3	Development of a Group Board Assurance Framework and Risk Management Framework.	Board Assurance Frameworks and risk management processes will remain in place for each Trust. Enable standardisation and consistency in a controlled and managed approach as determined by the Joint Committee.
4	Review and identification of the risks associated with the delivery of *Group Strategy and Group Annual Plan*.	
	2. Transforming Models of Care for the Population we Serve	
1	Development and approval of a *Group Clinical Services Framework* for the collective population we serve and associated decision-making processes.	Actively engage in co-creation and implementation of the Group Clinical Services Framework.

2	Approval of service/pathway/treatment configuration changes across the Group	
	3. Financial Sustainability – Use of Resources	
1	Sets and delivers Group financial recovery and long-term Group financial sustainability.	Responsible for developing and delivering financial plans as determined by the Group Programme Budget. Manage operational budgets.
2	Approval of new capital investment programme for the Group	Responsible for implementing local capital investment plans.
3	Approval of capital limits for each Trust within the Group.	Identifies local priorities for investment within the delegated limit.
	4. Group Mobilisation & Development	
1	Approval of *Group Operating Model*, *Accountability Framework* and associated *Integrated Performance Reporting*.	Works within the Group governance structure and accountability framework to deliver services ensuring that local governance aligns with group governance.
2	Oversight of delivery of the BSW Hospitals Group Case for Collaboration and emerging agreed priorities. Includes programme oversight of workstreams from case for collaboration – with details, phasing and resourcing agreed in *Annual Group-wide Plan*.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight. Delivery of change locally with Partners. Participates in group mobilisation and development workstreams.
3	Defines objectives, shape and structure of Group Corporate Services transformation. Approval of programme resourcing.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight.
4	Identification and approval of any further opportunities in support of Group Strategy.	Actively identify further opportunities to maximise economies at scale.
	5. Achieving Digital Maturity	
1	Responsible for the strategic oversight of successful delivery of the EPR Programme [via EPR Joint Committee activity]. Approves proposals for new budget and new benefits profile.	Ensures local delivery plans in place and appropriate relevant engagement for successful implementation.
2	Identifies, approves and implements digital transformation initiatives across the Group structure, as described in *Group Digital Delivery plan* [refer 1,2].	Ensures local IT infrastructure supports Group-wide strategy. Ensures local delivery plans in place and appropriate relevant engagement for successful implementation

Schedule 6 Governance Organogram for the Trusts' Appointment of Committees as at the Commencement Date

BSW Hospitals Group – Organogram



Acute Provider Collaborative in Bath and North East Somerset, Swindon and Wiltshire

Schedule 7 Data sharing and confidentiality

Part A: Confidentiality

1 In this Schedule "Confidential Information" means: all information, whether written or oral (however recorded), provided by one Trust (the Disclosing Trust) to the other Trusts (Receiving Trust(s)) and which (i) is known by the Receiving Trust(s) to be confidential; (ii) is marked as or stated to be confidential; or (iii) ought reasonably to be considered by the Receiving Trust(s) to be confidential.

2 The Trusts may disclose Confidential Information:

2.1 to their employees, agents or consultants who need to know such information for the purpose of discharging their obligations under this Agreement if they ensure that their employees, agents, or consultants to whom they disclose Confidential Information comply with this Schedule 7 and

2.2 as may be required by law, a court of competent jurisdiction or any governmental or regulatory authority.

3 The Trusts will not use each other's Confidential Information for any purpose other than to comply with this Agreement.

4 The Trusts acknowledge that they are subject to legal duties under the FOIA and EIR which may require them to disclose, on request, information relating to this Agreement and that they are also subject to the Code of Practice on Openness in the NHS (4 August 2003).

5 If a Trust receives a Request for Information (as defined in FOIA) or a request under regulation 5(1) of EIR (each, a Request) about their collaboration arrangements or the BSW Hospitals Group Joint Committee, prior to any disclosure of information to which an exemption to FOIA or EIR (as the case may be) may apply (Potentially Exempt Information) and recognising fully that the decision whether and what to disclose is for the Trust receiving the Request:

5.1 Notify the other Trusts of such Request

5.2 Consider any representations made by the other Trusts in relation to the Request and any possible exemptions and

5.3 Consult with the other Trusts in relation to any proposed disclosure as to whether any further explanatory material or advice should also be disclosed with the information in question.

6 Each Trust agrees that it will promptly inform the other Trusts of any media enquiries which it receives in relation to the collaboration arrangements. The Trusts will work co-operatively to agree a joint response to any media enquiries received in relation to the collaboration arrangements.

Part B: Independent Data Controllers

7 The Trusts shall, and shall procure that any of its staff and its other employees, agents and sub-contractors involved in the processing of Relevant Personal Data under this Agreement ("Personnel") shall, in connection with this Agreement and the transactions

and activities contemplated by it, comply with their obligations under Data Protection Legislation and this Schedule 7.

8 For the purposes of the Data Protection Legislation each Trust shall be an independent Data Controller of any Relevant Personal Data created in connection with the conduct or performance of this Agreement.

9 Each Trust shall implement and maintain appropriate technical and organisational measures (including, but not limited to, [encryption and password protection]), when transferring and/or processing Relevant Personal Data, to preserve the confidentiality, integrity, availability and resilience of Relevant Personal Data and prevent any unlawful processing or disclosure or damage, taking into account the state of the art, the costs of implementation, the nature, scope, context and purposes of processing as well as the risk of varying likelihood and severity for the rights and freedoms of the Data Subjects.

10 Each Trust shall notify the other Trusts without undue delay, and in any event within 48 hours of becoming aware of:

10.1 a Personal Data Breach where the breach has affected or could have affected the Relevant Personal Data;

10.2 a breach of technical and organisational security measures or any Data Protection Legislation where the breach has affected or could have affected the Relevant Personal Data;

10.3 an enquiry from the Information Commissioner's Office about the Relevant Personal Data; or

10.4 a request from a Data Subject exercising any of their rights under Chapter III UK GPDR in respect of the Relevant Personal Data (a "Data Subject Rights Request").

Each Trust agrees to keep the other Trusts regularly updated as to how the handling of such breach, enquiry or request.

11 Each Trust shall provide reasonable assistance to the other Trusts in ensuring compliance with its obligations under the Data Protection Legislation with respect of Personal Data Breach notifications and a Trust shall not make such notification without first consulting the other Trusts wherever possible.

12 Each Trust shall, as soon as reasonably practicable taking into account the nature of the processing provide reasonable assistance to the other Trusts, where that Trust has received:

12.1 a Data Subject Rights Request;

12.2 an enquiry from the Information Commissioner's Office about the Relevant Personal Data;

12.3 a complaint or request relating obligations served under the Data Protection Legislation which relates to the processing of Relevant Personal Data by any Trust; or

12.4 any other communication directly relating to the processing of any Relevant Personal Data created in connection with the conduct or performance of this Agreement in relation to such requests.

Wherever possible, no Trust shall not disclose, release, amend, delete or block any Relevant Personal Data in response to a Data Subject Rights Request or respond to such a request, complaint or communication without first consulting the other Trusts. Each Trust will bear their own costs in complying with their respective obligations under this Schedule 7.

13 Each Trust shall:

13.1 ensure that only those Personnel who need to have access to the Relevant Personal Data are granted such access and only for the purposes of performing their respective obligations under this Agreement;

13.2 take all reasonable steps to ensure the reliability of its Personnel;

13.3 ensure that all Personnel have completed training in Data Protection Legislation and in the care and handling of the Relevant Personal Data;

13.4 ensure that all Personnel are informed of the confidential nature of the Relevant Personal Data and are subject to appropriate contractual obligations of confidentiality; and

13.5 ensure that all Personnel comply with the obligations set out in this Schedule 7.

14 During the term and upon the termination of this Agreement, each Trust shall ensure that all Relevant Personal Data held by it shall be up-to-date and accurate.

15 Where transferring the Relevant Personal Data to the other Trusts or to a third party, each Trust shall:

15.1 ensure that such transfer is compliant with all applicable laws;

15.2 make such transfer in a secure manner; and

15.3 take all reasonable steps, at its own cost, to provide the Relevant Personal Data in a usable and compatible format.

16 Where transferring the Personal Data to a third party, each Trust shall enter into appropriate arrangements with all third parties containing written contractual obligations concerning the Relevant Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this Schedule 7 and where applicable, compliant with Article 26 or 28 UK GDPR.

17 No Trust shall transfer any Relevant Personal Data outside the UK unless the transferor ensures that:

17.1 the transfer is to a country approved under the applicable Data Protection Legislation as providing adequate protection;

17.2 there are appropriate safeguards in place, such as the Standard Contractual Clauses, pursuant to the applicable Data Protection Legislation; or

17.3 one of the derogations for specific situations in the applicable Data Protection Legislation applies to the transfer.

18 Each Trust shall retain Relevant Personal Data in a form which permits identification of Data Subjects for no longer than is necessary for the purposes for which it processes the Personal Data, as per its obligations under the Data Protection Legislation. Each Trust shall securely delete Relevant Personal Data which cannot be lawfully retained in accordance with Data Protection Legislation and good industry practice.

19 In this Schedule 7 the terms "Personal Data", "Processing", "Processor", "Controller", "Personal Data Breach" and "Data Subject" shall have the meanings ascribed to them under Data Protection Legislation, and the terms "Process" "Processes" and "Processed" shall be construed accordingly.

Part C: Joint Controller Status and Allocation of Responsibilities

20 With respect to personal data under Joint Control of the Trusts, as set out in Paragraph Schedule 725 below ("Shared Personal Data"), the Trusts envisage that they shall each be a Data Controller in respect of that Shared Personal Data in accordance with the terms of this Part C of Schedule 7 (Joint Controller Agreement) in replacement of Part B of Schedule 7. Accordingly, the Trusts each undertake to comply with the applicable Data Protection Legislation in respect of their Processing of such Shared Personal Data as Data Controllers.

21 The Trusts agree that the information governance team(s) of each Trust:

21.1 are the exclusive point of contact for Data Subjects and is responsible for using best endeavours to comply with the UK GDPR regarding the exercise by Data Subjects of their rights under the UK GDPR;

21.2 shall direct Data Subjects to the Data Protection Officer(s) or suitable alternative in connection with the exercise of their rights as Data Subjects and for any enquiries concerning their Shared Personal Data or privacy;

21.3 are responsible for the Trusts' compliance with all duties to provide information to Data Subjects under Articles 13 and 14 of the UK GDPR;

21.4 are responsible for ensuring the informed consent of Data Subjects, in accordance with the UK GDPR, for Processing in connection with the Joint Functions where consent is the relevant legal basis for that Processing; and

21.5 shall make available to Data Subjects the essence of this Part C of Schedule 7 (and notify them of any changes to it) concerning the allocation of responsibilities as Joint Controller and its role as exclusive point of contact, the Trusts having used their best endeavours to agree the terms of that essence. This must be outlined relevant privacy policies (which must be readily available by hyperlink or otherwise on all of its public facing services and marketing).

22 Notwithstanding the terms of Paragraph 21, the Trusts acknowledge that a Data Subject has the right to exercise their legal rights under the Data Protection Legislation as against the relevant Trust as Controller.

Undertakings of all Trusts

23 The Trusts each undertake that they shall:

23.1 report to the other Trusts every quarter on:

23.1.1 the volume of Data Subject Access Request (or purported Data Subject Access Requests) from Data Subjects (or third parties on their behalf);

23.1.2 the volume of requests from Data Subjects (or third parties on their behalf) to rectify, block or erase any Shared Personal Data;

23.1.3 any other requests, complaints or communications from Data Subjects (or third parties on their behalf) relating to the other Trusts' obligations under applicable Data Protection Legislation;

23.1.4 any communications from the Information Commissioner or any other regulatory authority in connection with Shared Personal Data; and

23.1.5 any requests from any third-party for disclosure of Shared Personal Data where compliance with such request is required or purported to be required by Law,

that it has received in relation to the exercise of the Joint Functions under this Agreement during that period;

23.2 notify each other immediately if it receives any Data Subject Request, complaint or communication made as referred to in Paragraphs 23.1.1 to 23.1.5. For the avoidance of doubt, this clause 23.2 does not apply to requests, complaints or communications made about the general operations of the Trusts as a whole;

23.3 provide the other Trusts with full cooperation and assistance in relation to any request, complaint or communication made as referred to in Paragraphs 21 and 23.1.1 to 23.1.5 to enable the other Trusts to comply with the relevant timescales set out in the Data Protection Legislation;

23.4 not disclose or transfer the Shared Personal Data to any third-party unless necessary for the provision of the Joint Functions and, for any disclosure or transfer of Shared Personal Data to any third-party, (save where such disclosure or transfer is specifically authorised under this Agreement or is required by Law) that disclosure or transfer of Shared Personal Data is otherwise considered to be lawful processing of that Shared Personal Data in accordance with Article 6 of the UK GDPR. For the avoidance of doubt, the third-party to which Shared Personal Data is transferred must be subject to equivalent obligations which are no less onerous than those set out in this Part C of Schedule 7

23.5 request from the Data Subject only the minimum information necessary to provide the Joint Functions and treat such extracted information as Confidential Information;

23.6 ensure that at all times it has in place appropriate technical and organisational measures to guard against unauthorised or unlawful Processing of the Shared Personal Data and/or accidental loss, destruction or damage to the Shared Personal Data and unauthorised or unlawful disclosure of or access to the Shared Personal Data;

23.7 use best endeavours to ensure the reliability and integrity of any of its Personnel who have access to the Shared Personal Data and ensure that its Personnel:

23.7.1 are aware of and comply with their duties under this Part C of Schedule 7 (Joint Controller Agreement) and those in respect of Confidential Information;

23.7.2 are informed of the confidential nature of the Shared Personal Data, are subject to appropriate obligations of confidentiality and do not publish, disclose or divulge any of the Shared Personal Data to any third-party where that Trust would not be permitted to do so;

23.7.3 have undergone adequate training in the use, care, protection and handling of Shared Personal Data as required by the applicable Data Protection Legislation;

23.8 ensure that it has in place appropriate technical and organisational measures as appropriate to protect against a personal data breach having taken account of the:

23.8.1 nature of the data to be protected;

23.8.2 harm that might result from a personal data breach;

23.8.3 state of technological development; and

23.8.4 cost of implementing any measures;

23.9 ensure that it has the capability (whether technological or otherwise), to the extent required by Data Protection Legislation, to provide or correct or delete at the request of a Data Subject all the Shared Personal Data relating to that Data Subject that the party holds; and

23.10 ensure that it notifies the other Trusts as soon as it becomes aware of a personal data breach.

24 Each Joint Controller shall use best endeavours to assist the other Controllers to comply with any obligations under applicable Data Protection Legislation and shall not perform its obligations under this Part C of Schedule 7 in such a way as to cause the other Joint Controllers to breach any of its obligations under applicable Data Protection Legislation to the extent it is aware, or ought reasonably to have been aware, that the same would be a breach of such obligations.

Shared Personal Data

25 All Trusts shall document and keep a register of types of Shared Personal Data that will be shared between the Trusts during the Term. This register will be coordinated by the Information Governance team(s).

Data Protection Breach

26 Without prejudice to Paragraph 27, each Trust shall notify the other Trusts without undue delay, and in any event within 48 hours, upon becoming aware of any personal

data breach or circumstances that are likely to give rise to a personal data breach, providing the other Trusts and their advisors with:

26.1 sufficient information and in a timescale which allows the other Trusts to meet any obligations to report a personal data breach under the Data Protection Legislation;

26.2 all reasonable assistance, including:

26.2.1 co-operation with the other Trusts and the Information Commissioner investigating the personal data breach and its cause, containing and recovering the compromised Shared Personal Data and compliance with the applicable guidance;

26.2.2 co-operation with the other Trusts including using such best endeavours as are directed by the Trusts to assist in the investigation, mitigation and remediation of a personal data breach;

26.2.3 co-ordination with the other Trusts regarding the management of public relations and public statements relating to the personal data breach; and/or

26.2.4 providing the other Trusts and to the extent instructed by the other Trusts to do so, and/or the Information Commissioner investigating the personal data breach, with complete information relating to the personal data breach, including, without limitation, the information set out in Paragraph 27.

27 Each Trust shall use best endeavours to restore, re-constitute and/or reconstruct any Shared Personal Data where it has lost, damaged, destroyed, altered or corrupted as a result of a personal data breach which is the fault of that Trust as if it was that Trust's own data at its own cost with all possible speed and shall provide the other Trusts with all reasonable assistance in respect of any such personal data breach, including providing the other Trusts, as soon as possible and within 48 hours of the personal data breach relating to the personal data breach, in particular:

27.1 the nature of the personal data breach;

27.2 the nature of Shared Personal Data affected;

27.3 the categories and number of Data Subjects concerned;

27.4 the name and contact details of the joint Data Protection Officer or other relevant contact from whom more information may be obtained;

27.5 measures taken or proposed to be taken to address the personal data breach; and

27.6 describe the likely consequences of the personal data breach.

Impact Assessments

28 The Trusts shall:

28.1 provide all reasonable assistance to each other to prepare any Data Protection Impact Assessment as may be required (including provision of detailed

information and assessments in relation to Processing operations, risks and measures); and

28.2 maintain full and complete records of all Processing carried out in respect of the Shared Personal Data in connection with this Agreement, in accordance with the terms of Article 30 UK GDPR.

Liabilities for Data Protection Breach

29 If financial penalties are imposed by the Information Commissioner on a Trust for a personal data breach ("Financial Penalties") then the following shall occur:

29.1 if in the view of the Information Commissioner, one Trust (Trust A) is responsible for the personal data breach, in that it is caused as a result of the actions or inaction of Trust A, its employees, agents, contractors (other than the other Trust) or systems and procedures controlled by Trust A, then Trust A shall be responsible for the payment of such Financial Penalties. In this case, Trust A will conduct an internal audit and engage at its reasonable cost when necessary, an independent third-party to conduct an audit of any such personal data breach. The other Trusts shall provide to Trust A and its third-party investigators and auditors, on request and at Trust A's reasonable cost, full cooperation and access to conduct a thorough audit of such personal data breach;

29.2 if no view as to responsibility is expressed by the Information Commissioner, then the Trusts shall work together to investigate the relevant personal data breach and allocate responsibility for any Financial Penalties as outlined above, or by agreement to split any financial penalties equally if no responsibility for the personal data breach can be apportioned.

29.3 If a Trust is the defendant in a legal claim brought before a court of competent jurisdiction ("Court") by a third-party in respect of a personal data breach, then unless the Trusts otherwise agree, the Trust that is determined by the final decision of the court to be responsible for the personal data breach shall be liable for the losses arising from such personal data breach. Where one or more Trusts are liable, the liability will be apportioned between the Trusts in accordance with the decision of the Court.

29.4 In respect of any losses, cost claims or expenses incurred by a Trust as a result of a personal data breach (the "Claim Losses"):

29.4.1 if a Trust is responsible for the relevant personal data breach, then that Trust shall be responsible for the Claim Losses;

29.4.2 if responsibility for the relevant personal data breach is unclear, then the Trusts shall be responsible for the Claim Losses equally.

30 Nothing in either Paragraph 28 or Paragraph 29 shall preclude the Trusts reaching any other agreement, including by way of compromise with a third-party complainant or claimant, as to the apportionment of financial responsibility for any Claim Losses as a result of a personal data breach, having regard to all the circumstances of the personal data breach and the legal and financial obligations of the Trusts.

Termination

31 The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement in consequence of any breach, including of this Part C of Schedule 7 in accordance with Clause 19 (Termination).

Sub-Processing

32 In respect of any Processing of Shared Personal Data performed by a third-party on behalf of a Trust, that Trust shall:

32.1 carry out adequate due diligence on such third-party to ensure that it is capable of providing the level of protection for the Shared Personal Data as is required by this Agreement, and provide evidence of such due diligence to the other Trusts where reasonably requested; and

32.2 ensure that a suitable agreement is in place with the third-party as required under applicable Data Protection Legislation.

Data Retention

33 The Trusts agree to erase Shared Personal Data from any computers, storage devices and storage media that are to be retained as soon as practicable after it has ceased to be necessary for them to retain such Shared Personal Data under applicable Data Protection Legislation and their privacy policy (save to the extent (and for the limited period) that such information needs to be retained by the Trust for statutory compliance purposes or as otherwise required by this Agreement), and taking all further actions as may be necessary to ensure its compliance with Data Protection Legislation and its privacy policy.

Part D: Controller to Processor Agreement

Allocation of responsibilities

34 With respect to personal data under Control of one of the Trusts, as set out in Paragraph 37 below ("Personal Data"), the Trusts envisage that for the purpose of the Data Protection Legislation that they shall, at times, each serve as the Controller and the others as the Processors in respect of that Personal Data in accordance with the terms of this Part D of Schedule 7 (Controller to Processer Agreement) in replacement of paragraphs Part B of Schedule 7 (Data Protection).

35 Accordingly, the Trusts each undertake to comply with the applicable Data Protection Legislation in respect of their Processing of such Personal Data in their respective roles as Controller and Processor.

36 The Controller retains control of the Personal Data and remains responsible for its compliance obligations under the Data Protection Legislation, including but not limited to, providing any required notices and obtaining any required consents, and for the written processing instructions it gives to the Processor.

37 A record will be maintained by all Trusts to detail the subject matter, duration, nature and purpose of the processing and the Personal Data categories and Data Subject types in respect of which a Trust will serve as the Processor and may process the Personal Data to fulfil the Joint Functions.

38 The Trusts acknowledge that a Data Subject has the right to exercise their legal rights under the Data Protection Legislation as against the relevant Trust as Controller.

Undertakings of the Trusts

39 The Processor will only process the Personal Data to the extent, and in such a manner, as is necessary for the exercise of the Joint Functions in accordance with the Controller's written instructions. The Processor will not process the Personal Data for any other purpose or in a way that does not comply with this Agreement or the Data Protection Legislation. The Processor must promptly notify the Controller if, in its opinion, the Controller's instructions do not comply with the Data Protection Legislation.

40 The Processor must comply promptly with any Controller written instructions requiring the Processor to amend, transfer, delete or otherwise process the Personal Data, or to stop, mitigate or remedy any unauthorised processing.

41 The Processor will maintain the confidentiality of the Personal Data and will not disclose the Personal Data to third-parties unless the Controller or this Agreement specifically authorises the disclosure, or as required by domestic law, court or regulator (including the Commissioner). If a domestic law, court or regulator (including the Commissioner) requires the Processor to process or disclose the Personal Data to a third-party, the Processor must first inform the Controller of such legal or regulatory requirement and give the Controller an opportunity to object or challenge the requirement, unless the domestic law prohibits the giving of such notice.

42 The Processor will reasonably assist the Controller, at no additional cost to the Controller, with meeting the Controller's compliance obligations under the Data Protection Legislation, taking into account the nature of the Processor's processing and the information available to the Processor, including in relation to Data Subject rights, data protection impact assessments and reporting to and consulting with the Commissioner under the Data Protection Legislation.

43 The Processor (and any subcontractor) must not transfer or otherwise process the Personal Data outside the UK without obtaining the Controller's prior written consent.

44 The Processor may not authorise any third party or subcontractor to process the Personal Data without the agreement of the Controller. The Trusts agree that the Processor will be deemed by them to control legally any Personal Data controlled practically by or in the possession of its subcontractors.

45 The Processor must, at no additional cost to the Controller, take such technical and organisational measures as may be appropriate, and promptly provide such information to the Controller as the Controller may reasonably require, to enable the Controller to comply with:

45.1 the rights of Data Subjects under the Data Protection Legislation, including, but not limited to, subject access rights, the rights to rectify, port and erase personal data, object to the processing and automated processing of personal data, and restrict the processing of personal data; and

45.2 information or assessment notices served on the Controller by the Commissioner under the Data Protection Legislation.

46 The Processor must notify the Controller immediately in writing if it receives any complaint, notice or communication that relates directly or indirectly to the processing of the Personal Data or to either party's compliance with the Data Protection Legislation.

47 The Processor must notify the Controller within 7 days if it receives a request from a Data Subject for access to their Personal Data or to exercise any of their other rights under the Data Protection Legislation.

48 The Processor will give the Controller, at no additional cost to the Controller, its full co-operation and assistance in responding to any complaint, notice, communication or Data Subject request.

49 The Processor must not disclose the Personal Data to any Data Subject or to a third-party other than in accordance with the Controller's written instructions, or as required by domestic law.

50 The Processor must at all times implement appropriate technical and organisational measures against accidental, unauthorised or unlawful processing, access, copying, modification, reproduction, display or distribution of the Personal Data, and against accidental or unlawful loss, destruction, alteration, disclosure or damage of Personal Data.

51 The Processor must implement such measures to ensure a level of security appropriate to the risk involved, including as appropriate:

51.1 the pseudonymisation and encryption of personal data;

51.2 the ability to ensure the ongoing confidentiality, integrity, availability and resilience of processing systems and services;

51.3 the ability to restore the availability and access to personal data in a timely manner in the event of a physical or technical incident; and

51.4 a process for regularly testing, assessing and evaluating the effectiveness of the security measures.

52 The Processor will ensure that all of its employees:

52.1 are informed of the confidential nature of the Personal Data and are bound by written confidentiality obligations and use restrictions in respect of the Personal Data;

52.2 have undertaken training on the Data Protection Legislation and how it relates to their handling of the Personal Data and how it applies to their particular duties; and

52.3 are aware both of the Processor's duties and their personal duties and obligations under the Data Protection Legislation and this Agreement.

Breaches

53 The Processor will within 48 hours and in any event without undue delay notify the Controller in writing if it becomes aware of:

53.1 the loss, unintended destruction or damage, corruption, or unusability of part or all of the Personal Data. The Processor will restore such Personal Data at its own expense as soon as possible.

53.2 any accidental, unauthorised or unlawful processing of the Personal Data; or

53.3 any Personal Data Breach.

54 Where the Processor becomes aware of the matters set out in Paragraph 53 above, it will, without undue delay, also provide the Controller with the following written information:

54.1 description of the nature of the matters set out in Paragraph 53, including the categories of in-scope Personal Data and approximate number of both Data Subjects and the Personal Data records concerned;

54.2 the likely consequences; and

54.3 a description of the measures taken or proposed to be taken to address the matters set out in Paragraph 53, including measures to mitigate its possible adverse effects.

55 Immediately following any accidental, unauthorised or unlawful Personal Data processing or Personal Data Breach, the Trusts will co-ordinate with each other to investigate the matter. Further, the Processor will reasonably co-operate with the Controller at no additional cost to the Controller, in the Controller's handling of the matter, including but not limited to:

55.1 assisting with any investigation;

55.2 providing the Controller with physical access to any facilities and operations affected;

55.3 facilitating interviews with the Processor's employees, former employees and others involved in the matter including, but not limited to, its officers and directors;

55.4 making available all relevant records, logs, files, data reporting and other materials required to comply with all Data Protection Legislation or as otherwise reasonably required by the Controller; and

55.5 taking reasonable and prompt steps to mitigate the effects and to minimise any damage resulting from the Personal Data Breach or accidental, unauthorised or unlawful Personal Data processing.

56 The Processor will not inform any third-party of any accidental, unauthorised or unlawful processing of all or part of the Personal Data and/or a Personal Data Breach without first obtaining the Controller's written consent, except when required to do so by domestic law.

57 The Processor agrees that the Controller has the sole right to determine:

57.1 whether to provide notice of the accidental, unauthorised or unlawful processing and/or the Personal Data Breach to any Data Subjects, the Commissioner, other in-scope regulators, law enforcement agencies or others,

as required by law or regulation or in the Controller's discretion, including the contents and delivery method of the notice; and

57.2 whether to offer any type of remedy to affected Data Subjects, including the nature and extent of such remedy.

58 The Processor will cover all reasonable expenses associated with the performance of the obligations under Paragraphs 53 to 55 unless the matter arose from the Controller's specific written instructions, negligence, wilful default or breach of this Agreement, in which case the Controller will cover all reasonable expenses.

59 The Processor will also reimburse the Controller for actual reasonable expenses that the Controller incurs when responding to an incident of accidental, unauthorised or unlawful processing and/or a Personal Data Breach to the extent that the Processor caused such, including all costs of notice and any remedy as set out in Paragraph 57.

Warranties

60 Each Trust warrants and represents that, in acting as Processor:

60.1 its employees, subcontractors, agents and any other person or persons accessing the Personal Data on its behalf are reliable and trustworthy and have received the required training on the Data Protection Legislation;

60.2 it and anyone operating on its behalf will process the Personal Data in compliance with the Data Protection Legislation and other laws, enactments, regulations, orders, standards and other similar instruments;

60.3 it has no reason to believe that the Data Protection Legislation prevents it from providing any of the Joint Functions; and

60.4 considering the current technology environment and implementation costs, it will take appropriate technical and organisational measures to prevent the accidental, unauthorised or unlawful processing of Personal Data and the loss or damage to, the Personal Data, and ensure a level of security appropriate to:

60.4.1 the harm that might result from such accidental, unauthorised or unlawful processing and loss or damage;

60.4.2 the nature of the Personal Data protected; and

60.4.3 comply with all applicable Data Protection Legislation and its information and security policies.

61 Each Trust warrants and represents that in acting as Controller, the Processor's expected use of the Personal Data for the Joint Functions and as specifically instructed by the Controller will comply with the Data Protection Legislation.

Impact assessment

62 The Trusts shall:

62.1 provide all reasonable assistance to each other to prepare any Data Protection Impact Assessment as may be required (including provision of detailed information and assessments in relation to Processing operations, risks and measures); and

62.2 maintain full and complete records of all Processing carried out in respect of the Personal Data in connection with this Agreement, in accordance with the terms of Article 30 UK GDPR.

Termination

63 The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement in consequence of any breach, including of this Part D of Schedule 7 in accordance with Clause 19 (Termination).

Data retention

64 At the Controller's request, the Processor will give the Controller, or a third-party nominated in writing by the Controller, a copy of or access to all or part of the Personal Data in its possession or control in the format and on the media reasonably specified by the Controller.

65 On termination of this Agreement for any reason, the Processor will securely delete or destroy or, if directed in writing by the Controller, return and not retain, all or any of the Personal Data related to this Agreement in its possession or control, only.

66 If any law, regulation, or government or regulatory body requires the Processor to retain any documents, materials or Personal Data that the Processor would otherwise be required to return or destroy, it will notify the Controller in writing of that retention requirement, giving details of the documents, materials or Personal Data that it must retain, the legal basis for such retention, and establishing a specific timeline for deletion or destruction once the retention requirement ends.

67 The Processor will certify in writing to the Controller that it has deleted or destroyed the Personal Data within 28 days after it completes the deletion or destruction.

Schedule 8 Scheme for Trust Board Appointments

Organisational Development Plan: to develop in Q1 2025-2026

Schedule 9 Recommendations

Recommendations approved by Boards [July/ September 2024].

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	26th March 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**
1. Partnership Report - Community Contract Transfer	Noted	
2. Health Inequalities quarterly report	Noted	
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. Emergency Preparedness Resilience & Response Annual Report	Good	
9. NCTR Audit	Noted	
10. UEC Plan	Noted	
11. Improving Together Strategic Planning Framework Review	Noted	

POINTS OF ESCALATION	N/A
KEY AREAS TO NOTE	**Partnership report** **RTT** Improvement continues on RTT but still off target year to date Patients waiting over 52 weeks down by 95 to 1,195 versus prior month Patients waiting over 65 weeks up by 1 to 43 (84% lower than last year). Noted that foot and ankle is a particular issue, but mutual aid from RUH taking 30 patients has been appreciated. 18 week RTT at 56.9% - the 5th consecutive month of improvement Lowest overall list size since April 2024 **ED** Combined 4 hour performance at 72.5% down from 73.6%, noting UTC wait at 149 mins, ED at 447 mins (first reduction in 5 months). 12-hour trolley waits down 24% to 378 in month. **Ambulance handovers** Decrease to 92 hours from 126 hours (the 5th consecutive month the target maximum average of 70 hours has not been met)

	130 patients waiting on trolleys greater than 4 hours and the number waiting greater than 8 hours has dropped to 5 from 29 in January. Priorities: - Relaunch discharge lounge improvement plan to discharge 12 patients by Noon. - Benefit realisation exercise underway to learn from bed reorganisation **EPRR** Annual Assurance Report approved with 97% compliance. The only 2 remaining areas of partial non-compliance are Business Impact Assessments and Business Continuity plans which form a focus for 25/26. **UEC plan for 2025/26** Responded to 2 Internal Audits (Admissions and NCTR) and incorporating ECIST report alongside internal lessons learned exercise. Length of stay is the key issue to focus on in coming year. **Strategic Planning Framework** Committee received the draft SPF for 25/26 and agreed the metrics and breakthrough objectives for assurance, including non-elective length of stay, at PPPC. Watch metrics will be reviewed in the April meeting. **Partnerships Report – Community Transfer** Committee was updated on the progress of 10 workstreams to ensure safe transfer of services to HCRG from 1 April. Primary risks relate to estates and facility legacy issues, financial impact and digital cutovers. **Health Inequalities Quarterly Update** Noted that data quality and analysis is in some cases problematic due to data limitations. Some correlation between deprivation and waits longer than 52 weeks at BSW level. Will be investigated at place.
BOARD ASSURANCE FRAMEWORK & RISKS	No new risks raised this meeting.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**Cancer** 28 day FDS at 80.2% for Jan (an improvement and above trajectory of 75.8%) 62 day performance improved from 73.4% to 75.5% with plastics still an issue – 46 breaches with 34 of them in Urology, Colorectal and Plastics 31 day performance at 89.7%. **DM01** Increase to 87.2% from 85.9% however some risk that when Audiology is added in future the performance may decrease. Total DM01 outpatient activity 2,016 above plan YTD.
REFERRALS TO OTHER BOARD COMMITTEES	N/A

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.
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Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	23rd April 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**
Operational Highlight Report (see below)		
1. IPR - DM01	Good	
2. IPR – RTT	Limited	
3. IPR – Cancer	Good	
4. IPR – ED / 4 hours	Partial	
5. IPR – Ambulance Handover	Limited	
6. Quarterly 15+ Risk Report	Good	
7. UEC Plan / Progress Monthly Update (Verbal)	Noted	
8. UEC Programme KPIs	Noted	
9. SPF Watch Metrics (Verbal update)	Noted	
10. Networks 6-monthly update (Verbal update)	Noted	
11. Partnership Report (Verbal update)	Noted	
12. NHS Performance Assessment Framework 25/26	Noted	

POINTS OF ESCALATION	N/A
KEY AREAS TO NOTE	**RTT** Improvement continues on RTT but still off target year to date Patients waiting over 52 weeks down to 950 from 1,195 in Feb Patients waiting over 65 weeks down to 21 from 43 18 week RTT at 58.0%, and increase of 1.2 percentage points. 2 x 78 Week breaches – one patient has been discharged and the other is being transferred elsewhere 12 week validation sprint funded by NHSE to take place next quarter. Lowest overall list size since April 2024 **ED** A 16% increase in patient numbers to 11,314 up from 9734 in February. Combined 4 hour performance at 70.1% down from 72.5%, noting UTC wait at 159 mins, ED at 420 mins. Overall average time up to 298 mins for the first time in 5 months. 12-hour trolley waits down 15% from 378 to 323 in month. The new MAU pathway was launched at the end of March.

	Ambulance handovers Decrease to 83 hours compared to 92 hours (and improvement for a second onth but the 6th consecutive month the target maximum average of 70 hours has not been met). An additional 291 arrivals. Expectation from NHSE has been adjusted down to 33 minute average handover time by June 2025. **NCTR** An increase of 3 to 91 patients per day. 132 patients with 14 day stay (up from 129), and 73 patients with 21 day stay as per last month. Overall 19% bed base = NCTR. **UEC plan** Areas of focus are: 1. SDEC 2. Ward processes - driving length of stay 3. Transfer of care - driving timely discharge **NHS Performance Assessment Framework (PAF)** Newly received NHS England requirements for acute, mental health, community trusts and and ICBs for 2025/26 were presented. Mapping of current position versus targets to be presented in June and aligned with watch metrics. **Partnerships Report – Community Transfer** The transfer has been smooth for patient care. There have been some IT connectivity issues. The Programme Board will continue to look at the mobilisation of the next tranche of services and continue to manage the interface between the Trust and HCRG. Swindon Borough Council are reviewing the Health and Wellbeing Board with a view to improving the delivery of health and wellbeing and reducing duplication between local authority and health partners. **Networks** An update on regional clinical network activity including the pathology and imaging networks.
BOARD ASSURANCE FRAMEWORK & RISKS	One new 15+ risk raised this meeting. Corporate risk relating to transfer of community services to HCRG and impact on patients.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**Cancer** 28 day FDS at 86.2% up from 80.2% for Jan 62 day performance improved from 73.1% (down from 73.4%) with Plastics still an issue – 49.5 breaches with 40 of them in Urology, Lung and Plastics 31 day performance at 93.5% from 89.7%. **DM01** Increase to 90.9% up from 87.1% with some specialities including MRI now being compliant, however some risk that when Audiology is added in future the performance may decrease.
REFERRALS TO OTHER BOARD COMMITTEES	N/A

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

Committee	**Quality & Safety Committee**
Meeting Date	20.3.25
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). Falls	Limited	
2. IP&C (IPR breakthrough objective)	Good	
3. IPR concerns and complaints (Non-Alerting Metric)	Limited	
4. IPR Maternity	Good	
5. Patient experience 6 monthly report	Good	
6. Quality Report for sepsis	Limited	
7. Improving Together Strategic Planning Framework	note	
8. Quality Accounts Priorities	note	
9. EDS Update	note	
10. CQC Preparedness	note	

POINTS OF ESCALATION	
	IPR: Reduction Total Harms • There has been a slight reduction in the overall harms in month, 159 from 173 in January. • It was noted that there had been a slight uptick in medication incidence, which on review were in fact 2 rather than the 5 recorded, following investigation of the events. These incidents related to dosage and parkinsonian medication error. **IPR: Continued monitoring Pressure Harms** • Reflective of the increased pressures within the organisation, there has been a further increase in pressure harms in hospital acquired, from 16 to 20, with seven category 3 pressure harms, whilst there has been a significant reduction in community acquired pressure harms from 23 in January to 9 last month. A strong action plan remains in place. **IPR: Infection Control** • All healthcare associated infections are now below NHS England trajectories**.** There has been a reduction in all gram negative infections likely due to the focussed catheter care work. • GWH remains well below target trajectory for *C.Difficile* infection number and comparative to last year. • *Methicillin-Sensitive Staphylococcus* (MSSA) numbers have remained static this month, but the trajectory for MSSA is internally set and this has been exceeded. A thorough review of skin prep/ hand hygiene is underway. • *Methicillin Resistant Staphylococcus Aureus* (MRSA) remains zero for 12th consecutive month. • Slight increase in *E.Coli* but below trajectory. **IPR: Breakthrough Objective: Falls** • This has seen a slight improvement with a reduction in overall falls and a modest reduction by one of falls with harm. As the incidence rates are continuing to drift away from trajectory the committee still felt they had less assurance around the management and action plan being effective. • A review of the A3 work and countermeasures towards this Breakthrough Objective was presented to the committee, but the committee reserved any change to the assurance rating until impact could be seen. • Deconditioning of patients continues to be a significant contributor.

	Complaints and Concerns • The complaint response rate has decreased (to 66%) and remains below the target of 80%. Despite focussed work, no improvement is being seen and the committee were assured that a review of the current A3 for improvement be reviewed and amended but were not able to feel assured over the impact until response rates improved.
	Maternity Integrated Performance Report • Significant progress against the CQC Action plan, including 24 hour triage provision and Safeguarding level 3 training, at 86 % close to target of 90%. • The committee received and were assured by the self assessment update against the Immediate and Essential Actions from the Ockenden report and trust position on CNST year 6 and 3 year maternity and neonatal delivery plans. • GWH is significantly below national stillbirth rate. • Digital move to `Badgernet' has been completed and now working towards embedding all new processes for documenting care, so far roll out going well with good staff engagement. Any issues identified have alternative work arounds in place until they are resolved on the system. • As the end of the reporting period for the Maternity Incentive Scheme (CNST) Year 6 approaches, compliance on all 10 standards are expected. • Staffing met acuity requirements. • Direct action in response to a higher incidence of post partum haemorrhage will be reported at the next committee meeting.
	Patient Experience 6 Monthly report • Whilst response times continue to fall below KPI targets, this is on a background of a high volume of cases, the sustained increase in cases is having a cumulative impact on turnaround times. • Waiting Times remain the dominant theme followed by communication. • The report highlights a selection of improvement projects across the Trust to improve patient experience. • Compliments highlight appreciation of clinical services provided, with notable areas including, Emergency Department, Acute Cardiac Unit, Woodpecker, PALS and Urgent Treatment Centre. • There has been an increase in the demand for translation services, with an updated use of Translation Services policy. • It was noted that currently there is no ability within the complaint data to systematically capture data on ethnicity, gender, disability etc. to understand whether minority groups are disproportionately affected. It is hoped the new EPR will enable this facility. • The committee were assured by the in depth analysis and reporting of the patient experience. There is a clear 6-month plan for further improvement work including new care reflections, work with estates to improve accessibility and further work to improve divisional processes.
	Quality report for Sepsis • GWH now has a sepsis lead for the Trust, responsible for the overall service of Sepsis, including. Guideline updates and creation, audit work, compliance of sepsis 6, teaching and supporting the ASK team for GWH. • 2024 had 226 deaths related to sepsis in GWH, which is 12.3% of total number sepsis attendances, which is significantly reduced to previous years but remains significant. • Sepsis admissions have a length of stay on average 13 days. • A sepsis audit trail was completed between June 2024 to September 2024. • There has been poor compliance with sepsis 6 bundle (only 25%) with administration of antibiotics within an hour at only 19%. • Sepsis 6 bundle compliance is now an area of focussed work. • Sepsis screening will become part of new EPR. • The ASK team are now no longer patient facing which resulted in duplication of work and not adding value. The ASK team now focuses on teaching and quality improvement projects related to sepsis care. • The committee were reassured that there is clearer understanding of current issues and improved leadership. The rating of limited reflects the poor sepsis 6 bundle compliance, antibiotic administration, mortality rates and a query around the accuracy of the data on total number of admissions and mortality rates as appears to be significantly and inexplicably lower than previous years, raising concern around coding error which is currently being assessed.

BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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

Committee	**Quality & Safety Committee**
Meeting Date	17.4.25
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). Falls	Limited	
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 Q4	Good	
6. Trust wide Learning from Deaths Report Q4 2024/25	Good	
7. Surgical Services CQC inspection - Highlights & Actions	note	
8. Getting It Right First Time Update	Good	
9. EDS Update	note	
10. Draft Quality Account 2024/25	note	
11. Risk register report April 2025	Note	
12. NHSE Letter 1/4/25 Working Together in 2025/26 to lay the foundations to reform	Note	
13. Safe Staffing Monthly	Note	
14. Report	Note	

POINTS OF ESCALATION	
	IPR: Reduction Total Harms • There has been a further reduction in the overall harms in month, 137 from 1159 in January, showing a consistent reduction with the lowest number of harms reported over the last 12 months. **IPR: continued monitoring Pressure Harms** • Following an uptake in January and February with increased cases, this month showed a significant reduction in hospital acquired pressure harms, with no category 4 harms recorded. One ward area has been identified as contributing the most over the year and additional support has now been put in place to embed good practice. **IPR: Infection Control:** • GWH remains well below target trajectory for *C.Difficile* infection number and comparative to last year. • *E.Coli* incidence has decreased to 1 and infection is now deemed more associated with community onset infections and hospital acquired covid infections. • There were zero cases of *Pseudomonas* in March, the Trust ending the year below trajectory with 19 cases vs the trajectory 30 cases predicted, demonstrating the successful focused work over the year. • *Methicillin-Sensitive Staphylococcus* (MSSA) numbers have decreased by one in month, but the trajectory for MSSA is internally set and this has been exceeded, a thorough review of skin prep/ hand hygiene is underway as the incidence rate is not improving. • *Methicillin Resistant Staphylococcus Aureus* (MRSA) has had the first incidence in a year and on investigation was deemed to be non preventable, as most likely community acquired. **IPR: Breakthrough Objective: Falls** • This has seen a significant a reduction in inpatient falls but the number of falls with moderate harm has increased to two in month.

	• The committee will receive a further review of the A3 work and countermeasures towards this breakthrough objective. • The falls policy and postural hypotension guidelines have been ratified and available to staff in the electronic documents system. • Deconditioning of patients continues to be a significant contributor.
	Complaints and Concerns • The complaint response rate has improved by 5% (to 71% with target 80%), the highest performance in the past 6 month. This is through Divisional focused efforts and continued A3 improvement meetings. The number of reopened complaints remain low at 2. Whilst improvement has been seen this month the committee has not changed the assurance rating until consistent improvement can be seen.
	Maternity Integrated Performance Report • Significant progress against the CQC Action plan including 24 hour triage provision. • Compliance in MSD1 and PROMPT training remains above threshold in most groups, but with a recent dip in anaesthetists associated with staff changeover. • The committee received and were assured by the self assessment update against the Immediate and Essential Actions from the Ockenden report and trust position on CNST year 6 and 3 year maternity and neonatal delivery plans with two actions also improving from amber to green. • GWH is significantly below national stillbirth rate. • Staffing met acuity requirements, and consideration of how deployment could be adapted to further enhance service delivery. • Direct action in response to a higher incidence of post partum haemorrhage has resulted in a working group to look at preventative actions. Actions put in place so far: cell salvage training to all theatre teams, grab bags of treatment support available in all birthing areas. The committee awaits a further update report.
	Q4 2024/25 Maternity and Neonatal Quality and Safety Report • Training requirements of all staff are continuously monitored and supported to ensure compliance. Additional funding has been put in place for Qualified In Specialty (QIS) for neonatal nurses to support reaching target compliance rate of 70%. • Following GWH leading the Maternity Support Worker (MSW) development programme across BSW, our MSW education lead has now completed the train the trainer program and now completing clinical skills training with band 2 and 3 staff at GWH. • Continued progress around equality and inclusion with the introduction of a 'passport' for maternity triage for women who do not speak English, enabling them to attend without having called ahead and delays through awaiting translation services. • Overdue Datix reporting has been noted impacted by vacancy in the delivery suite manager, Hazel ward manager and pelvic health role. • A vacancy imbalance has been noted within the service and centralised recruitment with then subsequent deployment to areas of greatest need is being focused on by the matrons. • Agency spend on band 5 nurses on neonatal has reduced with successful recruitment. • Actions against Ockenden, CNST 6 and Saving Babies lives continue to demonstrate successful compliance. • The committee were assured that all areas the report covers demonstrates clear understanding of the current position of service delivery and outcome and each area has clear action plans to encourage learning , development, enhanced service delivery and meet regulation requirements.
	Q4 2024/25 Learning from Deaths Report • The Standardised Hospital Mortality Index (SHMI) remains within the expected limits for GWH. • The Telstra Health data report is not accurate enough to be useful due to uncoded data and the contract for this service has not been continued. • There has been a spike in deaths over the winter but now reduced again to expected levels. This increase was seen throughout the Trust with no areas of concern identified and deemed seasonal increase. • SJR completion is a reduced in a planned way as not being undertaken in cases already in a coronial, PSIRF or clinical investigation process. This removal of duplication is resulting in better engagement and response to learning points. • The meeting schedule now has good purpose, engagement and attendance with clear actions and outcomes from learning.

	• The committee were assured by the clear progress in this area now, through committed leadership and appropriate adaptation to methodology to enhance learning.
	Getting it Right First Time Update • Good progress has been made within the Trust through collaborative working with Salisbury Foundation Trust, Royal United hospital, Bath and the Southwest Improvement Hub, the introduction of quarterly Divisional GIRFT reports, creation of benchmarking reports with shared learning and project management of historical and current review findings. • There has been noted very positive engagement of all staff following more triangulation of data and using GIRFT reviews to feed into existing workstreams, such that the GIRFT requirements influence the workstream action plans. • Following visits and deep dives, feedback has been positive with specific praise for our endocrinology service and paediatric rheumatology. • Areas for improvement have been identified in urology and interventional radiology, but actions are in place which feed into workstreams.
	Electronic Discharge Summary Update • The new Careflow electronic patient record based Electronic Discharge Summary system went live on 26/3/25. • Focus now is on assessing the quality of the data produced to assess the impact of the new service on the Trust EDS risk which currently scores 16.
	Draft Quality Account 2024/25 • This report was reviewed and noted. Data results still require updating. The Committee noted the proposed areas of focus for the coming year to be around: 1. Sepsis Bundle compliance 2. Patient Experience at night and day 3. Self administration of medications
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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

Committee	**People & Culture Committee**	
Date of Meeting	29 April 2025	
Committee Chair	Julian Duxfield, Non-Executive Director	
Link to Strategic Objective	Pillar 2: Workforce	
Link to Board Assurance Framework	BAF: SR 2 (Culture), SR 3 (Workforce Planning)	
Improving Together Pillar Metrics	Voluntary Turnover	Staff Recommendation as a place to work
	Equality, Diversity & Inclusion (EDI)	
Improving Together Breakthrough Objective	Improving Staff Survey – Q7c I receive the respect I deserve from my colleagues at work	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. **Apprenticeship Report**	Partial	No
2. **Annual Report for Education and Training**	Partial	No
3. **People Promise -End of Year Update**	Good	No
4. **2024 Trust Staff Survey Results**	Good	No
5. **Corporate Division Staff Survey Analysis**	Partial	No
6. **Medicine Division Staff Survey Analysis**	Limited	No
7. **Surgery & planned care Division Staff Survey Analysis**	Partial	No
8. **Family & specialist services Division Staff Survey Analysis**	Partial	No

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	There has been some good progress on developing apprenticeships, 143 staff are undergoing apprenticeship-based training and there are 7 'new to role' apprentices. GWH's apprenticeship levy (tax paid by employers who have an annual pay bill of more than £3 million, which can only be accessed to pay for apprenticeship training costs, collected monthly through PAYE) for 2024 was approx. £1.5m, but our levy spend was only £800k, although we do have two years to spend this. The committee approved the removal of the requirement for English & maths qualifications for entry to levels 2-4 training and GWH will support trainees to achieve these qualifications during training. The annual report on education and training demonstrated progress against the recommendations within the 2024 review. The Clinical Lead for Learning and Development was appointed in November 2024 as part of the restructure within the Academy and is working to ensure that all outstanding recommendations are achieved but it was recognised that this will take time to embed.

	A final report of the 12-month People Promise Retention project to implement a range of policies and initiatives to help deliver improved retention was received. This work included the delivery of: the 'Sexual Misconduct Policy' and training the set-up of 'exit conversations' on ESR, creating a quarterly dashboard to highlight reasons for leaving; a Trust-wide Induction booklet as part of the Trust induction experience; and regular Pension & Financial Workshops to support colleagues to plan for their future. The Trust Staff Survey results were shared and discussed. The results demonstrate that there was minimal movement when compared to last year's results. The Trust results are comparable to the average sector scores other than the People Promise Questions "We Work Flexible" which is significantly better than sector scores. The committee supported the decision to retain question 7C "I receive respect I deserve from colleagues" as a breakthrough question. It should be noted that the Trust had the highest response rate (71%) of any acute and community trust nationally, reflective of a successful targeted communications plan. The most significant section of the meeting was taken in reviewing the status of the plans which each division have for addressing issues raised by the latest staff survey. There is a range of approaches across divisions using the improving together methodology to focus on the key issues for their teams, departments and wards, but P&C cttee is unable to provide the Board with a 'good' level of assurance for any of the divisional plans at this stage due to the limited focus on specific improvement actions and design outcomes. The committee will take a further update from each division during the rest of the year to monitor progress. In addition, a monthly Trust Wide Staff Survey Working Group and monthly Executive review meetings provides a forum for divisional survey leads to give an oversight and assurance of their actions, progress, and learning, including their commitment to support the Trust's breakthrough objective which is focussed on staff feeling respected.
BOARD ASSURANCE FRAMEWORK & RISKS	The Committee's discussion of the IPR data focussed on the difficulties associated with delivering the workforce recovery targets and noted the significant increase in temporary staffing usage in recent months. Current processes to manage this headcount reduction do not appear to be delivering the reductions required with temporary staffing usage being a key issue. In addition to temporary staffing reduction, the Trust needs to make a 135wte substantive headcount reduction. To support this reduction the Trust is considering implementing a Mutually Agreed Resignation Scheme (MARS). In addition to the above items assured by the committee we were briefed on the current review of the national job evaluation scheme profiles for the Nursing and Midwifery bands 4-6. There is an annual cost risk to the Trust associated with this of approximately £10m. A task and finish group with Bath and Salisbury will ensure consistency of approach and aims to have the same JD's across the Group.

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Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**	
Meeting Date	24 March 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 11 Finance Position	Good	x
3. Improvement & Efficiency Program	Good	x
4. Community Contract Mobilisation Program Update	Good	x
5. Strategic Planning Framework Review 2025/26	Note	x
6. Risks – Estates and Facilities	Good	x
7. Update – Electrical incident	Good	x
8. HCRG cyber security incident update	Partial	x
9. GWH/Prime Final Partnering Agreement	Approve	x
10. Staff & Student Accommodation Development Strategy	Approve	x
11. BAF Strategic Risks – review of emerging risks	Approve	x

POINTS OF ESCALATION	**BSW Financial Update:** As reported in previous months the finance position at M11 remains adverse; 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. The Committee is assured that mitigating actions have been identified to address these challenges. Still, the outlook for 2024/25 remains exceptionally challenging. The Committee notes that the financial risk for the system is escalating and is high, with the outlook for 2025/26 forecasted as challenging, notwithstanding the actions agreed at the System Financial Recovery Board. Furthermore, the Committee's assurance rating of 'Limited' is based on the lack of independent challenge at the system level and immature governance processes or the lack thereof.
POINTS TO NOTE	**Month 11 Financial Position:** The Trust's adjusted deficit position is £9.5m, representing a £0.4m adverse variance from the plan. Income is £17.8m favourable to the plan, driven by ERF (£7.8m); an overperformance on NHSE Commissioned Drugs (£4.7m) and industrial action funding and the gap pay award (£1.4m). Overall, pay is £9.3m over the plan, which includes £0.5m of junior doctor's industrial action costs offset by income and £0.9 m under delivery of pay efficiencies. Non-Pay is £11.5m over the plan, including a £7m variance in clinical supplies and outsourcing, particularly in Medicine, Surgery, Women's & Children's. The Committee is assured that grip and controls are in place, including regular meetings, specifically with the 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 10, the programme has delivered £16.5m year to date, with 50% of this being delivered recurrently. An assurance rating of 'Good' was agreed upon for M10 as the Committee was reassured of the controls and initiatives in place to address efficiency challenges. M11 delivery is in line with the forecast as at M10, and therefore, an assurance rate of good has been given for this report. **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.
	HCRG Cyber Security Update: The Committee received an update on the local (GWH), regional (ICS) and national (NHSE) approach to the HCRG incident. IHCRG is a private provider of healthcare services to the NHS and a partner organisation to the ICS. They are not bound by, nor can they utilise the NHSE-provided cyber services. However, they are encouraged to share the same metrics as the ICS and NHSE for cyber. At the time of the report, further work is to be undertaken to assure the Trust of its wider supply chain cyber controls so we have better visibility of the risk and the impact.
BOARD ASSURANCE FRAMEWORK & RISKS	**Estates & Facilities Risk Register:** 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.

Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**	
Meeting Date	28 April 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 12 Finance Position	Good	x
3. Improvement & Efficiency Program	Good	x
4. 2025/26 Planning Update	Partial	x
5. Risks – Digital & EPR	Good	x
6. Data Protection, IT Resilience and Cyber Security Quarterly Update	Good	x
7. Digital Strategic Plan Quarterly Update	Good	x
8. Procurement Update	Good	x
9. Procurement Recommendation Report – Interventional Cardiology Consumables	Approve	x
10. West of England Imaging Network – FBC for approval	Approve	x
11. BAF Strategic Risks – review of emerging risks	Approve	x

POINTS OF ESCALATION	**BSW Financial Update:** The system financial position at M12 is breakeven (£0.0m variance). This position is after the recognition of the pro-rata share of £30m deficit funding and additional funding received in Month 11, £15m. Overall, ICB's year-to-date performance on ERF is 125.2% compared to the stretch plan of 117%. Reported performance equates to c. £46.3m above target. High numbers of NCTR remain across all BSW – Acute and Community beds. The NCTR position for the three system Acutes has remained at c. 20% across February and March and is, therefore, significantly above our plan. We recognise the significant work to be done to address this issue in the new financial year, and planning work is ongoing. The Committee notes that the financial risk for the system is escalating and is high, with the outlook for 2025/26 forecasted as challenging, notwithstanding the actions agreed at the System Financial Recovery Board. Furthermore, the Committee's assurance rating of 'Limited' is based on the lack of independent challenge at the system level and immature governance processes or the lack thereof.
POINTS TO NOTE	**Month 12 Financial Position:** The Trust completed the financial year with an adjusted surplus position of £1.4m, representing a £1.4m favourable variance from the plan. Income is £43.9m favourable to the plan, driven by ERF (£9.6m), an overperformance on NHSE Commissioned Drugs (£5.3m) and industrial action funding and the gap pay award (£4.4m). Additional education and training and other SLA income completed £4.4m above plan with the remainder of the favourable variance (£20.2m) due to pension funding offsetting cost. Overall, pay is £31.0m over the plan, which includes £0.5m of junior doctor's industrial action costs and pension costs of £20.2 m, both offset by income and £2.93 m under delivery of pay efficiencies. Non-Pay is £13.7m over the plan, including a £8.9m variance in clinical supplies and outsourcing, particularly in Medicine, Surgery, Women's & Children's. The Committee is assured that grip and controls are in place, including regular meetings, specifically with the workforce and financial recovery committees, to monitor spending and associated savings for the 2025/26 financial year.
	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 12, the programme has delivered £18.4m year to date, with 50% of this being delivered recurrently. An assurance rating of 'Good' was agreed upon for the M11 as the Committee was reassured of the controls and initiatives in place to address efficiency challenges. M12 delivery is in line with the forecast as at M11, and therefore, an assurance rate of good has been given for this report. **2025/26 plan:** The efficiency requirement for 2025/26 is £27.2m plus £5.3m unidentified deficit gap, representing a target of £32.3m. A total of £14.8m schemes have been identified, 45% of divisional targets are yet to be identified, and 54% of schemes are red rated. Therefore, transformational change and recurrent delivery must be significantly strengthened for 2025/26.
BOARD ASSURANCE FRAMEWORK & RISKS	**Digital Inc. 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	N/A
REFERRALS TO OTHER BOARD COMMITTEES	N/A

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	**08/05/2025**	Part 1 - Public	✓	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	-				

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 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 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 March (February for Cancer) are as follows:

STRATEGIC Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

March's performance shows the total number of patients waiting over 52 weeks at 950, a significant reduction of 245 from the previous month. Patients waiting over 65 weeks at the end of March was 21, a reduction from 43 last month, but 5 over the Trust revised operating plan trajectory (16 patients). The PTL size at the end of the month was 38190, a decrease of 1.2%.

There were 2 x 78-week breaches reported in March 2025 within Plastics (86 weeks) and Dermatology (79 weeks). The dermatology patient has since been discharged and an alternative provider is being sought for the Plastics patient to avoid further delay to their treatment.

A risk remains for April across a few specialties including Plastics, ENT, Urology, General Surgery, Orthopaedics and Gynaecology. The Trust is currently forecasting 18 x 65 week wait breaches at the end of April. Mitigating actions are being implemented including insourcing for Plastics, and wider system mutual aid.
A 12-week validation sprint has commenced with additional funding from NHSE to support cleansing of the active waiting list. The aim is to reduce the waiting list by a minimum 5% through administrative, technical and clinical validation processes.

- 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 (86.2% against 76.69% trajectory). Weekly review meetings are being held to review in month breach reasons in Urology, Upper GI, Colorectal, ENT, & Gynaecology. These will help identify and inform improvement opportunities that can be explored by the service and shared via the A3 Improving Together Methodology at the Trust Cancer Delivery Group.

At the end of February, there were 5.1% of patients waiting over 62 days on the PTL, which has recovered from the 7% reported in December. Pressure on the PTL is due to the number of long wait patients on a Plastics pathway which continues to grow as a result of the capacity issues for outpatients and minor operational procedures.

62-day performance for urgent suspected cancer referral to treatment declined slightly to 73.1% in February and is in line with the operating plan trajectory of 73.1%. In February, there were 49.5 breaches in total, with 40.0 of these attributed to the Urology, Plastics and Lung pathways. Urology & Plastics pathways are seeing issues with capacity for appointments and diagnostics.

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). 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 and risks around recruitment delays.

Cancer 31-day performance was at 93.5% in February. Performance was expected to recover to the 96% target in February but has deteriorated due to capacity challenges within

the Skin pathway. Outsourcing, waiting list initiatives and tumour site pathway reviews continue as part of improvement work to deliver the 96% standard.

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

There were 11,314 patients seen in ED/UTC in March, which is a 16.18% increase from February (9,734) noting that this is a shorter month. Volumes of attendances is reflective of what we saw during winter pressures i.e. October (11,300) & December (11,067), similarly respiratory admissions were up in March with patients being admitted with flu.

The total mean wait time for a patient in March increased by 10 mins since February to 159 minutes in UTC, which is within the national standard of 240 minutes. The mean wait type in ED had also increased for the first time in 3 months to 298 minutes and is therefore 58 minutes above the national 4-hour target. Non-admitted 4-hour length of stay performance has also mildly inflated by 7 minutes from February's 292 to 299. March launched the new MAU pathway, where patients who are referred to medicine can go directly to MAU (within safe criteria), reducing holding times in ED for clerking or clinical reviews. The ambition is to stream to MAU, short stay medical wards or direct to specialty.

Combined 4- hour performance was 70.1 %, a slight drop by 2 % since last month, but overall holding above 70 % for the past 4 months, however against the national standard of 95% we are 35.2 % below target.

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

Bed days lost in March due to no criteria to reside showed an average of 91 patients per day occupying the bed base, which is a 3 day increase from February. This rise is also reflected in an overall increase in our Stranded patients which showed, 132 patients with a 14-day length for stay in March compared to 129 in February. Super stranded patients at 21-days remained unchanged month on, holding at 73 patients. 19% of the bed base during March was reported as not meeting the criteria to reside. NCTR teams are supporting identification of patients with planned discharge pathways to escalation areas, to support good flow out of these areas and offer opportunities to reduce capacity to hold for weekend support when able to do so.

There is a noted risk for the month of April and beyond that NCTR volumes and length of time may extend given the recent change to community provides and the Swindon locality move from block beds to spot purchases, while contracts are out for procurement for new carer providers 2025/2026.

OPERATIONAL BREAKTHROUGH OBJECTIVE

- Ambulance handover delays

An average of 83 hours were lost per day from ambulance handover delays in March, which is down from the 92 hours in February and, being the 2nd consecutive month of a reduction. This is a 10.8 % improvement month on, but the sixth consecutive month during which the breakthrough objective of 70 hours was not met. There was an increase of ambulance handovers from February's 1,668 to 1,959, an additional 291 arrivals.

The Trust has set out the 'Great Flow Programme' that outlines the seven flow workstreams that will support improved flow across the organisation and wider, and by using Improving Together Methodologies will lead to improving pathway design and process.

The weekly regional Ambulance Handover performance meetings is helping to provide good learning and discussion with our ambulance partners and other acutes, which is fed back for consideration to frontline teams.

Escalation protocols were re-reviewed in March to support the constant flow to all escalation spaces on the wards including, an additional patient in the risked assessed corridors while there remain long holds for ambulances offloads and additional patients in the emergency department corridors. Release to Rescue by 45 minutes changes are likely to be implemented within BSW by June this year.

ALERTING WATCH METRICS

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

Diagnostics – February validated DM01 performance improved to 87.7% from 85.9% in January.

Changes to DM01 reporting guidance effective from 1st April 2025 are under review, as the inclusion of additional waiting list types for Audiology has the potential to negatively affect performance by up to 10%.

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 a reduction in the number of harms in month to 137 from 159 in February. This is the lowest number of harms reported over the last 12 months.

The has been a decrease in the number of falls in month to 85 compared to 106 in March. The number of falls with moderate harm or above has increased to two in month, compared to one in February.

There has been an increase in Klebsiella and Methicillin-resistant Staphylococcus aureus (MRSA), the first case in 2024/25 but a decrease E. coli, methicillin-susceptible Staphylococcus aureus (MSSA) and COVID Hospital acquired.
The number of Family and Friends (FFT) positive responses for March is 89.0%, just below the Trust 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 March two patients experienced falls that resulted in moderate harm or above. The number of patients with two or more falls has decreased significantly in month to three.

Alerting Watch Metrics
The number of complaints received in month has increased to 65 compared to 51 in February. There has been a increase in complaint response rates to 71% compared to 66% in February.

Non-alerting Watch Metrics
The Emergency Department and Urgent Treatment Centra positive response rate has decreased to 74.4% and is just below the internal target of 79.7%.

C.*difficile* numbers have remained stable in month at four.

The overall Family and Friends positive response rate for January is 89.0% and is just below the new stretch target.

MSSA numbers have decreased in month to three compared to four in February. Cannula care has been the most common theme, and one Division are focusing there A3 improvement around this topic.

There has been one Methicillin-resistant Staphylococcus aureus (MRSA) case reported in month, which puts us over the target of zero. This was a community-onset case, deemed healthcare-associated because the patient received care in the Urgent Treatment centre two days previously. The case has been investigated and there were no missed opportunities during the care provision. The Integrated care Board are in agreement and have stated that they do not wish to hold an investigation meeting for this case.

The numbers of *E. coli* infections fell in month to six compared to seven reported cases in February.

The number of hospital-acquired pressure ulcers has decreased in month to 11, compared to 20 in February. There were no category four pressure ulcers in month.

Further points to note relating to non-alerting watch metrics include:
- Safer staffing fill rates remain above the National target of 85%.

Seven Patient Safety Incident Investigations have been declared in March, one was agreed as meeting the criteria of Never Event, oral medication administered via a parenteral route. All 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% in the 2024 Staff Survey (59.6% last year) – Q4 pulse survey shows a significant decline to 51.8%
- **Staff Voluntary Turnover**
  Target 11% achieving 8.5% (Feb data) – continues to be stable
- **EDI disparity (reducing discrimination disparity**)
  Target 9.4% achieving 11.9% in the 2024 Staff Survey (12.7% last year) – Q4 pulse survey shows a significant increase to 15.1% however pulse survey is less representative due to the sample size as demonstrated in previous pulse survey results.

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 from 2025/26 onwards.

The national average for this question is 70% in the 2024 Staff Survey, against which a stretch target of 73% has been set. Currently, The Trust performance is 69% (2024 Staff Survey results) and 69% in the Q4 Pulse Survey.

Alerting Watch Metrics
In-month sickness absence decreased to 4.9% in February (compared to January 5.1%), back in line with the position in December however above levels 12 months ago (4.4%).

HR Scorecard

Vacancy Rate
In March our vacancy rate reduced again, decreasing from 167WTE to 163WTE (3.0%) and continuing below the target of 7%. Our Healthcare Support Worker vacancy has further improved in March, decreasing to 35WTE in-month compared to 72WTE in January. Our Registered Nursing vacancy continues to be over-established at -33WTE (excluding Corporate and Pre-registered), and our Medical & Dental vacancy position has improved in March, decreasing to 62WTE (67WTE in February).

Bank Spend
Bank spend in March was £2.7M, which was £1.34M above the in-month target and an increase on the previous month. Our year-end position was £26.1M, which was £4.9M above the planned spend of £21.2M. There was a significant increase in bank usage in

March with an additional 49WTE of resource being used compared to February; notably an additional 8WTE was used for special/enhanced care, 13WTE for escalation/additional capacity, 9WTE for maternity leave cover, and 6WTE for covering sickness absence.

Agency Spend
In-month agency spend in March was £0.61M, a small increase compared to February and accounting for 2.14% of our total paybill spend (below the target of 4.5%). Our full year spend is £5.65M, which is above the £5.38M target by £0.27M however is a significant reduction compared to last year (£9.9M in 2023/24). Agency WTE usage also increased in March, with further nursing staff being used to cover seasonal pressures and additional agency mental health nursing.

Workforce Recovery
We used 5,802WTE to deliver our services in March, finishing the year +298WTE to our planned levels. Our substantive workforce increased slightly in month; however the primary driver of the above plan position is temporary staffing with bank usage at 177WTE above plan and agency 24WTE above plan.

Focusing on 2025/26, this end of year position poses a challenge for the Trust as unmet reductions from this year will be rolled into next year, alongside additional temporary staffing reductions and removal of Corporate WTE growth. The Workforce Recovery meeting has been reconvened and following an initial scoping meeting in March a high-level delivery plan has been agreed, focusing in Q1 on reviewing all administration and estates posts to identify opportunities for reductions, reviewing fixed term contracts, removing vacant posts, and drafting an outline MARS programme.

Use of Resources

The Trust finished the 2024/25 financial year with an adjusted surplus position of £1.4m, which represents a £1.4m favourable variance to plan. Income finished £43.9m ahead of plan, driven by overperformance on ERF (£9.6m), NHSE commissioned drugs (£5.3m) and central funding for surge, industrial action and the gap on pay award (£4.4m). Additional education, training and other SLA income finished £4.4m above plan, with the remainder of the favourable variance (£20.2m) due to pension funding offsetting cost. ERF performance finished above the 112% stretch target, including advice and guidance, at 117.5%.

The pay position of £31.0m adverse to plan included £20.2m of pension costs and c.£0.5m of junior doctor industrial action costs, both offset by income, and a £2.3m under-delivery of pay efficiencies. Temporary staffing pressures relating to vacancies, escalation and mental health provision accounted for the rest of the pay variance, partially offset by centrally held reserves (e.g. maternity / paternity leave).

Operational non-pay spend finished £13.7m over plan, which included £8.9m 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 £4.8m over plan, £3.1m of which is passthrough related and offset by income.

The efficiency plan finished £3.4m under the target of £21.9m. Of the £18.5m savings delivered, 49% was recurrent. For 2025/26, the efficiency target is £24.2m plus £2.8m of undelivered recurrent savings from 2024/25 to give a total of £27.0m. There is a further gap

to achieve a breakeven plan, including the impact of an ICS £11m saving requirement (of which £3.5m is allocated to GWH). The total gap for us is £5.4m, giving a total Trust wide cost reduction requirement of £32.4m.

Breakthrough Objectives
The financial breakthrough objective was 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 finished the 24/25 financial year with a £1.4m favourable position to plan. This was achieved largely through non-recurrent central funding received in year. Our underlying position remains challenging; we under-achieved against our £21.9m savings plan by £3.5m, with only 49% of the total savings of £18.4m being delivered recurrently. There are various recovery workstreams in progress which will continue and be refreshed as necessary in 25/26, 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. 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. Focussed training for the remaining requisitioners around best practice is a key next step.

Strategic Alignment – select one or more		✓ Outstanding care		✓ Valued teams		✓ Better together		✓ Sustainable future

Link to CQC Domain – select one or more	**Safe**	☐	**Caring**	☐	**Effective**	☐	**Responsive**	☐	**Well-led**	☐

Risk + Oversight	**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Trust Management Committee & PPPC
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?	✓	☐	☐

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

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/Committee/Group is requested to:

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

Accountable Lead Signature	Benny Goodman, Chief Operating Officer
Date	**16/04/2025**

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

April 2025

March 2025 & February 2025 data period

Improving together

Service Teamwork Ambition Respect

Content & introduction

Great Western Hospitals NHS Foundation Trust

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

Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total 104 week waits	0	0	0	0	1	1	0	0	0	0	1	0	0
Total 78 week waits	0	3	4	3	3	12	6	5	3	1	3	2	2
65 weeks wait performance vs plan (size adjusted)	100.0%	70.0%	117.9%	148.4%	154.6%	200.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Proportion of PTL over 65 week waits (size adjusted)	0.0%	0.4%	0.6%	0.7%	0.6%	0.7%	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%
Under 18 elective activity rate vs baseline	100%	123.9%	119.0%	114.4%	117.0%	131.8%	124.8%	221.8%	153.8%	109.8%	140.0%	108.9%	117.2%
Faster diagnosis rate	75% (Nat)	59.2%	66.7%	70.2%	75.2%	81.8%	78.8%	79.5%	78.9%	79.5%	80.2%	86.2%	Reported one month behind
62-day performance	85% (Nat)	63.1%	64.3%	69.4%	68.1%	70.3%	70.8%	78.1%	70.4%	73.4%	75.3%	72.7%	Reported one month behind
Proportion of patients seen within 4 hours	95% (Nat)	75.9%	75.3%	75.0%	77.1%	79.5%	77.4%	72.6%	74.0%	74.7%	73.6%	72.5%	70.1%
Number of mental health patients spending >12 hours in an emergency dept	7	14	9	6	6	7	3	9	1	8	8	5	12
Readmission rate	14.8%	14.0%	15.9%	15.1%	14.7%	16.0%	14.8%	13.7%	14.0%	14.5%	15.0%	14.6%	15.4%
Summary Hospital-level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months	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)	4.2%	4.2%	4.6%	5.2%	4.5%	4.3%	4.9%	4.9%	4.9%	5.1%	4.9%	Reported one month behind
Leaver rate	11.0% (Int)	8.6%	9.7%	11.0%	9.6%	11.0%	10.6%	11.0%	9.7%	9.9%	9.0%	10.4%	Reported one month behind
Implied productivity	0	-13%	-17%	-15%	-17%	-15%	-13%	-11%	-14%	-15%	-14%	-13%	Waiting for data
Proportion of staff in senior leadership roles who are from BME background	16% (Nat)	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.4%	5.0%	5.0%	4.9%	4.9%	6.7%
Proportion of staff in senior leadership roles who are women	64% (Nat)	56.7%	56.7%	56.7%	57.4%	58.3%	56.7%	56.9%	55.0%	55.0%	55.7%	54.1%	53.3%
Proportion of staff in senior leadership roles who are disabled	3.2% (Nat)	1.7%	1.7%	1.7%	1.6%	1.7%	1.7%	3.5%	3.3%	3.3%	3.3%	3.3%	3.3%

Key Indicators

Great Western Hospitals NHS Foundation Trust

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

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

Executive Summary

Great Western Hospitals NHS Foundation Trust

Total Harms

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

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

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

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

Patient Experience (FFT)

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

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

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

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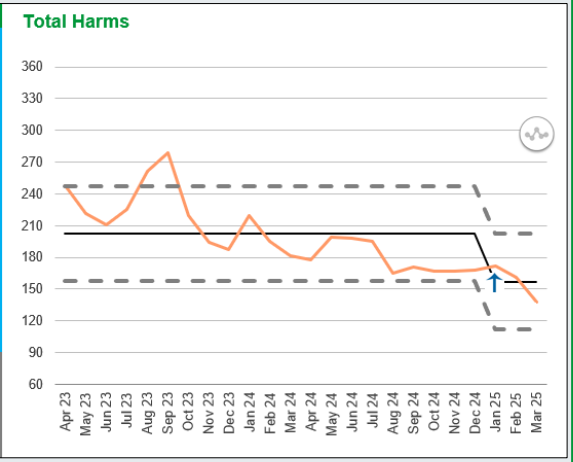
Total Harms

To achieve and sustain zero avoidable harm.

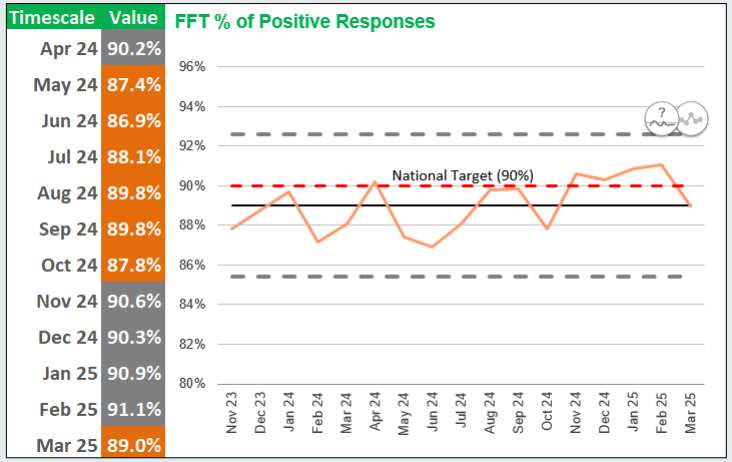
Timescale	Value
Apr 24	178
May 24	199
Jun 24	198
Jul 24	195
Aug 24	165
Sep 24	171
Oct 24	167
Nov 24	167
Dec 24	168
Jan 25	172
Feb 25	161
Mar 25	138



Patient Experience (Friends & Family Test)

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

Timescale	Value
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%
Jan 25	90.9%
Feb 25	91.1%
Mar 25	89.0%



Counter Measures

The total number of harms has reduced in month, 138 compared to 161 in February.

There has been one Methicillin-resistant Staphylococcus aureus (MRSA) one case in March, our first for 2024/5 which puts us over the target of zero. This was a community-onset case, deemed healthcare-associated . The case has been investigated and there were no missed opportunities.

The number of falls has decreased significantly in month to 85. The lowest number since October 2024.

There was a small dip in the overall Trust wide positive response rate for FFT in March with a Family and Friends (FFT) 89.0% just under the increased target of 90% set in 2024/25. Enhanced communication and visibility improvement actions are being taken in Inpatient and Front Door areas.

A quarterly snapshot of FFT benchmarking across BSW has been compiled to highlight comparative performance and identify areas for improvement.

Continued targeted funding will support A3 complaint meetings, with a focus on strengthening complaint response writing and addressing historical challenges.

Executive Summary

NHS Great Western Hospitals NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance
In February, there were 49.5 breaches in total, with 34.0 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 (34.3% 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 start to see fewer breaches 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 February Plastics was responsible for 25.3% of breaches, without these performance would have been 79.9%

RTT: Number of patients waiting over 52 weeks

RTT performance increased by 1.14% in March, delivering 58.03% (interim target for March 2026 is 60%). The total number of patients waiting over 52 weeks was 950, a significant reduction of 245 from last month.
Patients reported waiting over 65 weeks at the end of March was 21 against our trajectory of 16. A number of these were due to late conversions of non-admitted patients to admitted pathways, as well as patient choice and complexity of clinical pathways.

2 x 78-week breach (included above) reported in March 2025 including 1 Plastics (appointment cancelled in March) and 1 Dermatology patient with a complex diagnostic pathway. The latter has now been discharged and an alternative provider is being sought for the Plastics patient.

A risk remains for April across a few specialties including Plastics, corneal grafts, foot & ankle surgery and potential conversion risk in Urology and General Surgery.
A validation sprint commenced 7th April and will support cleansing of the waiting list as well as proactive management of long waiters to ensure surgery is still desired.

Significant progress is being made to reduce the wait to first appointment, booking processes and oversight of the active waiting list across all divisions.

Benny Goodman | Chief Operating Officer

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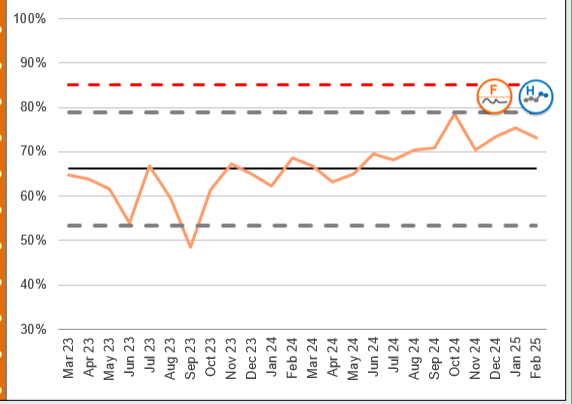
Cancer 62 Day

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

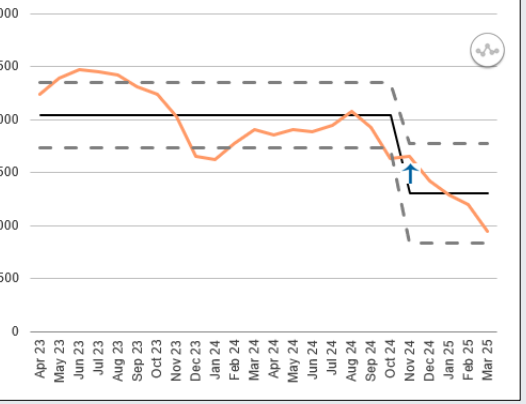
Timescale	Value
Mar 24	66.7%
Apr 24	63.1%
May 24	65.1%
Jun 24	69.4%
Jul 24	68.1%
Aug 24	70.3%
Sep 24	70.8%
Oct 24	78.5%
Nov 24	70.4%
Dec 24	73.4%
Jan 25	75.3%
Feb 25	73.1%



RTT: Number of patients waiting over 52 weeks

To eliminate over 52-week waiters as soon as possible and to reduce to <1% of PTL by end March 2026

Timescale	Value
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
Jan 25	1,290
Feb 25	1,195
Mar 25	950



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 24 with weekend clinics to clear backlog and provide the necessary additional capacity. Improvements in the 62D performance are expected from February/March 25
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. OUH providing additional registrar support where they can.

Risk: Insufficient capacity to eliminate waits over 65 weeks in 3 key specialties (Foot&Ankle, Plastics and corneal grafts)
Mitigation:
- Mutual aid fully utilised as it becomes available
- 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.
- 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.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime (ED & CEU) in March 2025 was 420 minutes against the national standard of 240 minutes . This is an expected progressive improvement as some winter pressures are alleviated.

March was a challenging month though, the aftermath of IP&C issues impacting flow and admission timeliness across the first half of the month. Proactive decisions on escalation bed space within the ward base supported improved flow which supported an improving position, additional focus on alternative to admission pathways further supported this position.

Emergency Care – Urgent Treatment Centre - Mean Stay

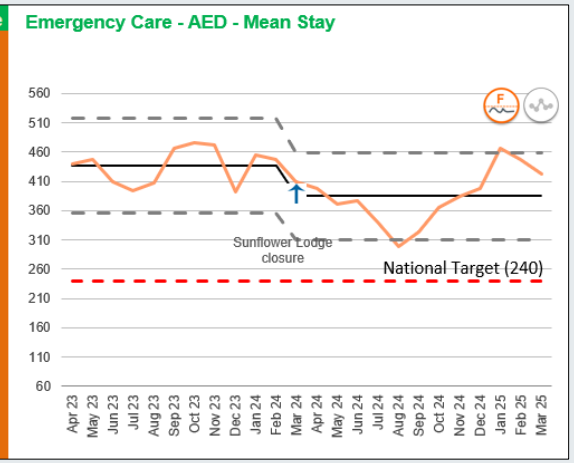
The total attendance mean time wait for a patient in March 25 was 161 minutes against the national standard of 240 minutes. This has increased from 150 mins in February but this is a reflection of staff unplanned absence and unfilled locum/bank shifts in the period.

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.

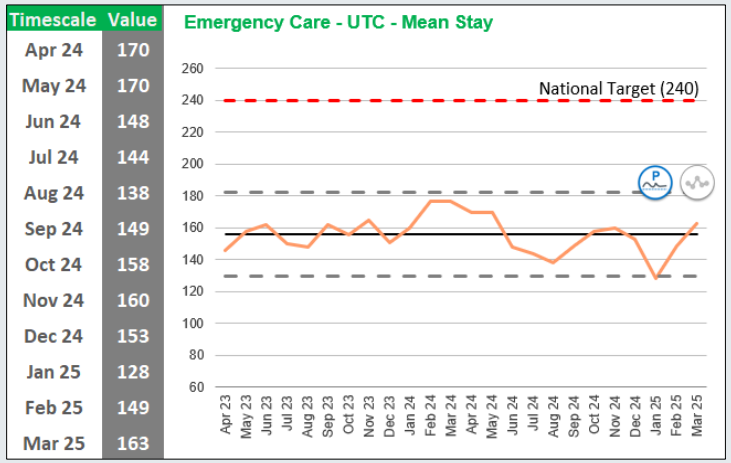
Timescale	Value
Apr 24	398
May 24	371
Jun 24	377
Jul 24	340
Aug 24	299
Sep 24	324
Oct 24	365
Nov 24	384
Dec 24	397
Jan 25	467
Feb 25	447
Mar 25	423



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
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
Jan 25	128
Feb 25	149
Mar 25	163



Counter Measures

- Full review of Medical & ACP model completed; increased staffing approved
- Recruitment as above - to reduce agency and increase substantive body. This will improve the financial sustainability of department but also improve quality of care across the IFD 24/7;
  - Substantive RN for CEU & THP 24/7
  - Recruitment strategy for ED Registrar vacancy
- Joint approach to IFD 'management' and daily operational oversight – IFD Silver & huddles.
- Rapid Assessment Area working group and process revision.
- Increased EPIC-T presence in Rapid Assessment – arriving ambulance early assessment
- Medicine Emergency flow programme
- 7-day rota review and implementation
- Medical & Practitioner workforce model approved and added to budget;
  - Establish funded medical model for UTC (5.6 wte)
- ICB support to reduce attendances to UTC - increased community clinic places - Pharmacy 1st, Paediatric Acute Respiratory Hubs.
- Short term additional medical cover to mitigate surges and impact on ED
- Additional triage capacity now implemented with improved triage performance seen since June.
- Implementation of Acute Physician in Charge role (APIC) - improving post take to Medicine.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Department & Urgent Treatment Centre - Emergency Attendances

Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC).

There were 11,314 patients seen in ED/UTC in March, which is a 16.2% increase from February (9734).

Inpatient Spells - GWH - Number Non-Criteria to Reside (NCTR) Days
Bed days lost in March due to no criteria to reside showed an average of 100 patients per day occupying the bed base. 21 days LoS decreased slightly to 13 patients on average within the Trust for March.

The month of March has continued to be highly pressured from a flow perspective. Weekend system calls for NCTR have continued – offering assurance that weekend flow maintained. Slightly improvement in hitting 60 target on Saturdays and increase in Monday discharges. **LoS reviews twice weekly to commence in April system wide.**
NCTR: Over the period of March highest NCTR pathway was PW1 the biggest cohort
PW0's - 88% leaving on day **0 RTD** – this remains the same as previous month. Work continues with divisions to improve this further with attendance at divisional huddles and escalation via silvers.
PW1's – 23% leaving on day **1 RTD** – which is a downward trajectory from Jan 24. The data needs to be further broken down into areas - (meeting with informatics in April). 15.30 calls for wiltshire introduced towards end of March to improve midday performance. **Home first was the highest at 124 over the last 12 months.**
PW2's – 38% leaving on day **2 RTD** - this is a slight increase on previous month. April will be particularly key for monitoring with the changes in community provider.
PW3's – 19% discharged on day 3 RTD – this is an increase on the 5% in January.

Benny Goodman | Chief Operating Officer

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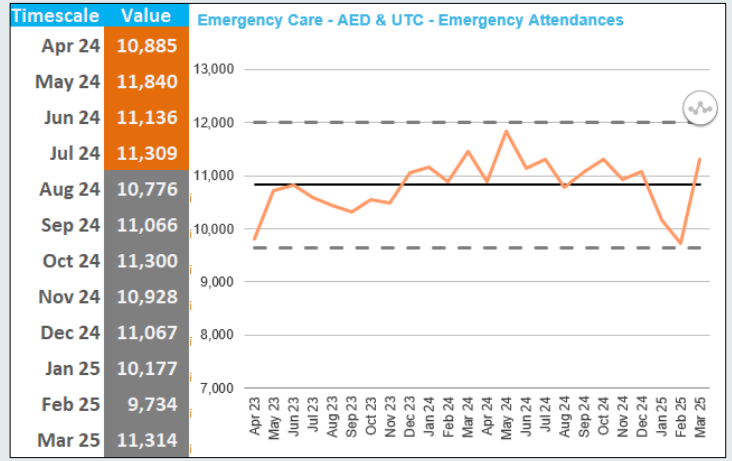
Emergency Care – Emergency Department & Urgent Treatment Centre - Emergency Attendances

To ensure patients are cared for in the appropriate setting

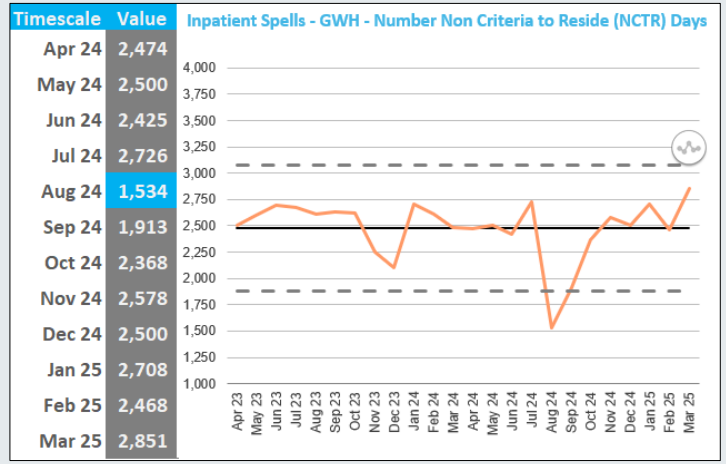
Timescale	Value
Apr 24	10,885
May 24	11,840
Jun 24	11,136
Jul 24	11,309
Aug 24	10,776
Sep 24	11,066
Oct 24	11,300
Nov 24	10,928
Dec 24	11,067
Jan 25	10,177
Feb 25	9,734
Mar 25	11,314



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
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
Jan 25	2,708
Feb 25	2,468
Mar 25	2,851



Counter Measures

- Dedicated porters in ED & MAU trialled in January/February– – delays of ambulance handovers and bed transfers reduced, review being undertaken in March.
- Assessment and pathway changes to support direct access from ED & UTC to most appropriate admission areas – On-going.
- Co-ordinated approach to managing IFD areas with Front Door Escalation oversight, and IFD huddles.
- Review & development of MAU pathways and review of current function and caseload. - Work commenced 31st March – weekly meetings to review in place.
- Hospital at Home – continued increased capacity and utilisation reaching full capacity in March - **risk community provider changes in April.**

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 – **Limited due to DCL being used in escalation for overnight beds March continued use**
- Review wards that have opportunities for higher discharges prior to midday and over weekends – ongoing. - **NCTR calls over weekend period supported by senior op leads**
- Pre-empting discharges 24 hours in advance & preparing TTAs in advance – 15:30 calls to be introduced mid-March to close partner actions and plan for tomorrow's discharges.

Reflections:
- Standardising discharge processes including discharge summaries and medicine to take away – potential risk I April with SwICC changes.
- Applying improving together methodology to change initiatives.
- Workforce planning to improve alignment of Acute Medical clinical Workforce to demand.
- Reverse Boarding has been enacted when there is 2 THP patients – site/divisional understanding.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Voluntary Staff Turnover (rate)

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

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

The Trust has seen a downward trend seen in its voluntary turnover rate from July 2022, with performance below the 11% target being consistently sustained. Voluntary turnover decreased in February to 8.5% 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.

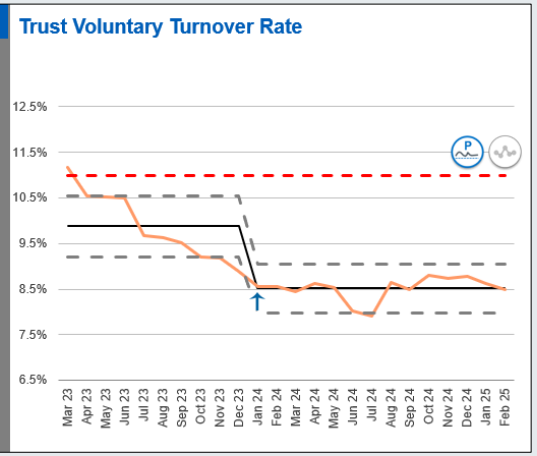
The number of staff who would recommend the organisation as a place to work increased from 53.3% in 2022 to 59.6% in the 2023 Annual Staff Survey. Whilst a small decline was seen in this metric throughout the year, the 2024 Annual Staff Survey results show a sustained result at 59.6% however deterioration was seen in Q4 at 51.8%.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

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

Timescale	Value
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%
Dec 24	8.8%
Jan 25	8.6%
Feb 25	8.5%



Staff % recommend the organisation as a place to work

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

Counter Measures

- Voluntary Turnover has decreased in February to 8.5% (8.6% in January).
- The People Promise Manager closure report will be shared at this month's People and Culture Committee. Highlights include:
  - Implementation of sexual safety policy and training
  - Digital Exit interviews
  - Refresh Stay Conversation
  - Refresh Fresh Eyes
  - Launch of Expectations of Line Manager
  - Implementation of 90 day induction booklet
- Turnover has remained stable for 2 years, therefore this metric will change to a watch metric for 25/26 reporting and be replaced with sickness absence.

- The number of staff who would recommend the organisation as a place to work remained the same in the 2024 Staff Survey (59.6%). The Q4 data shows a significant reduction in this question, reporting that 51.8% of staff would recommend the organisation as a place to work.
- The Q1 Pulse Survey has recently opened and will be open until the end of April.
- Clever together led a TMC away day on the 8th April to co-design a Trust-wide framework of expected behaviours, aligned to our STAR values . The purpose is to provide staff with clarity, consistency, and confidence on expected behaviours.
- On the 29th April Clever together and the Trust will launch "the big conversation" to ensure all staff have an opportunity to co-design the behaviours.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

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

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

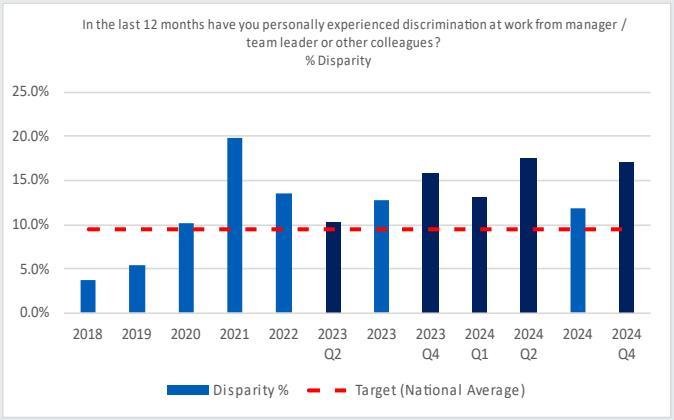
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

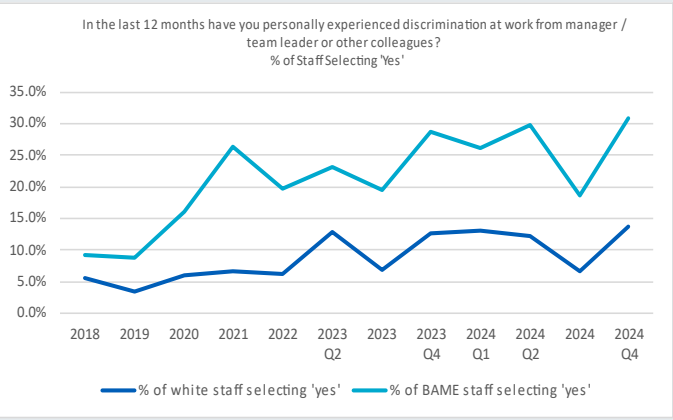
Disparity has improved in the 2024 staff survey results, reducing from 12.7% in 2023 to 11.9% in the 2024 Staff Survey.

Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

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





Counter Measures

- The EDI Lead showcased the work of EDI Champions at a national event, the programme has been selected as a case study by NHS England. The Trust currently has 62 champions. In an annual survey in February 2025, 41% of champions felt they had a positive impact on their team and 20% a wider system impact; furthermore 47% of those surveyed felt their presence and actions enabled behavioural change in their area of work (a score of 3/5) and 14% felt they had made significant change (score of 5/5).
- The Equality Delivery System review 2024-25 scoring took place 31.03.25. Scoring for 'Workforce Health and Wellbeing' and 'Inclusive Leadership', Domain 2 and 3, has improved from 'Developing' in 2024 to 'Achieving' in 2025. Staff involved recognised the breath of initiatives that are underway, changes in leadership engagement and support and improvements in some EDI metrics.
- Mentoring is underway in the Trust, however, there are only 11 active mentoring relationships, the volunteer team will support Trust-wide promotion alongside digital communications in April. The EDI Lead will attend Divisional Board meetings ahead of summer to request local leadership and management buy-in for all EDI initiatives involving Employee Resource Groups (staff networks, champions etc).

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

The Trust finished the 2024/25 financial year with an adjusted surplus position of £1.4m, which represents a £1.4m favourable variance to plan. Income finished £43.9m ahead of plan, driven by overperformance on ERF (£9.6m), NHSE commissioned drugs (£5.3m) and central funding for surge, industrial action and the gap on pay award (£4.4m). Additional education, training and other SLA income finished £4.4m above plan, with the remainder of the favourable variance (£20.2m) due to pension funding offsetting cost. ERF performance finished above the 112% stretch target, including advice and guidance, at 117.5%.

The pay position of £31.0m adverse to plan included £20.2m of pension costs and c.£0.5m of junior doctor industrial action costs, both offset by income, and a £2.3m under-delivery of pay efficiencies. Temporary staffing pressures relating to vacancies, escalation and mental health provision accounted for the rest of the pay variance, partially offset by centrally-held reserves (e.g. maternity / paternity leave).

Operational non-pay spend finished £13.7m over plan, which included £8.9m 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 £4.8m over plan, £3.1m of which is passthrough related and offset by income.

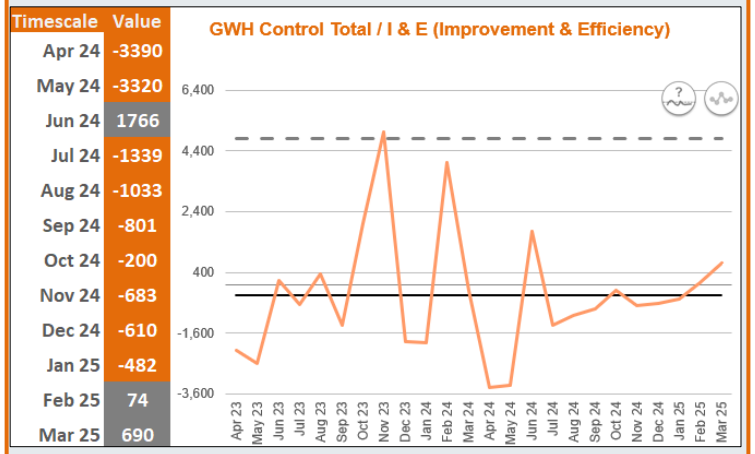
The efficiency plan finished £3.4m under the target of £21.9m. Of the £18.5m savings delivered, 49% was recurrent. For 2025/26, the efficiency target is £24.2m plus £2.8m of undelivered recurrent savings from 2024/25 to give a total of £27.0m. There is a further gap to achieve a breakeven plan, including the impact of an ICS £11m saving requirement (of which £3.5m is allocated to GWH). The total gap for us is £5.4m, giving a total Trust wide cost reduction requirement of £32.4m.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
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
Jan 25	-482
Feb 25	74
Mar 25	690



Counter Measures

- Efficiency savings were £1.8m below target in month. The efficiency programme finished £3.5m behind plan with pay accounting for £2.3m, income £0.2m and non-pay £1.0m. Of the £18.4m of savings delivered, 49% is recurrent.

Executive Summary

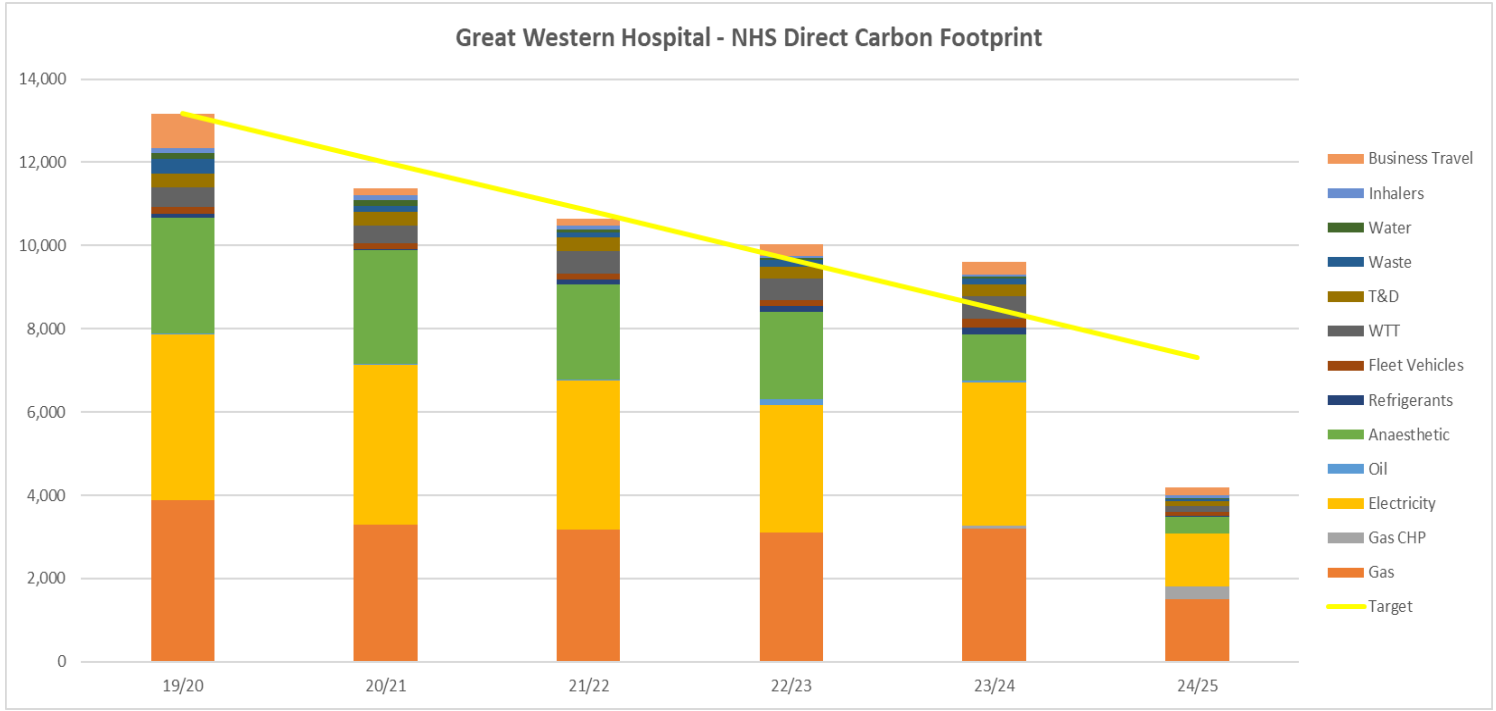
Great Western Hospitals NHS Foundation Trust

Carbon Footprint / Sustainability

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

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.



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.

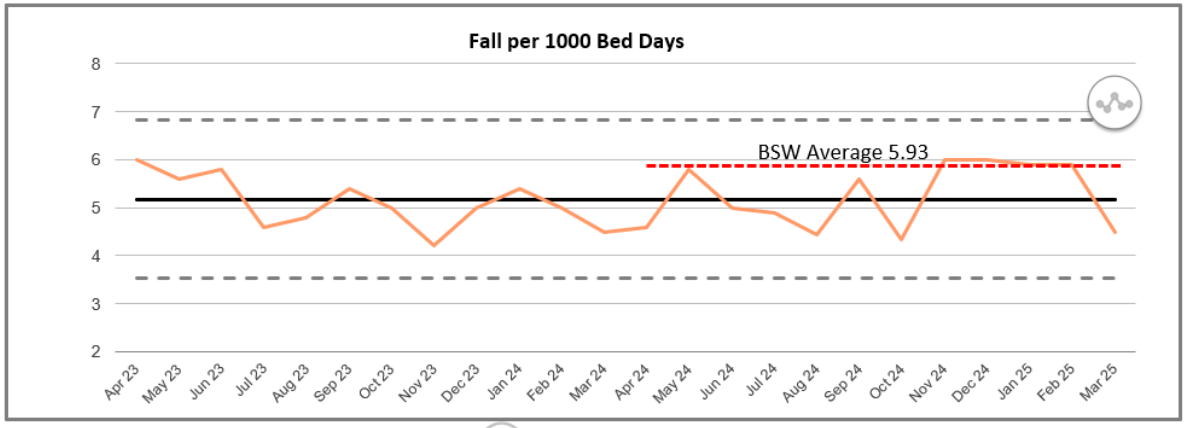
Simon Wade
Chief Financial Officer

2024/25 Breakthrough Objectives

Reducing Falls & Falls With Harm

Great Western Hospitals NHS Foundation Trust

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
4.6	5.8	5.0	4.9	4.4	5.6	4.3	6.0	6.0	5.9	5.9	4.5



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.

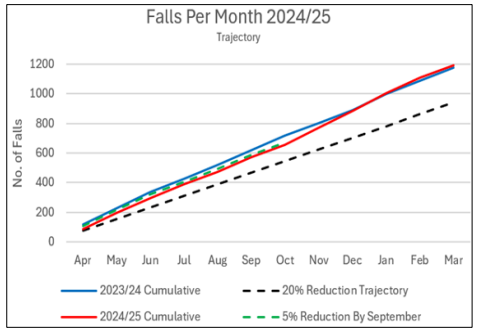
Aim for 2024/25

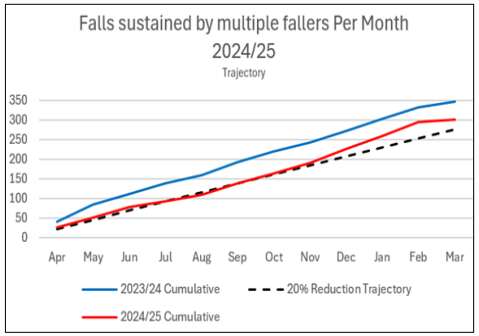
Reduction in the number of Total Falls by 20%
Reduction in the number of patients experiencing moderate harm or above by 20%
Reduction in the number of patients that fall more than once by 20%

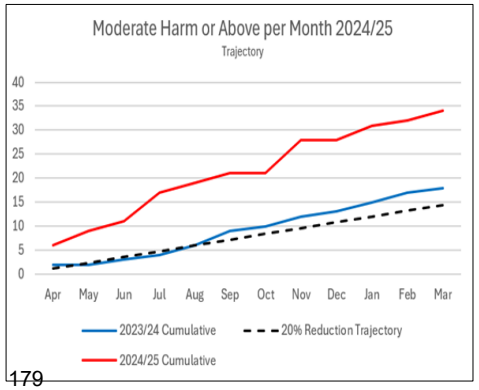
We are driving this measure because..

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 decreased significantly in month to 85 compared to 106 in February. The number of falls with moderate harm or above has increased to two in month, compared to one last month.

Falls sustained in patients who have fallen more than once has decreased to three in month (15 in February).

Improvement Actions completed
The Falls Policy and postural hypotension guidelines have been ratified and will be available to all staff via the electronic documents system (EOLAS).

Assessment documentation for the new Electronic Patient Record has been agreed by the Falls Leads in Salisbury Foundation Trust, the Royal United, Bath and the Great Western. Some documentation is outside the original scope and has been submitted as a change request.

New recliner chairs have been purchased and delivered across in-patient ward areas. The aim is to improve care and facilitate a smoother discharge process which is achieved through a more objective assessment that replicates the equipment used at home, prior to discharge.

A Clinical Practice Educator has been identified to support falls, starting 2nd April. The focus will be on training relating to falls, enhanced care and deconditioning.

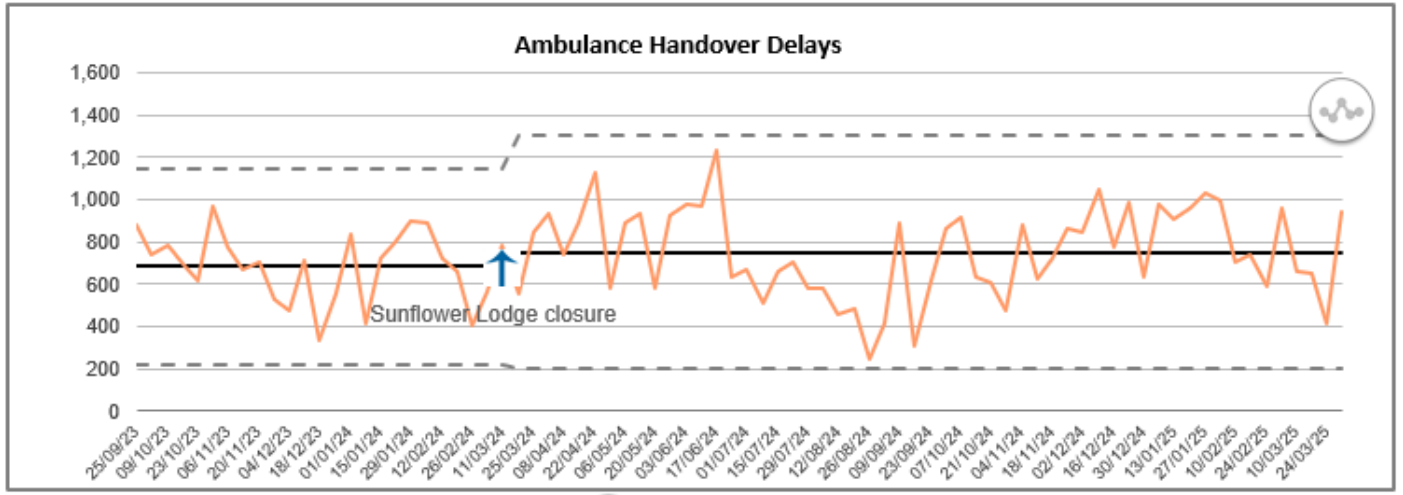
The first weekly falls review meeting took place in April, and attendance and key learning objectives were agreed.

2024/25 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Ambulance Handover Delays

13/01/25	20/01/25	27/01/25	03/02/25	10/02/25	17/02/25	24/02/25	03/03/25	10/03/25	17/03/25	24/03/25	31/03/25
911	963	1028	999	704	739	587	960	657	652	412	942



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 83 hours were lost per day from ambulance handover delays in March, down from 92 hours in February. This is a 10% improvement in the month, but the sixth consecutive month during which the breakthrough objective of 70 hours was not met. There were 80 four-hour breaches reported in March, reduced from 130 in February. Six-hour delays reduced from 39 to 21 and there were 7 eight-hour delays (a marginal increase of 2).

Time in the ED department has deteriorated for non-admitted pathways and admitted pathway delays continue to be experienced due to ongoing high bed occupancy at 97% in March and 18.2% of the bed base occupied with patients not meeting criteria to reside. Performance in the first half of March was also significantly affected by ward closures due to infection, prevention and control. This peaked with 68 ward beds having restrictions, with up to 22 closed and empty beds at times affecting both medical and surgical wards.

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 refreshed UEC plan includes priorities such as increasing medical same day emergency care (SDEC), a relaunch of the Discharge Lounge improvement plan; and ongoing implementation and evaluation of timely hospital handover processes with partners.

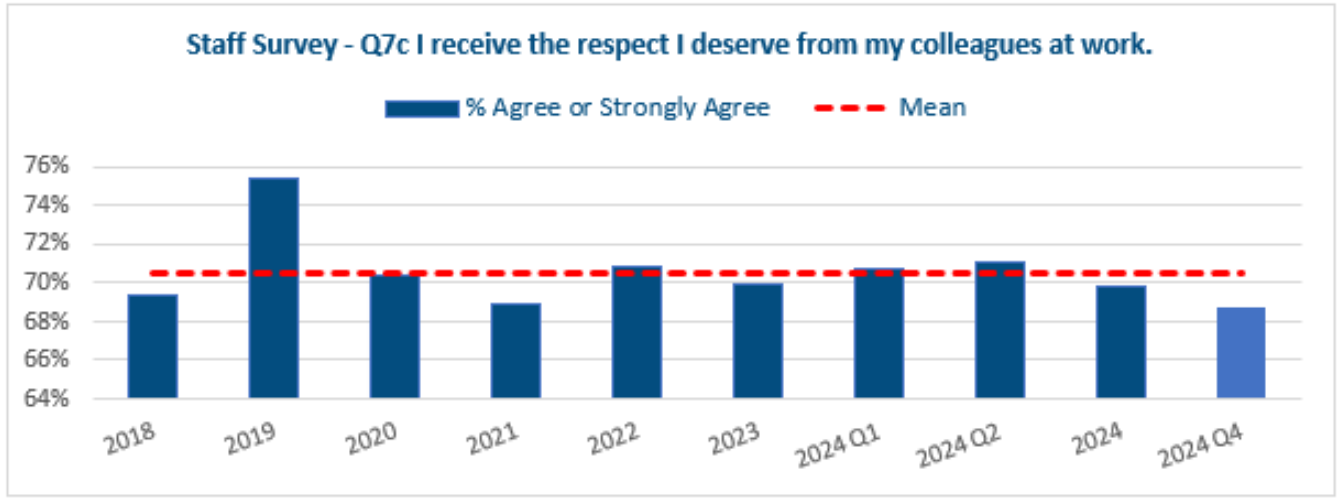
Surge and escalation protocols in response to ambulance offload delays were reviewed and changes implemented in February to ensure that all temporary escalation spaces are used proportionately and safely to reduce ambulance offload delays over 75 minutes. Planning for 45 minutes is underway as part of requirements to implement national operating plan requirements from April 2025.

2024/25 Breakthrough Objectives

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

Great Western Hospitals NHS Foundation Trust

2018	2019	2020	2021	2022	2023	2024 Q1	2024 Q2	2024	2024 Q4	2025 Q1
69.40%	75.44%	70.37%	68.85%	70.80%	69.96%	70.70%	71.10%	69.80%	68.70%	



Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

- Q7C ("I receive the respect I deserve from my colleagues at work") saw a small improvement in the 2024 Staff Survey, increasing from 69.5% to 69.8%, however a small reduction to 68.7% was seen in the Q4 pulse survey.
- Free text and full data has been shared with Divisions to review and consider as part of their A3 reviews to create local countermeasures to improve staff survey results in the highest impacting areas.
- The Staff Survey Working Group has been refreshed to focus on sharing learning and escalating improvement ideas which require Trust-wide interventions, for example the Emergency Department have identified the violence at work policy as being ineffective and this will be escalated to the Health & Safety team and will be a Trust-wide countermeasure.
- Analysis of the 2024 Staff Survey results has highlighted Unregistered Nursing & Midwifery as an area of focus for Q7C. Work is underway to reestablish the Nursing away days and use this as an opportunity to engage with staff to develop nurse-lead interventions.

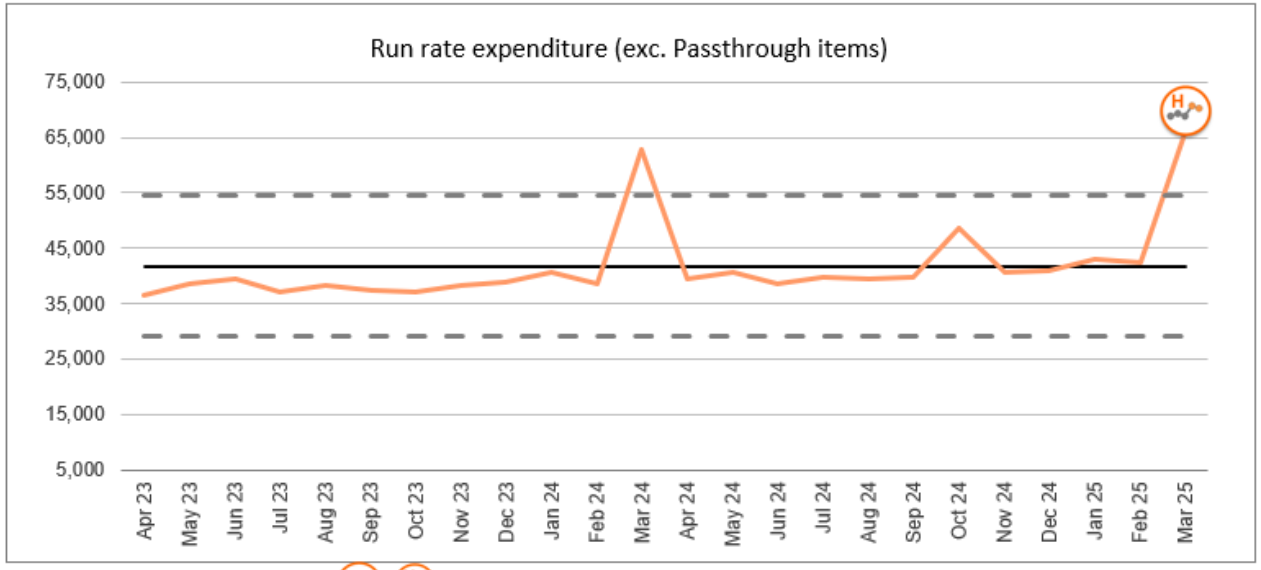
Risks

- 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

Financial Recovery

Expenditure	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total expenditure (excl. passthrough items)	39,339	40,664	38,705	39,705	39,538	39,904	48,729	40,649	40,834	42,865	42,370	65,856
Medicine	12,248	12,820	12,457	12,931	11,862	12,206	16,193	13,250	12,909	13,581	13,246	14,812
SWC	10,484	10,848	10,666	10,633	10,818	10,628	15,049	10,865	11,573	11,003	11,344	11,984
ICC	5,397	5,420	5,057	5,578	5,685	5,620	7,188	5,962	6,181	5,634	5,310	5,723
Corp	7,947	8,022	8,014	8,169	8,348	7,971	8,915	8,008	8,262	8,313	9,080	9,183



Understanding the Data

The data shows the run rate by division, which has been trending upwards since Apr-23. There are notable increases in Mar-24 and Mar-25 which are for pension liability costs. Note these are offset by income. The other notable increase in Oct-24 is for pay award. Overall the trend is upwards. The Trust must look to maintain tight grip & control over all aspects of costs, particularly in light of the £32.4m savings target for 25/26.

We are driving this measure because...

The Trust finished the 2024/25 financial year with a £1.4m favourable position to plan. This was achieved largely through non-recurrent central funding received in year.

Going forward into 25/26, 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 in 25/26, in addition to efficiency savings expected as part of a normal planning round.

Performance

- As at M12 24/25 the Trust has a year-to-date (YTD) adjusted deficit position of £8.8m, which represents a £1.4m favourable variance to plan.
- We finished £3.5m 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	Dec-24	Jan-25	Feb-25	Mar-25	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)	?	61%	69%	66%	71%	
	No. of complaints received	SPC	H	49	91	51	65	
	Number of reopened complaints	SPC	H	3	4	2	2	
IP & C	MSSA	2.00	?	1	4	4	3	
FFT	Daycases Positive Responses	95.0% (Int)	?	94.6%	96.1%	94.7%	94.5%	
	Maternity Positive Responses	91% (Int)	?	91.7%	88.9%	87.9%	85.0%	

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

Performance & Counter Measure

The complaint response rate in March improved by 5%, representing the highest performance against target in the past six months. This positive trend reflects focused efforts at a divisional level, supported by the PALS team's writing support resources. Following a dip in February, 65 new complaints were received in March, signalling a renewed increase in activity and underlining the importance of maintaining timely responses. A3 improvement meetings also recommenced in March, supporting ongoing service enhancements. The number of reopened complaints remains low at two, suggesting that the quality of responses is good.

Due to the transition to the new electronic maternity record system, no digital responses were captured in the March dataset for Maternity, as text messages could not be generated from a data extract. Consequently, only the maternity Patient Experience Co-ordinator entries and Friends and Family Test (FFT) cards were used to collate feedback in the reporting month.

There were three cases of MSSA (methicillin-susceptible Staphylococcus aureus) in March, down from four in February. Only one March case was hospital-onset; that case has no clear source of infection however learning around cannula care was identified. This has been the most common theme over recent months, although it is not the cause in most cases, and the Division of Medicine are adopting cannula care as the focus of their next A3.

Risks

Our contracted provider of FFT has informed us of their plans to stop their processing service of FFT cards. SMS data processing will continue. This will significantly impact our data collection.

Concerns persist regarding accessibility challenges on-site, particularly due to heavy doors. Full external access assessment now recommended.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Dec-24	Jan-25	Feb-25	Mar-25
Harm	Patient safety incident investigation	SPC		6	2	2	7
	Falls rate per 1000 bed days	SPC	L	6	5.9	5.9	4.5
	No. of Falls in month	SPC	L	118	117	106	85
	No. falls with moderate harm or above	SPC		1	3	1	2
	Medication incidents with moderate harm	SPC		1	0	2	2
	Pressure Ulcer (Hospital Acquired)	SPC		11	16	20	11
	Pressure Ulcer (Community Acquired)	SPC		13	23	9	11
Concerns and Complaints	No. of concerns received	SPC		306	349	300	324
IP & C	C.Diff	6.42		7	4	4	4
	MRSA	0		0	0	0	1
	E.coli	8.33		6	3	7	6
	Klebsiella	2.92		2	1	0	5
	Pseudomonas	2.50		1	0	0	0
	COVID (hospital acquired)	SPC		1	1	8	2

Performance & Counter Measure

There were seven Patient Safety Incident Investigations (PSII) reported in the month of March. One meeting the criteria of Never Event. All will be investigated under the Patient Safety Incident Review Framework (PSIRF). There are 22 PSII's in progress with ten overdue against Trust internally set timelines.

The number of concerns received rose from 300 in February to 324 in March. The recurring themes continue to centre on waiting times, and difficulties contacting services for updates. This indicates ongoing pressure on teams and highlights the need for improved access, clearer information-sharing, and strengthened pathways for proactive updates to patients and families.

The number of falls in month (85) has decreased from the previous month (106). There has been two falls with moderate harm or above in month.

There were 11 category 2-4 pressure ulcers acquired in hospital, a decrease from 20 in February. The number of category two pressure harms has also decreased from 14 to seven and category three from seven to four. There were eleven harms on seven patients. One harm was device-related.

There are two medication incidents with moderate harm , both are under review.

There was one case of MRSA (Methicillin-resistant Staphylococcus aureus) in month, which puts us over the target of zero. There were three cases of methicillin-susceptible Staphylococcus aureus (MSSA) in March, a decrease from four in February. We are over our internally-set trajectory. One March case was hospital-onset; no clear source of infection however learning around cannula care was identified. There were six cases of E. coli in March, down from seven in February. Only one case was hospital-onset, which continues a theme of E. coli now being more associated with community-onset infections. There were five cases of Klebsiella in March, up from zero in February, only one case was hospital onset. There were zero cases of *Pseudomonas* in March. The Trust will end the year under trajectory (19 cases, trajectory 30).

Risks

There remains a risk due to the lack of accessible information, which does not fully meet the requirements of the Accessible Information Standard and the Equality Act. To address this, a field has been introduced in Nervecentre for recording this information, alongside a website contact form that will route queries directly to PALS as an interim measure.

Our Care

Non-Alerting Watch Metrics

NHS Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Dec-24	Jan-25	Feb-25	Mar-25
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	98.0%	97.3%	95.2%	98.5%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	101.7%	99.4%	99.7%	108.8%
FFT	Overall response rate (%)	28% (Int)	?	28.8%	31.4%	33.6%	29.1%
	Positive response (%)	90.0% (Int)	?	90.3%	90.9%	91.1%	89.0%
	ED & UTC Response Rate	16.3% (Int)	?	17.2%	19.8%	19.1%	18.8%
	ED & UTC Positive Responses	79.7% (Int)	?	79.0%	85.6%	83.6%	74.4%
	Inpatients Response Rate	23.8% (Int)	?	26.9%	28.5%	27.6%	27.9%
	Inpatients Positive Responses	90.2% (Int)	?	90.7%	89.9%	88.7%	89.7%
	Daycases Response Rate	23.8% (Int)	?	25.5%	28.0%	29.4%	27.3%
	Outpatients Positive Responses	97.0% (Int)	?	97.2%	97.6%	97.6%	98.0%
	Maternity Response Rate	31.8% (Int)	?	24.0%	29.2%	25.5%	100.0%

Performance & Counter Measures

Safe Staffing fill rates has increased in March and is now well above the National target and are within safe parameters.

In March, Front Door positive response rates showed a dip which contributed to the overall slight dip in the Trust wide positive response in month. In response, targeted work has been carried out in Front Door areas to ensure patients are more regularly informed about their care and what they are waiting for. Inpatient feedback continues to highlight communication as a key theme, which is being addressed through increased visibility and engagement from ward managers and there is a slight upturn in positive response rate on the back of these endeavours.

The sample size for the Family and Friends Test (FFT) in some areas—Emergency Department (ED), Inpatients, and Day Cases—was reduced from November 24. This adjustment aims to create a more targeted approach, align with system partners, and manage costs more effectively. Maternity continues to have a 100% collection rate. Response rates have decreased in March across all areas, with exception of day case.

Changes in maternity response rate can be attributed to the changes in systems and subsequent impact to FFT text messaging.

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	Dec-24	Jan-25	Feb-25	Mar-25	Trend
RTT	No. of >=18 weeks waiters		H	18418	18002	21989	22161	
	No. of >=52 weeks waiters		H	1423	1403	1195	950	
DM01	No. of patients on DM01 waitlist			5519	6181	6345	One month behind	
	DM01 performance %	99% (Nat)	F	84.7%	85.9%	87.7%	One month behind	
	DM01 6 week wait breaches		H	847	873	779	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	73.4%	75.3%	72.7%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	91.1%	89.7%	72.7%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	72.5%	69.6%	67.5%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	?	79.5%	80.2%	86.2%	One month behind	

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Performance & Counter Measure

Diagnostics

March's validated DM01 performance showed an increase in performance from 87.7% in February to 90.9% in March . The number of patients on the waiting list has increased by 1,140 to 7,485 driven by a reduction in agency use in non-obstetric ultrasound. There are now only 865 patients waiting over 6 weeks vs 8,301 in October 2023 and 779 in February 2025.

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 2,302 on the waiting list and 135 over 6 weeks. Medicare reduced usage continue to support US activity until the end of the financial year. A locum sonographer is also being sourced to help with the more complex long waiters. WLIs continue to be in place to support Endoscopy.

Cancer

68.7% of the 62-day breaches were with the Plastics, Colorectal & Urology pathways.

31D performance fell short in February due to capacity in the Skin pathways, accounting for all 14 pathway breaches: Elective capacity in ENT accounted for 5 Plastics breaches, with Outpatient capacity being responsible to 4 further breaches in Plastics and 5 in Dermatology.

Cancer waiting times for first appointment remain below standard. Skin is the largest contributors with 39.2% of all breaches. Outpatient capacity was the main reason for breaches, being responsible for 66.7% of breaches.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-24	Jan-25	Feb-25	Mar-25	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	74.7%	73.6%	72.5%	70.1%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	7.8%	10.0%	9.0%	8.1%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	53.1%	50.1%	51.9%	48.3%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	15.1%	19.7%	17.5%	16.1%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	3391.50	3874.76	2572.48	2558.59	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1745	1634	1539	1752	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	93%	94%	92%	89%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	1392	1388	1207	1308	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	74.1%	79.9%	72.4%	66.8%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	1016	1112	832	866	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	54.1%	64.0%	49.9%	44.2%	

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Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4-hour performance (type 1 and 3) reduced from 72.5% to 70.1%. This is 5.9% below the 23/24 national target. The reduction in performance relates to type 1 performance reducing and impacting our overall position.

Total % over 12 hours (Type 1) has **improved** from 17.5% to 16.1%. This is still over target due to delayed onward flow to admission areas, although multiple measures implemented to help mitigate this. Any prolonged LOS in ED leads overcrowding and subsequent delays in ambulance offload.

Ambulance handover delays over 15 minutes **decreased** from 2572 hours to 2559 hours (phase 1 breakthrough objective = 2100 hours).

Number of ambulance handovers over 30 minutes has **increased** from 1207 to 1308.

Number of ambulance handovers over 60 minutes **decreased** from 50% to 44%.

Management of 'Timely Handover Process' with ambulance patients off-loaded inro in ED corridors, predominantly maintained as four trolley spaces: Total patients nursed in ED corridor - **451** in February, and **572** in March.

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.

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-24	Jan-25	Feb-25	Mar-25
RTT	No. of >=78 weeks waiters	SPC	L	1	3	2	2
Cancer	No. of referrals received	SPC		1603	2045	1812	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	92.7%	97.8%	94.0%	91.9%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.0%	0.1%	0.1%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5735	5176	4961	5662
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	85.4%	83.3%	83.0%	81.7%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		60.7%	60.5%	57.3%	54.9%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		56.8%	68.0%	59.3%	54.8%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	199	180	197	206
	Emergency Care - AED - Median Stay	240 (Int)	?	240	240	240	298
	Emergency Care - UTC - Median Stay	240 (Int)	P	142	119	139	159
	Total Number of Ambulance Handovers	SPC	L	1879	1738	1668	1959
	Average hours lost to ambulance handover delays per day	SPC		103	126	92	83

Performance & Counter Measure

ED & UTC

Number of ambulance conveyances has increased by 291 from February to March (1668 to 1959) - greater than both December & January. Average daily hours lost decreased in March 25 from 92 to 83.

Triage performance for ED has decreased from 57.3% to 54.9%. Triage within 30 minutes is 74.8% (meantime 23 minutes).

For Type 3 (UTC only) triage performance has decreased from 59.3% to 54.8%. Triage within 30 minutes is 80.2% (meantime 20 minutes).

Median stay in ED increased to 298 minutes. Median stay seen in UTC increased from 139 mins to 159 mins.

Temporary escalation areas maintained in ED to facilitate THP 75 min ambulance offload (since mid December) - now 24hr.

Risks

Prolonged time in ED department and associated harm from exit delay, especially post 12 hours.

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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-24	Jan-25	Feb-25	Mar-25
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		633	761	734	660
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		276	300	292	299
	Elective Patients Average Length of Stay (Days)	SPC		3	4	3	3
	Non-Elective Patients Average Length of Stay (Days)	SPC		5	5	5	5
	Community Average Length of Stay (Days)	SPC	H	23	26	27	23
	GWH Discharges by Noon (%)	SPC		17.6%	16.3%	16.5%	15.8%
	Number of Stranded Patients (over 14 days)	SPC		126	135	129	132
	Number of Super Stranded Patients (over 21 days)	SPC		66	77	73	73
	Adult general and acute type 1 bed occupancy	SPC		97.0%	97.3%	97.0%	94.2%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	L	17.0%	17.9%	18.2%	19.0%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.1%	95.6%	95.4%	95.5%

Performance & Counter Measure

Patient Flow

- Bed occupancy decreased in month.
- Trust wide UEC Flow and Transformation programme phase 2 is now in progress
- Rapid Ambulance Handover Standard Operating procedure being enacted – still discussions being held at system level to move towards a maximum of 45 minute handover times for ambulance crews.
- Review of Better Care Fund commitments to support reduction in discharge ready delays.

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.

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Use of Resources

Great Western Hospitals NHS Foundation Trust

Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Dec-24	Jan-25	Feb-25	Mar-25
Use of Resources	Capital Expenditure (£'000)	SPC		1684	2353	5127	Waiting for data
	Pay (£'000)	SPC		28225	28630	27959	47806
	Non Pay (£'000)	SPC		15918	17764	18289	20422

Performance & Counter Measure

Year-to-date capital spend at M12 is £36.8m against an increased plan of £36.4m, giving an overspend against plan of £0.4m. This has been offset against a system underspend in order to maximise utilisation of resources.

M12 pay costs are £19.8m higher than M11 driven by pension costs offset by income.

Non-Pay is £2.1m higher than M11 driven by higher clinical supplies and drugs costs.

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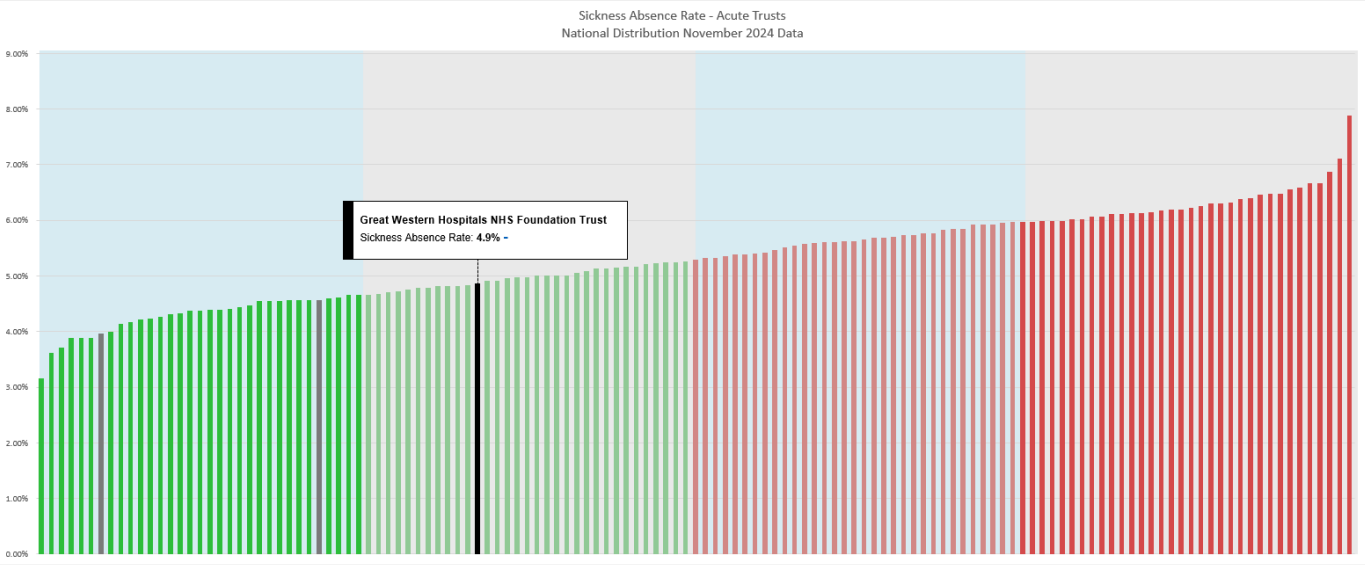
Risks

The Trust finished the year with a £3.5m shortfall against the £21.9m cash releasing efficiency plan. M12 delivery was £1.7m behind a plan of £3.5m. Of the £18.4m savings delivered, 49% was recurrent. A total of £2.8m of undelivered recurrent target will carry forward into 25/26, bringing the total plan to £27m with a further £5.5m of system savings to bring the overall total to £32.4m. Divisions and services must work to develop recurrent cash releasing schemes.

Our People

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-24	Jan-25	Feb-25	Mar-25	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	4.9%	5.1%	4.9%	One month behind	



Performance & Counter Measure

- In-month sickness absence decreased to 4.9% in February, back in line with the position in December however above levels 12 months ago (4.4%).
- 10 absence audits have been completed between January and March, 9 of the audits scored over 80% and one at 61% (new manager in post for 6 weeks). A further interim audit will follow in April for this ward. Positives outcomes include:
  - Staff are reporting sickness correctly
  - Managers understand and can apply the new policy
  - Occupational health referrals were effective in supporting staff back to work

  Areas for improvement:
  - Manager's conducting regular 1-2-1 meetings
  - Managers completing WARM meetings within 48 hours
  - Discussing and recording of OH reports
  - Completing self-certification forms to cover the first 7 days of sickness
  - Absence markers not consistently being discussed and recorded in WARM meetings
  - Managers to ensure they build in time for the people management aspects of their role
- To support the launch of the New Policy the People Operation teams are attending Divisional meetings to share the new policy and provide a bite-size training session on application of the policy.
- Current national benchmarking data (November 2024 – NHS Digital) shows our absence position remained static compared to October, reporting at 4.9% and in the 2nd lowest quartile for Acute Trusts.

Risks

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

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Our People

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-24	Jan-25	Feb-25	Mar-25
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	9.9%	9.0%	10.4%	One month behind

Plan Area	Metric	Target /SPC Target Icon	2017	2018	2019	2020	2021	2022	2023	2024
Workforce	Staff Survey response rates	44% (Nat)	46.5%	43.6%	40.0%	53.4%	39.5%	58.7%	69.0%	71.0%
	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%	70.4%	70.9%
	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	57.5% (Avg)	59.6%	54.1%	60.4%	57.1%	56.1%	56.4%	56.5%	Waiting for data

Performance & Counter Measure

- Leavers within their 1st year of employment increased slightly in February to 10.4% however remains below the Trust KPI.
- 2024 Staff Survey response rates were 71%, an improvement on the 2023 rate and the highest response rate for 'Acute and Acute & Community Trusts' nationally.

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

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend Vs Last Month	Trend Vs Mar-24
		Vacancy																	
	W	Vacancy Rate	%	7.00%	3.93%	4.19%	4.04%	3.98%	3.44%	3.82%	3.53%	3.31%	3.53%	3.44%	3.34%	3.06%	2.98%	↓	↓
	W	Vacancy Rate	WTE	-	213.76	227.43	219.66	216.12	186.71	207.11	191.29	179.89	192.27	187.54	182.32	167.40	162.89		
	W	All Nursing Vacancy	%	7.00%	2.21%	2.20%	1.73%	1.73%	0.96%	1.30%	0.64%	0.72%	1.49%	1.99%	1.78%	1.24%	1.01%	↓	↓
	W	All Nursing Vacancy (Reg & Unreg)	WTE	-	59.14	58.90	46.13	46.07	25.61	34.47	17.00	19.26	39.90	53.22	47.73	33.37	27.15		
	W	All Registered Nursing Vacancy	WTE	-	9.70	4.67	4.75	14.57	5.24	0.02	-27.25	-36.48	-28.09	-24.47	-24.01	-10.00	-8.16		
	W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	-7.35	-19.60	-12.95	-3.59	-11.35	-23.55	-47.80	-49.08	-41.52	-42.81	-41.32	-37.51	-33.85		
	W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	49.44	54.23	41.38	31.50	20.37	34.45	44.25	55.74	67.99	77.69	71.74	43.37	35.31		
	W	Medical Vacancy	%	7.00%	7.47%	8.30%	6.78%	6.67%	7.82%	10.39%	8.99%	7.84%	6.37%	7.36%	8.01%	8.92%	8.25%	↓	↑
	W	Medical Vacancy	WTE	-	56.06	62.23	50.71	49.94	58.44	77.65	67.20	58.64	47.53	54.93	60.01	66.79	61.77		
	W	STT/AHP Vacancy	%	7.00%	3.74%	3.39%	3.67%	3.63%	3.00%	2.30%	3.92%	4.31%	3.71%	2.28%	2.21%	1.67%	1.91%	↑	↓
	W	STT/AHP Vacancy	WTE	-	31.72	28.78	31.27	30.91	25.62	19.64	33.48	37.01	31.82	19.62	19.03	14.42	16.50		
	W	SMA Vacancy	%	7.00%	5.76%	6.68%	7.77%	7.58%	6.57%	6.44%	6.30%	5.55%	6.24%	5.10%	4.74%	4.51%	4.91%	↑	↓
	W	SMA Vacancy	WTE	-	66.84	77.52	91.55	89.20	77.04	75.35	73.61	64.98	73.02	59.76	55.55	52.82	57.47		
	W	Recruitment Time to Hire - AFC	Days	46.00	38.40	39.50	39.40	43.20	40.40	43.80	44.10	42.80	41.40	39.50	42.19	44.30	33.60	↓	↓
	W	Recruitment Time to Hire - Bank	Days	46.00	39.30	43.30	33.30	44.00	22.90	-	30.30	26.70	42.90	37.50	42.90	42.70	38.30	↓	↓
	W	Recruitment Time to Hire - Medical	Days	46.00	32.60	39.00	39.44	35.30	44.20	57.40	37.25	38.40	44.50	36.80	45.02	41.00	36.50	↓	↑
		Workforce Utilisation																	
	W	Establishment WTE	WTE	-	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	5,458.82	5,470.42	5,470.42		
	W	Substantive WTE	WTE	-	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	5,276.50	5,303.02	5,307.53		
	W	Additional Substantive WTE	WTE	-	24.78	20.17	5.53	8.24	9.23	6.30	7.64	9.62	13.99	11.26	12.96	13.66	16.45		
	W	Bank WTE	WTE	-	380.50	286.32	301.97	326.11	333.04	333.94	318.99	325.94	348.20	325.04	380.78	365.40	413.99		
	W	Agency WTE	WTE	-	60.09	49.52	43.70	38.63	45.95	44.39	30.74	39.41	43.36	61.07	59.80	52.05	64.42		
	W	Budgeted vs Worked WTE Variance	WTE	-	251.61	128.59	131.54	156.87	201.51	177.52	166.07	195.08	213.27	209.84	271.22	263.71	331.97		
	W	Actual Worked vs Budgeted %	%	-	104.63%	102.37%	102.42%	102.89%	103.71%	103.27%	103.06%	103.58%	103.91%	103.84%	104.97%	104.82%	106.07%		
	W	Total Workforce Cost £	£	-	£25.92M	£25.13M	£25.50M	£25.21M	£25.57M	£25.87M	£25.27M	£36.50M	£26.75M	£28.12M	£27.24M	£27.93M	£28.58M		
	W	Agency Spend as % of Total Spend	%	4.50%	2.04%	1.83%	1.30%	2.01%	1.94%	1.58%	1.01%	1.23%	1.64%	1.60%	2.52%	1.97%	2.14%	↑	↑
	W	Agency Spend £	£	-	£0.53M	£0.46M	£0.33M	£0.51M	£0.50M	£0.41M	£0.26M	£0.45M	£0.44M	£0.45M	£0.69M	£0.55M	£0.61M		
	W	Agency Target £	£		£0.96M	£0.54M	£0.52M	£0.51M	£0.49M	£0.47M	£0.46M	£0.44M	£0.42M	£0.41M	£0.39M	£0.37M	£0.36M		
	W	Agency Spend vs Target £	£ Diff	£0.00M	-£0.44M	-£0.08M	-£0.19M	£0.00M	£0.01M	-£0.06M	-£0.20M	£0.01M	£0.01M	£0.04M	£0.30M	£0.18M	£0.25M	↑	↑
	W	Bank Spend £	£	-	£2.55M	£1.89M	£2.02M	£2.23M	£2.32M	£2.04M	£1.88M	£2.29M	£2.15M	£2.21M	£1.71M	£2.66M	£2.70M		
	W	Bank Target £	£		£0.00M	£2.19M	£2.12M	£2.04M	£1.96M	£1.88M	£1.81M	£1.73M	£1.65M	£1.57M	£1.50M	£1.42M	£1.34M		
	W	Bank Spend vs Target £	£ Diff	£0.00M	£2.55M	-£0.31M	-£0.10M	£0.19M	£0.36M	£0.15M	£0.07M	£0.56M	£0.50M	£0.64M	£0.22M	£1.24M	£1.36M	↑	↓
	W	Registered Nursing Bank Fill	%	45.00%	90.40%	90.86%	94.13%	90.81%	85.23%	82.25%	85.50%	83.28%	84.19%	77.28%	83.99%	84.92%	85.52%	↑	↓
	W	Unregistered Nursing Bank Fill	%	70.00%	78.92%	81.89%	87.18%	86.23%	79.50%	77.63%	78.67%	71.95%	71.89%	65.05%	70.73%	74.37%	76.95%	↑	↓

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend Vs Last Month	Trend Vs Mar-24
		Retention																	
	W	All Turnover %	%	13.00%	10.72%	10.85%	10.57%	10.24%	10.47%	10.91%	10.70%	11.08%	11.14%	11.24%	11.08%	11.01%	-	↓	↑
	W	Voluntary Turnover %	%	11.00%	8.45%	8.62%	8.53%	8.02%	7.90%	8.66%	8.50%	8.80%	8.75%	8.78%	8.62%	8.48%	-	↓	↑
	W	Number of Leavers	Headcount	-	62	45	46	58	46	72	58	60	49	49	37	35	-		
	W	Number of RN Leavers	Headcount	-	15	13	17	20	14	15	10	14	17	16	9	10	-		
	W	Registered Nursing Vol Turnover	%	-	7.19%	7.33%	7.52%	7.17%	7.36%	7.70%	7.30%	7.39%	7.32%	7.47%	7.25%	7.28%	-		
	W	Number of Unreg Nursing Leavers	Headcount	-	13	11	10	13	6	12	14	14	10	13	1	5	-		
	W	Unregistered Nursing Vol Turnover	%	-	10.87%	11.16%	11.00%	10.91%	10.69%	11.10%	10.34%	10.87%	10.98%	10.97%	10.27%	9.77%	-		
	W	Leavers within 1st Year - Rolling 12 Month	%	-	11.72%	10.68%	9.74%	10.98%	9.57%	11.00%	10.62%	11.04%	9.68%	9.90%	9.02%	10.37%	-		
	W	Number of starters	Headcount	-	52	62	44	64	61	69	102	67	51	48	69	65	-		
		Absence																	
	D	Sickness Absence % Rolling 12 Month	%	3.50%	4.59%	4.52%	4.45%	4.48%	4.57%	4.57%	4.53%	4.57%	4.59%	4.59%	4.61%	4.65%	-	↑	↑
	D	Sickness Absence %	%	3.50%	4.13%	4.19%	4.16%	4.61%	5.19%	4.55%	4.26%	4.87%	4.88%	4.94%	5.14%	4.92%	-	↓	↑
	W	Long Term Sickness %	%	2.00%	1.90%	1.92%	1.92%	2.12%	2.50%	2.57%	2.12%	2.29%	2.26%	2.33%	2.12%	2.49%	-	↑	↑
	W	Short Term Sickness %	%	1.50%	2.23%	2.28%	2.24%	2.49%	2.69%	1.98%	2.14%	2.58%	2.62%	2.60%	3.02%	2.42%	-	↓	↑
	W	Sickness Absence Cost £	£	-	£669.2k	£675.4k	£708.3k	£748.9k	£850.4k	£755.3k	£727.5k	£873.5k	£860.3k	£866.9k	£897.5k	£773.1k	-		
	W	WTE Days Lost	WTE	-	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	8,081.5	8,414.0	7,299.3	-		
		Learning & Development																	
	W	Mandatory Training Compliance %	%	85.00%	92.31%	92.46%	91.37%	91.59%	92.42%	89.84%	89.85%	90.58%	89.79%	90.06%	90.27%	90.03%	90.03%	↑	↓
	W	Role Essential MT %	%	85.00%	93.79%	94.03%	91.84%	92.30%	94.14%	89.00%	89.52%	90.57%	88.86%	89.37%	89.79%	89.70%	89.86%	↑	↓
	W	CQC Safe MT %	%	85.00%	90.85%	90.90%	90.86%	90.84%	90.71%	90.88%	90.25%	90.58%	90.97%	90.95%	90.89%	90.45%	90.24%	↓	↓
	W	Bank-Only Mandatory Training Compliance %	%	85.00%	86.51%	84.26%	83.54%	82.60%	84.77%	86.96%	82.88%	82.42%	84.73%	85.86%	83.96%	81.72%	80.81%	↓	↓
	W	Appraisal Compliance %	%	85.00%	85.26%	84.18%	84.39%	84.74%	84.88%	84.67%	84.09%	84.90%	84.29%	83.46%	84.51%	84.35%	84.40%	↑	↓
	W	Non Medical Appraisal Compliance %	%	85.00%	84.59%	84.40%	83.99%	84.87%	84.95%	84.71%	84.37%	84.94%	84.60%	83.81%	84.63%	84.44%	84.24%	↓	↓
	W	Medical Appraisal Compliance %	%	85.00%	90.10%	82.58%	87.32%	83.81%	84.40%	84.38%	82.07%	84.58%	82.09%	80.94%	83.68%	83.68%	85.48%	↑	↓

Our People

Workforce Scorecard

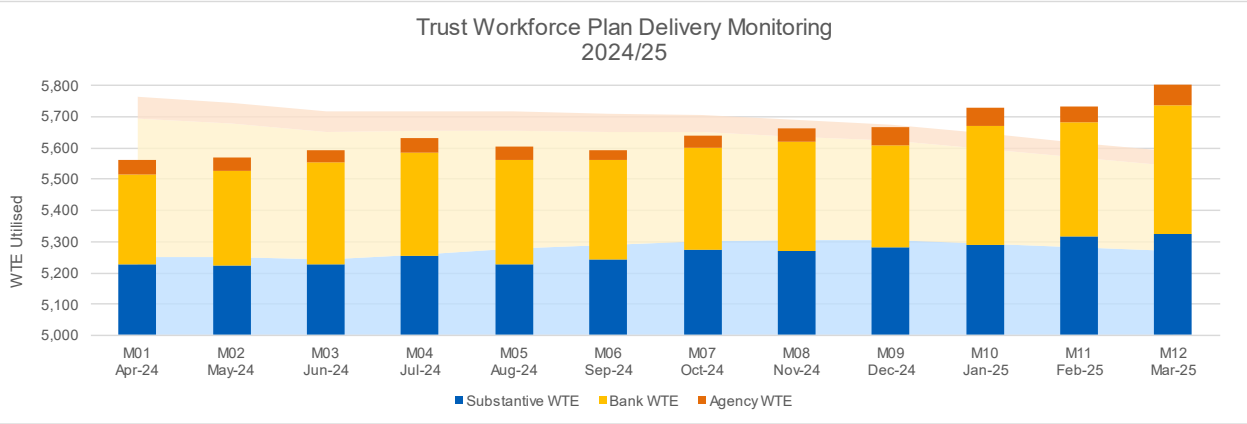
NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend Vs	
																		Last Month	Mar-24
		Demographics																	
	W	Staff in Leadership Roles % (B8a+)	%	-	4.28%	4.28%	4.23%	4.26%	4.29%	4.25%	4.21%	4.28%	4.30%	4.26%	4.29%	4.25%	4.27%		
	W	Staff in Leadership Roles WTE (B8a+)	WTE	-	272.00	272.00	269.00	271.00	273.00	273.00	271.00	276.00	277.00	275.00	278.00	276.00	277.00		
	W	% of Leadership Roles who are Female (B8a+)	%	-	70.59%	70.59%	69.89%	70.11%	70.33%	70.70%	70.11%	70.29%	70.40%	70.18%	70.50%	69.93%	69.68%		
	W	% of Leadership Roles who from BME (B8a+)	%	-	6.25%	6.25%	6.32%	6.64%	6.59%	6.23%	6.27%	6.16%	6.50%	6.55%	6.47%	6.52%	6.50%		
	W	Staff in Leadership Roles % (B8c+)	%	-	0.90%	0.94%	0.94%	0.94%	0.96%	0.93%	0.93%	0.90%	0.93%	0.93%	0.94%	0.94%	0.92%		
	W	Staff in Leadership Roles WTE (B8c+)	WTE	-	57.00	60.00	60.00	60.00	61.00	60.00	60.00	58.00	60.00	60.00	61.00	61.00	60.00		
	W	% of Leadership Roles who are Female (B8c+)	%	-	56.14%	56.67%	56.67%	56.67%	57.38%	58.33%	56.67%	56.90%	55.00%	55.00%	55.74%	54.10%	53.33%		
	W	% of Leadership Roles who from BME (B8c+)	%	-	3.51%	3.33%	3.33%	3.33%	3.28%	3.33%	3.33%	3.45%	5.00%	5.00%	4.92%	4.92%	6.67%		
	W	% of Leadership Roles who are disabled (B8c+	%	-	1.75%	1.67%	1.67%	1.67%	1.64%	1.67%	1.67%	3.45%	3.33%	3.33%	3.28%	3.28%	3.33%		
	W	Male % of Workforce	%	-	18.36%	18.39%	18.52%	18.51%	18.56%	18.48%	18.32%	18.40%	18.46%	18.51%	18.58%	18.61%	18.67%		
	W	Female % of Workforce	%	-	81.64%	81.61%	81.48%	81.49%	81.44%	81.52%	81.68%	81.60%	81.54%	81.49%	81.42%	81.39%	81.33%		
	W	BME % of Workforce	%	-	26.36%	26.56%	26.76%	27.05%	27.31%	27.53%	27.99%	28.30%	28.40%	28.46%	28.67%	29.29%	29.43%		
	W	White % of Workforce	%	-	65.61%	65.36%	65.09%	64.99%	64.84%	65.00%	64.54%	64.41%	64.30%	64.17%	63.94%	63.48%	63.22%		
	W	ER Cases Closed	Number	-	25	19	60	46	59	48	43	55	46	51	45	28	32		

Our People

Great Western Hospitals NHS Foundation Trust

Workforce Delivery Plan



		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**	**5,730**	**5,734**	**5,802**
	Variance	-104	-82	-35	5	-21	-30	20	57	77	165	195	289
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	5,289	5,317	5,324
	of which Overtime	**20**	**6**	**8**	**9**	**6**	**8**	**10**	**14**	**11**	**13**	**14**	**16**
	Variance	6	4	16	26	-14	-11	8	4	14	32	69	87
Bank	Plan	387	373	359	346	332	318	305	291	277	264	250	237
	Actual	**286**	**302**	**326**	**333**	**334**	**319**	**326**	**348**	**325**	**381**	**365**	**414**
	Variance	-100	-71	-33	-13	2	1	21	57	48	117	115	177
Agency	Plan	60	58	56	55	53	51	49	47	45	44	42	40
	Actual	**50**	**44**	**39**	**46**	**44**	**31**	**39**	**43**	**61**	**60**	**52**	**64**
	Variance	-10	-14	-18	-9	-8	-20	-10	-4	16	16	10	24
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%	12.45%
	Actual	**10.85%**	**10.57%**	**10.24%**	**10.47%**	**10.91%**	**10.70%**	**11.08%**	**11.14%**	**11.24%**	**11.08%**	**11.01%**	
	Variance	-0.05%	-0.33%	-0.95%	-0.72%	-0.28%	-0.49%	-0.60%	-0.55%	-0.45%	-1.19%	-1.44%	-
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%	4.14%
	Actual	4.52%	4.45%	4.48%	4.57%	4.57%	4.53%	4.57%	4.59%	4.59%	4.61%	4.65%	
	Variance	0.17%	0.12%	0.17%	0.28%	0.28%	0.25%	0.34%	0.37%	0.36%	0.45%	0.51%	-

Performance & Counter Measure

- In month 12 we used 5,802WTE to deliver our services. This was our highest in-month usage this year and represents a year-end position to plan of +289WTE. There has been a small increase in substantive WTE in March (6WTE) however the largest driver for usage above plan is temporary staffing which has seen an increase in both bank and agency usage in month 12 (61WTE across bank and agency compared to February).
- Overall usage in March was +332WTE higher than our establishment of 5,470WTE.

Impact on Workforce

- Our year end position for 2024/25 is +289WTE to plan. This is higher than the forecast outturn submitted in the 2025/26 plan and so will increase our reduction requirements for next year by 64WTE.
- 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.

Risks & Mitigations

- There is risk that workforce levels continue above plan in 2025/26 worsening our financial position. The Workforce Recovery Meeting is being reestablished to support and monitor reduction plans.
- At present the Trust does not have material plans on how reductions for 2025/26 will be realised, and with continuing operational pressures there is further risk of growth.

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

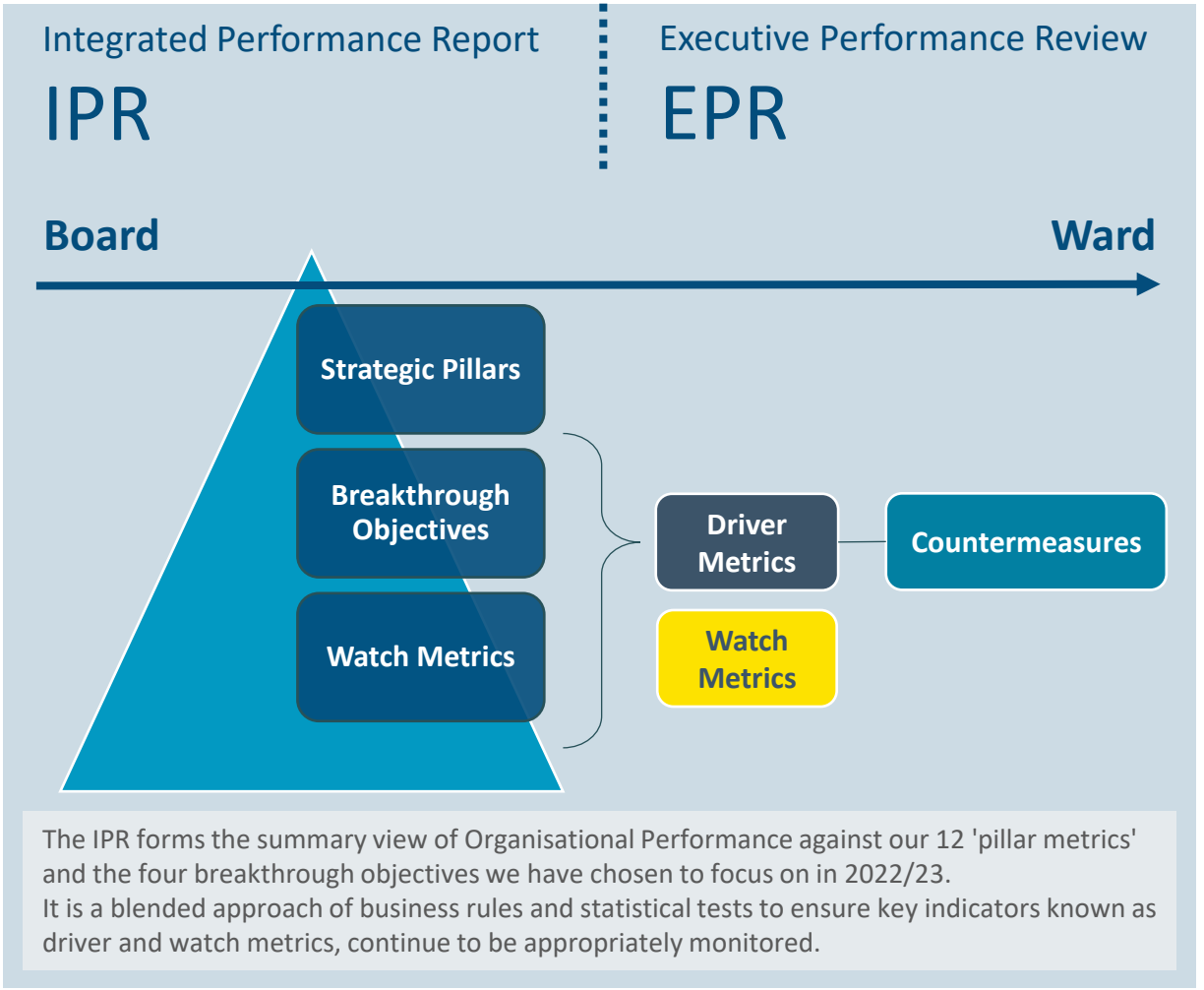
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

NHS
Great Western Hospitals
NHS Foundation Trust

Our Vision

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

Our four strategic pillars

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

24/25 Strategic Planning Framework

NHS Great Western Hospitals NHS Foundation Trust

Our Vision

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

1 Our four strategic pillars

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

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

4 Overlap

Corporate Projects

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

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

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

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust

Level	Daily	Weekly	Monthly
	Continuous Improvement on Drivers		Performance Management on Driver & Watch Metrics
Exec			Exec Performance Meeting
Division		Divisional Weekly Driver	Divisional Performance Meeting
Speciality		Speciality Weekly Driver	Speciality Performance Meeting
Frontline	Improvement Huddles		Frontline Performance Meeting

Information Flow

Information Flow

Building a culture of continuous improvement

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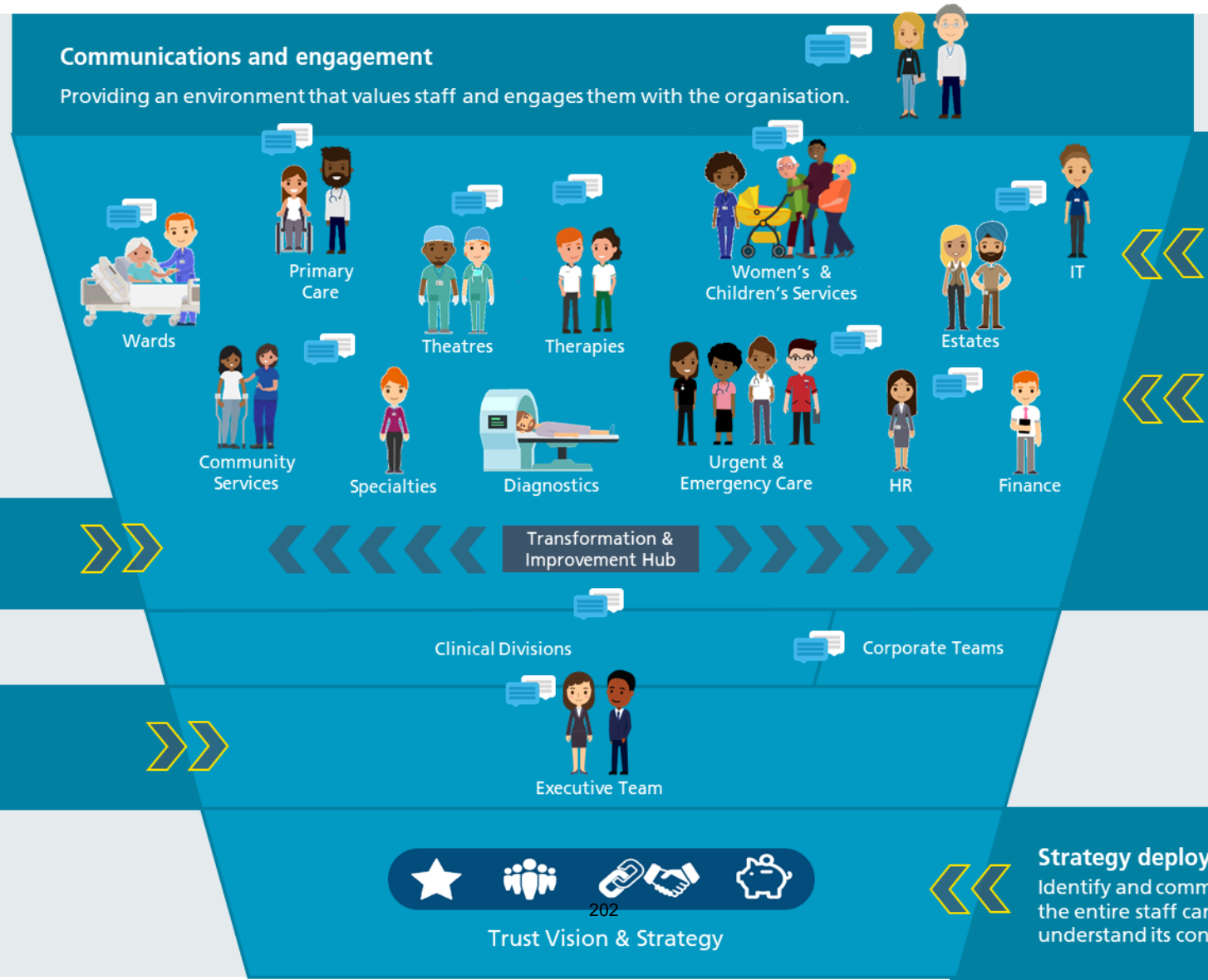


Transformational projects
Using improvement methodology to create step-change improvement.

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

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

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

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

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

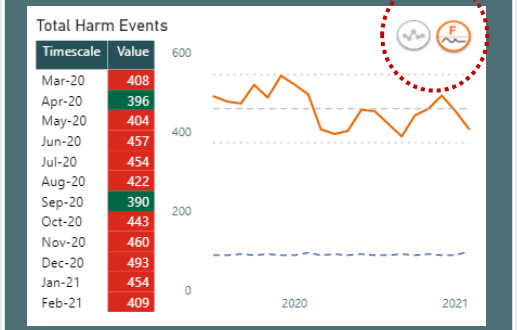
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

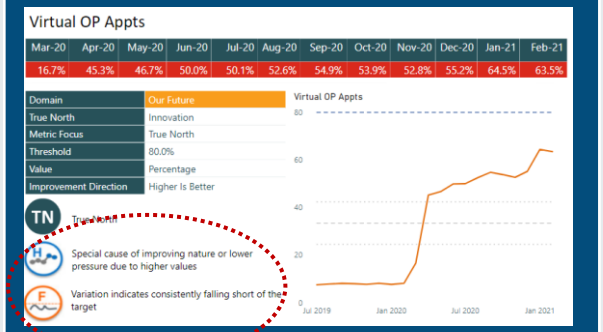
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

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

Agreed Terms

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Agreed Terms

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

NHS
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NHS Foundation Trust

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

Board Committee Assurance Report

Committee	**Mental Health Governance Committee**
Meeting Date	25 April 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 Q4 Report	Substantial	x
2. Use of the Mental Health Act 2024/25 Annual Report		For approval
3. Mental Capacity Act Q4 Report	Good	x
4. Use of Deprivation of Liberty Safeguards Q4 Report	Good	x
5. Mental Health Workplan 2024/25 End of Year Report	Good	x
6. Division of Medicine – Quarterly Report	Good	x
7. Right Care Right Person Update	Good	x
8. Surgery, Women's and Children's Service Quarterly Report	Good	x

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	*Use of the Mental Health Act [MHA]* The committee was assured that appropriate action had been taken in response to the two legal breaches of the MHA that had occurred during Q3. These had been identified promptly and the effected patients notified quickly. Bespoke training had subsequently been provided to Clinical Site Managers covering necessary MHA processes and that training, coupled with the exceptionality of the breaches and the well-established robust oversight provided by the Mental Act Administrator was sufficient for a return to a substantial assurance rating. The Board should note that a complaint brought by a patient in relation to one of those legal breaches was under investigation.
	Use of the MHA 2024/35 Annual Report The committee noted the draft Annual Report detailing the use of the Mental Health act during 2024/25 and recommended it for approval by the Board.
	The use of the Mental Capacity Act [MCA] 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 the MCA. However, the resource burden created by a number of complex cases involving the Court of Protection continued to grow and was expected to be further impacted by the absence of the MCA Lead such that, whilst plans were in place to address that absence through secondments, it was expected that there would be insufficient resource to complete the MCA audits that have been a source of assurance. It therefore remained a concern that resource constraints meant that audits had not and would not, with the exception of utilising a BSW self audit tool that had been developed by the MCA Lead and adopted across the system, be taking take place.
	The use 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 and it was noted that plans were in place to further strengthen aspects of the Masterclass training that was being provided. Further, the results of a DoLS audit provided a high level of assurance that DoLS practice was, to some a degree, of an appropriate standard and that the identified areas for improvement were to be a focus in the 202/26 Mental Health Workplan.
	Mental Health Workplan 2024/25 End of Year Report The committee noted the substantial completion of the actions included in the 2024/25 workplan and that outstanding partially completed actions were those involving a multi agency approach that extended across years which had been forwarded into the 2025/26 workplan.
	Division of Medicine Quarterly Report A good assurance rating was maintained. This reflects the work done, in partnership with AWP to ensure that the mental health needs of patients are met but the committee noted the significant challenges that remain. In relation to liaison activity the committee noted the information provided by AWP that had recorded a 50% increase in liaison activity over the last two years. Also of note were the longer stays in ED, with up to 6 daily mental health presentations, which meant that it was not always possible for patients to be cared for within the observation unit. This created a risk associated with Majors Chairs which was being monitored through the risk register. Of further note was the RMN spend to address the significant complexity of patients with mental health needs who were being cared for in an acute setting for longer than the optimum period. This spend was robustly monitored with a risk matrix to support decision making.

	Right Care Right Person [RCRP] Update GWH has continued to contribute both operationally and strategically in collaborative work across the system and a need for data to assess the impact that RCRP is having has been recognised. Individual cases are discussed and learning identified at regular challenge and assurance meetings with Wiltshire Police and GWH has now been monitoring internal concerns and incidents over a twelve-month period with nothing of significance identified. In these circumstances it was agreed that this update would no longer feature as a standing item on the committee's agenda and that future oversight would be through the Mental Health Operational Group with matters brought to the committee's attention as necessary.
	Division of Surgery, Women's and Children's Services Quarterly Report A good assurance rating was maintained. In relation to Children's Services the committee noted that work on the creation of the safe room had been delayed. This safe room will serve to address the significant risks associated with caring for children and young people exhibiting high risk behaviours on a paediatric ward and the committee welcomed the news that work was expected to begin imminently. Also welcomed was the extension of funding for Children's Mental Health Training. There continued to be close collaborative working between GWH and CAMHS although the admission of young people awaiting a specialist Tier 4 bed continued to impact on RMN spend and a review of that spending pattern had been undertaken and oversight had significantly improved. In relation to maternity services, the committee welcomed the work being done at system level to support birth partners being able to access mental health support following a bereavement. It was noted that adoption of Badgernet in Q3 was going to support the collection of mental health data with a focus on ante natal referrals but data was not yet available. This was because of challenges associated with how real time changes can be made the system. Work was being undertaken to understand what can be controlled at a local level and once this was understood the intention was to place prompts on the system which would support local data collection.
BOARD ASSURANCE FRAMEWORK & RISKS	*15+ Risk Report* The committee noted the established process to monitor risks at divisional level and that there continued to be no 15+ risk to report.
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	**Trust-wide Quarterly Learning from Deaths Report Q4**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Dr Steve Haig, Interim Chief Medical Officer				
Report Author	Dr Laurie Powell, Trust LfD Lead, Sharon Edwards, CAEMT Manager				
Appendices	Trust-wide Quarterly Learning from Deaths Report Q4				

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 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 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:

We continue to work on improving processes to demonstrate adequate learning from deaths within the trust – several processes have changed, or are in the process of changing, and we are not yet able to observe the impact of these changes. We have previously discussed that we hope to be able to improve assurance over the coming 6-12 months, and are optimistic that improved attendance at quarterly meetings, monthly sub-group meetings and improved analysis and use of data to guide learning and improvement work shows that we are making progress.

Report

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

- The latest SHMI data publication covers the period October 2023 to September 2024. This shows the Trust to be 'As Expected'; Reviews for Septicaemia and Pneumonia in progress.

- HSMR for data period August 2023 to July 2024 is 110.8, which is statistically significantly higher-than-expected although continues to follow a downward trajectory.
- There is a continued higher volume of super spells and observed deaths with a diagnosis of R69 (uncoded activity); it is difficult to fully interpret data and use it to full advantage of Telstra Health reports due to lags in the data. Internal data monitoring continues and is reviewed alongside Telstra Health reports.
- Internal Mortality data shows Divisions returning to expected levels following the Christmas period and into the new year; however, some specialities remained under close monitoring.
- There have been additional reviews into deaths on Trauma Unit which were reportedly higher than average, and into deaths in Respiratory which showed no concerns.
- SJR completion rate remained largely below average for this quarter and less than 2023/24.
- 163 SJR's were completed out of 372 deaths (44%) so far in Q4; 84% of care delivered was deemed to be good or excellent; increased from 80% in Q3.
- New trial of "sifting process" to identify most appropriate way of reviewing deaths.
- LfD weekly meeting between the LfD leads to review external and internal data and assessment of actions required and workplan objectives to deliver.
- Quarterly meeting took place on 10th March and was again well-attended.
- BSW meeting on 17th March 2025 – discussed report from Public Health looking at death rates in the region, specifically looking at spread across deprivation quintiles.

Strategic Alignment – select one or more		☐ Outstanding care		☐ Valued teams		☐ Better together		☐ Sustainable future

Link to CQC Domain – select one or more	**Safe**	✓	**Caring**	✓	**Effective**	✓	**Responsive**	✓	**Well-led**	✓

Risk + Oversight	**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Patient Quality Sub-Committee and 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?	☐	✓	☐
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	☐	☐	✓

Explanation of above analysis:

Recommendation / Action Required

The Board/Committee/Group is requested to:

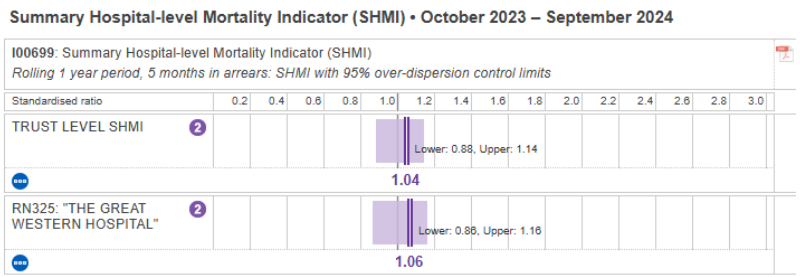
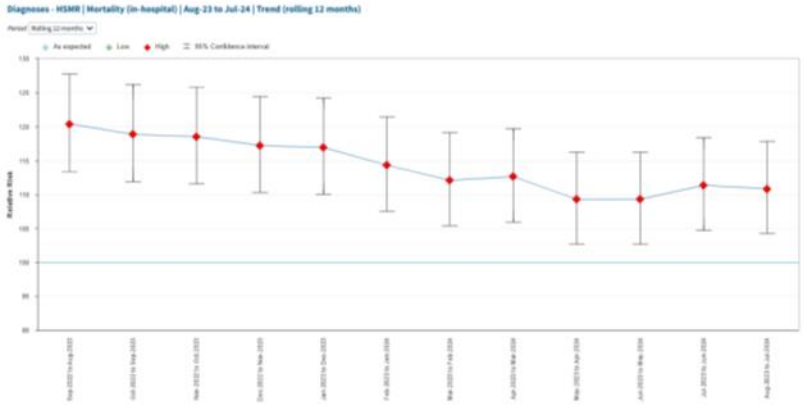
Acknowledge work in progress by the Learning from Deaths Team.

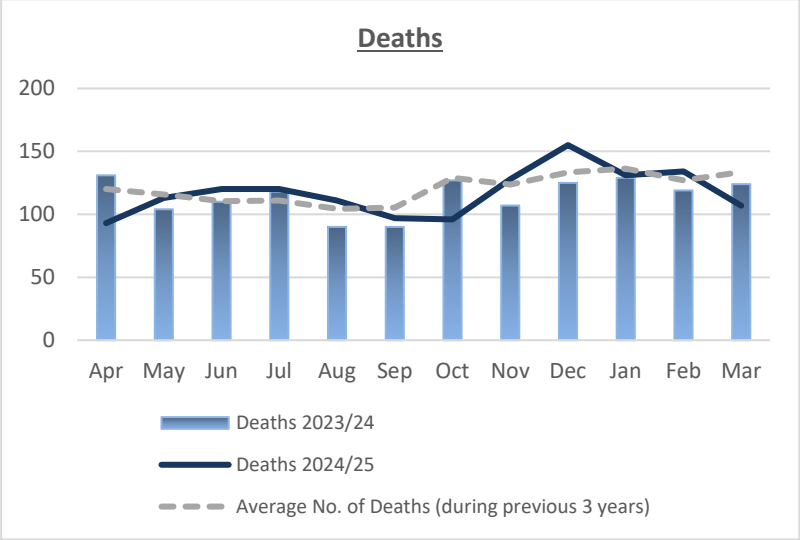
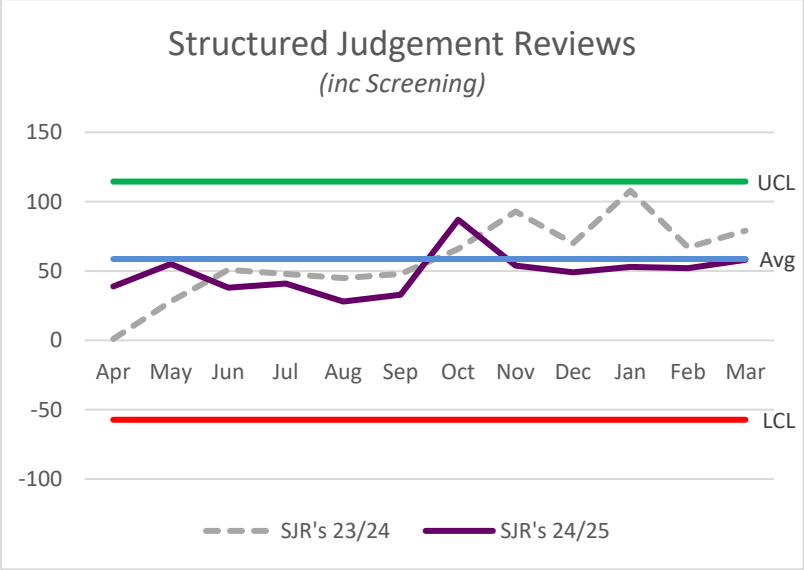
Accountable Lead Signature	
Date	**28/04/2025**

Trust-wide Quarterly Learning from Deaths Report

MONTH/YEAR: April 2025 (Q4 Data)

The Trust-wide Quarterly Learning from Deaths Report is produced using a combination of external data sources (Telstra health, NHS Digital), internal data and information gathered from specific internal Coding and Clinical Case note reviews, analysis and outcomes from Structured Judgements Reviews (SJR's) and any other mortality-related activity or data.

SHMI *(External Data)*	**CURRENT POSITION**	**FORWARD ACTION PLAN**
	The latest SHMI data publication covers the period October 2023 to September 2024. This shows the Trust to be 'As Expected'. A review of the diagnostic indicators shows the Trust continues to have marginally higher than expected figures for Pneumonia showing 264 observed deaths during the period, vs 247.2 expected deaths, with aspiration Pneumonia (inc. food vomitus) at 56 observed deaths vs 46.5 expected deaths. There are currently no alerts around these indicators and the numbers remain 'As expected' as described by the NHSE Clinical Indicator Previewer. Deaths from Septicaemia (except in labour) are also higher than expected, with 117 deaths observed compared with 102.7 expected.	Data for both pneumonia and septicaemia indicators continue to be higher than expected. The limited review looking at "Hospital Acquired Pneumonia" has been shared with the Pneumonia lead, and a meeting is planned to discuss the report and any actions required.
TELSTRA HEALTH *(External Data)*	**CURRENT POSITION**	**FORWARD ACTION PLAN**
	**HSMR** for data period August 2023 to July 2024 is 110.8, which is statistically significantly **higher-than-expected** compared to hospital trusts nationally. However, the rolling 12-month trend in HSMR continues to follow a downward trajectory. The latest analysis is based on HES extract for 24/25 but with a three-month data lag applied; this excludes the 3 most recent months of data available (August 2024 - October 2024) as it is heavily affected by a delay in fully coding discharges – this is evidenced by the higher volume of super spells and observed deaths with a diagnosis of R69 (uncoded activity). Weekday data shows 109.7, which is **higher-than-expected.** Weekend data shows 115.5, which is **higher than expected.**	The LfD team continue to work with Telstra Health to review and report on externally received data, and to respond to concerns or alerts identified. Due to the volume of uncoded activity, it is difficult to fully interpret data and use it to full advantage or determine and respond to relative risk alerts as genuine alerts. Internal data monitoring continues and is reviewed alongside Telstra Health reports which provides an additional level of oversight to also respond or foresee where concerns or internal alerts may arise, as previously completed (septicaemia and pneumonia).

Trust Activity *(Internal Data)*	CURRENT POSITION	FORWARD ACTION PLAN
	Mortality data showed Divisions returning to expected levels following the Christmas period and into the new year; however, some specialities remained under close monitoring due to the previously high number of deaths reported in Q3 - General Medicine, Respiratory and Emergency Department, who saw particularly high number of deaths in their department. In SWC, General Surgery also remained under monitoring, alongside Trauma and Orthopaedics who also reported higher number than expected of deaths on the Trauma Unit. February saw an unexpected rise in the number of deaths and a review of the data identified slightly higher than average admission levels for this period; the proportion of deaths for this quarter reached 1.6% of total admissions (average 1.3%). Mortality Data continues to be distributed weekly to Divisional Leads and Executive Mortality Team.	A weekly review of data to closely monitor the mortality rates; where areas of concern are identified, correlating data is reviewed accordingly. Actions completed: 5/8 deaths on Trauma Unit have so far been reviewed using the SJR Tool; 4 reviews identified excellent care, 1 review identified gaps and care was deemed adequate. Respiratory data was also reviewed which identified a combination of diagnoses and causes of death expected for this time of year including Influenza, COPD and Pneumonia. There was a high proportion of Community Acquired Pneumonia contributing to this mortality group. Mortality data at the start of March 2025 shows levels returning to below average figures, although at the time of reporting, data for March is yet to be concluded. At present the proportion of admissions where the outcome is death is currently reported to be 1.3%.
STRUCTURED JUDGEMENT REVIEWS *(Internal Data)*	**CURRENT POSITION**	**FORWARD ACTION PLAN**
	SJR completion rate remained largely below average for this quarter and less than 2023/2024. However, as an action from the previous quarter, SJR training has been a focus in the new year and in response to the request for support from the Divisions, data shows that 76% of SJR's have been completed by specialties. Of the reviews completed, Excellent and Good care was deemed in 84% cases which is an increase from 80% reported in Q3. In 11.7% reviews, care was deemed to be adequate. In 3.1% of the reviews, care was deemed to be poor or very poor, with opportunities for improvement around identifying deteriorating patients, delays in diagnosis, inpatient falls and significant delays/gaps in Consultant/Senior reviews. 2 patients (1.2%) recorded under Well Babies, were progressed through a separate review process and therefore no care scores are provided.	The current SJR process was reviewed to understand where efficiencies could be made, particularly for mandatory category SJRs. This identified double-handling of reviews for care (investigation + SJR, complaints + SJR). Where this occurred, over a 4-week period, mortality cases were allowed to follow the respective internal process without supplementing with an SJR; this accounted for approximately ¾ of deaths. The pilot also demonstrated time saved was focused on facilitating and tracking remaining mandatory categories (Elective deaths, LD patients, Hospital Acquired infections). Mandatory category SJR's were completed by the MRP which remains a successful process (avoids bias) and means there is less time-pressured requirement for clinicians and specialities to complete mandatory reviews which was proving difficult to achieve alongside regular speciality SJR reviews (non-mandatory categories). Forward plans are in still in progress for final agreement.

CODING/CLINICAL REVIEWS *(Internal Data)*	CURRENT POSITION	FORWARD ACTION PLAN
1. Pneumonia & Aspiration Pneumonia (identified via SHMI)	Review of hospital acquired pneumonia completed and shared with Pneumonia Lead.	Meeting with pneumonia lead to discuss action plan. This is a theme identified across the BSW system, with SFT also having more deaths than expected. Further discussion within the BSW system mortality group to review system-wide learning and action.
2. Hip Fracture Review	Report finalised and handed over to hip fracture team. No further action from mortality team required at present – we will continue to monitor GWH status in NHFD.	
3. Inpatient Falls Review	Report finalised and handed over to falls team. No further action from mortality team required at present – we will continue to monitor deaths associated with falls.	

OTHER UPDATES *(Workplan priorities)*

- Trial of "sifting process" to identify most appropriate way of reviewing deaths. Discussions with national teams about processes working well in other trusts has led to design and trial of process at GWH. In line with best practice, except for specific scenarios, deaths will not be reviewed by multiple processes – the most appropriate process will be identified and prioritised (e.g. Inquest, patient safety review, SJR). This will mean that the number of SJRs will reduce as deaths associated with incidents being investigated will not have an SJR completed in addition, however themes emerging from patient safety investigations will be discussed and actioned via the Learning from Deaths sub-group.
- Grand Round presentation (24th April) – the Learning from Deaths team will be presenting at the trust "Grand Round" on 24th April, to demonstrate current processes and work occurring within the trust. It is hoped that there will be representation from other teams supporting the LfD agenda within the trust.

Learning from Deaths – Subgroup Meetings *(Monthly review of collated data and identification of actions. Attendance from Medical Examiner, legal team, patient safety, clinical coding, LfD team)*

Since the last report there have been 3 LfD subgroup meetings.
There continues to be a weekly meeting between the LfD leads to review external and internal data and assessment of actions required and workplan objectives to deliver. This includes the completion of the internal trust wide reviews, the implementation of the trust framework for the Mortality Review Programme, discussion and implementation of policy and pathways (including the Medical Examiner referral pathway for SJRs and the LfD policy).
Next Scheduled Meeting: Monday 5th May 2025

Trust-wide Learning from Deaths Meetings *(Quarterly review of data summaries & actions, shared learning of review outcomes and speciality M&M Meetings. Attendance expected from departmental M&M leads, Medical Examiner, Learning Disability team)*

The Quarterly meeting took place on 10th March and was again well-attended by specialty leads, AMD Paul Devonish and Governor Judith Furze. Feedback from the meeting was good, however more time is requested to discuss learning occurring within the specialities.
Next Scheduled Meeting: Monday 9th June 2025

BSW System mortality group *(Monthly meeting with mortality teams from Bath and Salisbury, ICB Chief Medical Office, Swindon Borough Council to identify and improve mortality across the system)*

Last meeting was 17th March 2025 – discussed report from Public Health looking at death rates in the region, specifically looking at spread across deprivation quintiles. Further discussion required regarding ToR, as no representation from primary care, so currently acute trusts and ICB representatives.
Recent meetings include updates regarding:

- Telstra contract (ongoing discussion) – GWH will not be renewing contract with Telstra Health from September 2025 – it is likely that RUH and SFT will follow. Discussions underway to identify how we can benchmark internal data across the 3 trusts.

- Public Health
- Interstitial lung disease project with Prospect Hospice
- Mortality "Community of Practice" work – initiative set up by colleagues in Bristol, where mortality teams come together to discuss best practice and learning

Next scheduled meeting: Monday 28th April 2025

SHMI (Summary Hospital Level Mortality Index)
Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS England Digital

Report Title	**Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Benny Goodman, Chief Operating Officer				
Report Author	Sarah Orr, Head of Emergency Planning				
Appendices	EPRR Assurance Report & ICB Assurance Letter				

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 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 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:

60/62 standards are fully complaint and we have been rated as Substantially Compliant

Report

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

The purpose of this report is to provide the Board with assurance on Trust compliance with the EPRR core standards following completion of the annual assurance process.

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

Providers and commissioners of NHS-funded services complete an assurance self-assessment based on the EPRR core standards. This assurance process is led nationally and regionally by NHS England and locally by Integrated Care Boards (ICBs).

The NHS core standards for EPRR cover 10 domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

The report attached includes a summary of the Trust's activity to comply with the standards in 2024 and the priority areas for improvement in 2025/26.

A copy of the letter of assurance for 2024 is also enclosed from the ICB to GWH which shows the Trust as substantially compliant against the core standards (60 out of 62 standards). Two areas of partial compliance are in business continuity analysis and business continuity planning. The work programme for 2025/26 includes plans to make this fully compliant in the next annual assessment.

Strategic Alignment – select one or more		✓ Outstanding care		✓ Valued teams		✓ Better together		✓ Sustainable future

Link to CQC Domain – select one or more	**Safe**	☐	**Caring**	☐	**Effective**	✓	**Responsive**	✓	**Well-led**	✓

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	Risk 1269 We have seen multiple estates and IT issues and do not have good oversight of what impacts may be and what risks we are carrying due to non-compliance against BIAs	12
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Reviewed at PPPC	
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?	☐	✓	☐
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	☐	✓	☐
Explanation of above analysis:			

Recommendation / Action Required

The Board/Committee/Group is requested to:

The implementation of the assurance plan will be monitored through the EPRR Steering Group.

The Board is requested to note the substantial compliance for EPRR standards in 2024

Accountable Lead Signature	Benny Goodman, Chief Operating Officer
Date	**01/05/2025**

Bath and North East Somerset,
Swindon and Wiltshire Together

Emergency Preparedness, Resilience & Response – Assurance Report 2024

Prepared for BSW ICB
By: Great Western Hospital
Dated: 6th September 2024

Written by: Sarah Orr
Role: Head of EPRR
Date: 6th September 2024

Approved By AEO:
Date: 6th September 2024

Bath and North East Somerset,
Swindon and Wiltshire Together

Table of Contents

1. Executive Summary

The following paper outlines the continued progress of the EPRR agenda at Great Western Hospital (GWH) 2024 and provides detail as to how we have continued to progress and maintain standards whilst embedding learning from our incident response.

2. Background Assurance Process

The table below details the assurance compliance for Great Western Hospital since 2020 to date.

Organisation	2020	2021	2022	2023	2024
GWH	Substantial	Substantial	Substantial	Fully	Substantial

Overall, substantially compliant, 60/62 standards.

Two areas partially compliant:

- **Business Impact Analysis**: existing documents are not robust and require further development
- **Business Continuity Plans**: the gaps within the Business Impact Analysis drive the need for improving business continuity plans to ensure they are resilient

3. EPRR 2023/24

Since the EPRR assurance process in September 2023 there have been further developments and key changes at GWG the detail of which can be seen below:

3.1 Staffing

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

3.3 Training September 2023 – present

Training Title	Training Provider	Date & Timings	Participants
BSW LHRP Executive - Accountable Emergency Officer Development Day	ICS and External Speakers	21/11/2023	Felicity Taylor-Drewe – AEO Sarah Orr Phil Ralls

Principles of Health Command	BSW ICB and LHRP Partners	TBC	
Fire Training	GWH	Quarter 4 2023/2024	
CBRN Tent Training	GWH – EPRR – Practical Session	19/06/24	ED staff x 10
Loggist Training	GWH	31st January 2024	8 staff
GWH 6 monthly full alert cascade test	GWH	02/02/2024 & 02/07/2024	
ED Mass Casualty Training and PRPS Overview -	GWH	05/03/2024	12 GWH Staff
K1a GWH Emergency Preparedness Resilience and Response Policy, plans, and procedures in relation to a major incident, critical incident, or business continuity event	GWH	15/03/2024	6 GWH Staff
K1b GWH Org Structure in and Out of Hours	GWH	15/03/2024	6 GWH Staff
K4 Core EPRR Legislation and non-statutory guidance	GWH	19/03/2024	6 GWH Staff
K5 Alerts and notifications - On Call Training	GWH	21/03/2024	
SW EPRR Symposium	NHSE	20/03/2024	AEO and EPRR Managers
K6 Defensible decision making	GWH	09/04/2024	4 GWH staff attended
K7 Shared situational awareness	GWH	17/04/2024	4 GWH staff attended
supporting general incident response for all on call staff	GWH	13/05/2024 & 15/05/2024	
Mass Casualty Plan Overview – for On Call Managers, On Call Directors and Matrons.	GWH	Three two-hour sessions: 24/04/2024 02/05/2024 23/05/2024	6 GWH staff attended
CBRN Awareness Training:	GWH	28/06/2024 02/07/2024	4 GWH staff attended. 4 GWH staff attended

3.4 Exercising September 2023 – present

Name of Exercise	Type of Exercise	Date & Timings	Exercise Lead	Participants
GWH – Ward Fire Evacuation Exercise	Evacuation with DWFRS	01/03/2024	Sarah Orr & Nick Harvey	
ED Mass Casualty Training	Tabletop	05/03/2024	Sarah Orr	10 attended
Theatres Fire Exercise (table top)	GWH	11/04/2024	Phil Ralls	All theatre staff – 100 attended
Cyber Comms Exercise	GWH	18/04/2024	Phil Ralls	8 staff attended, comms, IT and EPRR
Fire evacuation exercise of Aldbourne ward with support from DWF	GWH	20/05/2024	H&S, supported by EPRR	14 attended
ED Mass Casualty Training	Tabletop	17/05/2024	Sarah Orr	10 attended
CBRN Exercise	Live Exercise	19/06/2024	Attended by SWAST as part of annual assurance CBRN audit	13 staff attended
ED Mass Casualty	Table top	21/06/2024		9 staff attended

3.5 Training Scheduled –

Training Title	Training Provider	Date & Timings	Participants
Defensible Decision Making	Sarah Orr	30/09/2024 10/10/2024 23/10/2024 06/11/2024	On Call Managers, On Call Directors, Matrons, Managers and ward managers
Mass Casualty Overview	Sarah Orr	08/10/2024 17/10/2024 19/11/2024 25/11/2024	On Call Managers, On Call Directors, Matrons, Managers and ward managers

3.6 Exercising Scheduled

Name of Exercise	Type of Exercise	Date & Timings	Exercise Lead	Participants
Cyber Exercise	Tabletop	11/02/2025	Philip Ralls	TMC
ED Mass Casualty	Tabletop	07/03/2025 10/04/2025 06/05/2025	Sarah Orr	ED staff + 2x On Call Staff
CBRN Exercise	Live exercise	22/05/2025 25/05/2025 22/09/2025	Sarah Orr	ED Staff, 2x On Call Staff and volunteers
Fire Exercise	Live Exercise	17/04/2025	Nick Harvey and Steve Hince	Theatres Staff

4. Incident Responses

4.1 Critical Incident Responses from September 2023 to date

Date of Incident	Type of Incident	Impacting	Incident Declaration	Key Learning
28/11/2023	OPEL 4 – Paediatric surge pressure	GWH	Business Continuity	• Stood down 27/12/2024
02/01/2024	Operational Pressure	GWH	Critical Incident	• Stood down 04/01/2024
01/04/2024	Operational Pressure – number of triggers reached	GWH	Critical Incident	• Stood down 05/04/2024

4.2 Major Incident Responses / Business Continuity Incidents from September 2023 to date

Date of Incident	Type of Incident	Impacting	Incident Declaration	Key Learning
02/10/2023	Industrial Action Response	BMA Consultants	Business Continuity Incident	
20/12/2023	Industrial Action Response	BMA Consultants / Junior Drs	Business Continuity Incident	• GWH Stood down 23/12/2023
04/01/2024	Industrial Action Response	BMA Junior Drs	Business Continuity Incident	• GWH Stood down 09/01/2024

26/02/2024 Declared (IA ran from 07.00 24/02/2024 – 23.59 28/02/2024)	Industrial Action Response	BMA Junior Drs	Business Continuity Incident	• GWH Stood down
30/05/2024	Operational site pressure, 4 fire alarm activations and all lifts in operable	GWH Site	Business Continuity Incident	•
11/06/2024	Long waits in ED & MEU)20 hours +)		Business Continuity Incident	• Stood down 12/06/2024
27/06/2024	Industrial Action Response	BMA Junior Drs	Business Continuity Incident	• Stood down 02/07/2024
09/07/2024	Total Power Outage	GWH	Major Incident	• Full debrief conducted across the trust with clear actions identified. • Top 5: ○ Communications Failure ○ Gaps in business continuity plans ○ Liden incident room not fit for purpose ○ Inability to evacuate patients/staff/visitors that are in a wheelchair or have mobility issues unless ski sheets are use ○ Incident Response Structure needs strengthening

4.3 Debriefs from September 2023 to date.

Date of debrief	Date of Incident	Type of incident	Partners attended	Key Learning
Debrief 30/10/2023	Incident 02/10/2023 – 05/10/2023 Industrial action	Business Continuity	BCW ICB – Louise Cadle (Facilitator), GWH – Sarah Orr, Phil Ralls	• The operational health response was successful with strong collaborative efforts from all partners. • Identified leads for each acute but supported by appropriate colleagues from various specialities.

				• Experience from previous strike action planning with the continual development of incident coordination plans and templates was extremely helpful. • Locally agreed incident coordination structures – reporting, touchpoint calls. • Dates for returns were communicated in advance which enabled operational planning. • Communications to primary care worked well and feedback was positive from primary care colleagues. • Early identification of risks with joint working across the ICS was beneficial particularly with previous experience of strike action. • Internal dynamic problem solving to address gaps. • Staff fatigue and moral low. • Reluctance to support again. Lack of online rostering for medical staff impacted tracking of staff due on shift or striking.
03/11/2023	Exercise Inundation	Louise Cadle (Facilitator) GWH		• Understanding numbers, we can shelter and where, and where the provision for food and welfare will be sourced. • Understand if supporting other LRFs and taking displaced vulnerable people, is there any local resource support coming with them. • Ensure those attending cells have clear roles defined and clear lines of communication e.g., for health and social care cell versus vulnerable people cell and all attendees are present Utilisation of resources – could resources available be written into plan – understand how mapping can be used in this situation.

				• Increase understanding and awareness for need of situational awareness including resources available. • Need to have a clear understanding of how communication will be managed to ensure neighbouring partners have situational awareness. • In future exercise to assess the linkage between SCG, TCG, various cells and partners internal structures. • In future exercise the recovery element

5. Areas of good practice –

- GWH member of the BSW LHRP Risk Working Group
- Leading system debriefing
- Sharing best practice with Gloucester
- Coordinating the opening of the Integrated Front Door
- Demonstrating command and control expertise in live incident response

6. Developments to consider for 2024/25

- **Embedding learning**: Lots of improvements to be made following the power major incident debrief to improve both business continuity plans and overall incident response
- **Mass Casualty plans development and exercising**: Requirement to develop further plans to reflect the increased demand so that GWH can respond effectively to a Major Incident that results in a large number of casualties
- **Cyber Response**: Enhance plans following learning from exercises and incidents Expand business continuity plans for software outages to span several months of downtime following learning from the Synnovis (Guys and St Thomas) cyber-attack.

7. Recommendations

- Through the Business Continuity Working Group, drive improvement and engagement with Business Continuity Analyses and plans
- Business case for software to mange business continuity plans that will ease the time burden on staff, minimise risk by giving a comprehensive picture of interdependencies and where there may be areas for greater development.

Annex Key highlights from Cyber Comms Exercise 18/04/2024.

Key Highlights from the Exercise:

1. **Enhanced Role Clarity and Coordination:** The exercise provided a valuable platform for identifying and exploring specific roles within your team. A structured approach (with some degree of flexibility) is essential for efficient incident/crisis management and ensures that everyone knows their responsibilities from the onset of a crisis.
2. **Development of Pre-defined Media Communications:** We discussed at large the requirement of enhancing your already extensive library of pre-defined response, in developing additional pre-defined responses for some alternative potential scenarios. These templates, ranging from emails to alert cascade messages saved in MS Word, are designed to expedite our response time, and ensure consistency in our communications across all platforms.
3. **Collaboration with External Agencies:** Discussions on engaging with supporting agencies such as the local police and Swindon Borough Council were particularly fruitful. These relationships are vital for a coordinated response to cybersecurity threats and for leveraging external expertise, when necessary, in conjunction with LRF, NHS Digital Support.
4. **Interactive Team Engagement:** The level of engagement during the exercise was great to observe. By dissecting and debating each other's ideas, you fostered a good understanding and refinement of your strategies. This type of collaboration is invaluable and leads to more robust and effective communication strategies.
5. **Strategic Public Statements:** The team effectively tackled the development of holding statements and other critical public communications. This practice is crucial for maintaining trust and managing public perception in the wake of a cybersecurity incident.
6. **Executive Involvement and Support:** Recognising the importance of executive backing in times of crisis, we discussed and simulated scenarios involving executive support. This includes pre-screening of communications and involving Subject Matter Experts (SMEs) to provide accurate and authoritative information to the media.
7. **Information Security / MFA:** Discussed at length the need to ensure shared platforms are suitably secure, consideration of using Mult-Factor Authentication, or extended passwords, and or more frequent password resets.

Achievements in Key Areas:

- **Cybersecurity Awareness:** Enhanced understanding of potential threats and proactive measures to protect sensitive information.
- **Crisis Communication Planning:** Improved the understanding of readiness for immediate and effective communication during crises.
- **Information Security Protocols:** Strengthened procedures to safeguard data and prevent unauthorized access.
- **Stakeholder Engagement:** Deepened the understanding of potential connections with essential internal and external stakeholders.
- **Team Coordination Without Digital Tools:** Demonstrated ability to maintain operational coordination even without reliance on digital communications by exploring other avenues to deliver your key message(s).

- **Public Relations Management:** Refined strategies to manage media interactions and public relations dynamically.

This exercise was a good starting point to highlight all the positives that your team have in place at this current time to support your capability to respond to emergencies but also highlighted areas where we can continue to develop and strengthen your approaches enhancing your preparedness is greatly appreciated and pivotal to yours and the Trust's continued success.

30 October 2024

Via Email

Dear Rob

Great Western Hospital NHS Foundation Trust - EPRR Core Standard Assurance Summary 2024

Many thanks for preparing the self-assessment, supporting evidence and your engagement at the EPRR assurance review meeting held on 10th September. This letter summarises the outcomes from the meeting, capturing agreed actions and points from our discussions.

The Core Standards have been reviewed and in addition to the Core standards self-assessment, you provided a comprehensive report detailing the achieved EPRR portfolio in the last year and at the assurance review meeting Sarah provided a detailed update reflecting on the year and the look forward.

It was agreed that two core standards are now partially compliant following learning from the major incident declaration following a full power outage at GWH.

Core Standard	Standard	Organisational Comment	Timescale
CS 46	Business Continuity Impact Assessment	A Business Continuity Working Group has been established to take this work forward.	Dec 2024
CS47	Business Continuity Plans	Further develop BCPs following gaps highlighted by BIAS	Mar 2025

Compliance level

Organisation	2021	2022	2023	2024
GWH	Substantial	Substantial	Full	Substantial

Organisational Rating	
Fully	
Substantial	
Partial	
Non-Compliant	

Outcome from the 2024 EPRR Core Standards Deep Dive Review - Cyber

Further work is required across Cyber resilience and in particular consolidating response arrangements and system-wide learning from incidents.

Headlines

The EPRR team played a key role in coordinating their internal incident response to industrial action from Junior Doctors and Consultants. The lessons learnt from this experience were later embedded into planning for strike action by Serco in September with key support functions being impacted.

GWH Integrated Front Door launch was supported through the planned works and transition to a new Emergency Department (ED) opening by the EPRR team working closely with key leads to ensure a seamless opening of a new ED and closing of the old ED. Lessons identified through this process are being shared with Portsmouth Hospitals who are also undergoing a similar project.

A major incident was declared 9th July 2024 when a full power outage was experienced. This provided an excellent opportunity to test all Business Continuity Plans and incident coordination arrangements in a live incident. NHS England commended the trust on its leadership through the incident providing timely updates and continually reviewing the situation with clear de-escalation triggers.

Despite the ongoing pressures several internal training sessions have taken place including Defensible Decision-making and Mass Casualty response. There is more work to ensure the entire trust is engaged with training and exercise.

GWH have also played a key part in establishing the Risk Working Group within the Local Health Resilience Partnership which has enabled the risk management process to be streamlined linked to capabilities this has included a strong governance process. A great piece of work demonstrating collaboration across BSW.

Set priorities for 2025 include:

- Embed learning from the major incident will be the focus for the coming year with a review of all critical functions and business continuity plans.
- Deliver a mass casualty exercise to test their new Integrated Front Door.

The outcomes of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHS England South West. The ICB will be required to present a system summary of the assurance process to the LHRP.

NHS England will produce and submit a regional report to the NHS England National Team by end of December 2024.

Finally, thanks must go to you and the EPRR team for your hard work over the last year, while managing other concurrent issues and incidents.

Yours sincerely

Rachael Backler
Chief Delivery Officer
NHS Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board

Report Title	**2024 Trust Staff Survey Results**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Jude Gray, Chief People Officer				
Report Author	Angela Morris, Senior People Partner				
Appendices	Staff Survey Benchmark and Trend Data				

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 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 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 annual staff survey results were received by the Strategic People & Culture Sub-Committee 15/04/2025 before being presented to the People & Culture Committee 29/04/2025 at which a 'good' assurance level was received.

A monthly Trust Wide Staff Survey working group provides a forum to divisional survey leads for oversight and assurance of actions, progress, and learning, to support the Trust breakthrough objective.

Report

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

The Trust achieved a response rate 71% (4,228 colleagues), being the highest staff survey response across NHS England.

The majority of the Trust People Promise scores in the 2024 National NHS Staff Survey are in line with the sector scores. When looking at the People Promise scores, the scores for 'We

work flexibly' are significantly better than similar organisations. The scores for compassionate culture and advocacy are significantly worse.

The themes of Morale and Staff Engagement remain key performance indicators for the Trust. Both theme scores are in line with the sector, with no significant difference to 2023 scores.

At question level, 7 scores are in the top 20% range of similar organisations. There are 98 scores that are in the intermediate 60% and 3 in the bottom 20%.

Of the 7 questions raking in the top 20%, questions include flexible working, positive action on health and wellbeing, discrimination on grounds of gender and sexual orientation, and reporting leaving the organisation.

The 3 questions ranking in the bottom 20% of sector scores relate to level of pay, unrealistic time pressures, and reporting physical violence at work.

The majority of the People Promise scores for 2024 Bank staff within the Trust are significantly better than the substantive Trust scores. The scores for 'We are safe and healthy', compassionate culture, diversity and equality are significantly better than the substantive scores. The scores for development and line management are significantly worse.

The Trust implemented significant change management programmes during 2024 including a new IFD and bed reconfiguration moves. These and the loss of community contract do not appear to have negatively influenced staff responses against the pillar ("I would recommend my organisation as a place to work"), and breakthrough question ("I receive the respect I deserve from colleagues at work"), with no significant change these questions against last year.

Strategic Alignment – select one or more		✓ Outstanding care		✓ Valued teams		✓ Better together		☐ Sustainable future

Link to CQC Domain – select one or more	**Safe**	✓	**Caring**	✓	**Effective**	✓	**Responsive**	✓	**Well-led**	✓

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

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

A subset of questions in the staff survey are directly related to staff experience of diversity and inclusion and provide indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Summary of results relating to EDI/inequalities:-

- Improvement in BME staff experiencing harassment, bullying or abuse from colleagues in last 12 months: reduced by 1.69% since 2023; higher than the benchmark average by 2.85%.

- BME staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months: increased 1.18% since 2023.
- Percentage of staff with a long-term condition (LTC) or illness who have experienced harassment, bullying and abuse from patients: reduced by 0.81%, this is 4.51% higher than the benchmark average and a continuing downward trend for the third year in a row.
- Percentage of staff with LTC or illness experiencing harassment, bullying and abuse from a manager: increased by 1.38% and 0.88% lower than the benchmark average.
- Percentage of staff with LTC or illness experiencing harassment, bullying or abuse from colleagues in the last 12 months: increased by 3.54%, in contrast to having reduced by 5.61% the year before. Higher than the benchmark average by 1.52%.

Focussed actions to support improvement in the EDI pillar metric question 16b are identified in the report and include:

- Inclusion and Recruitment Champions.
- Leadership Skills training includes interview skills for ethnic minority and internationally educated staff.
- EDI conference focused on allyship and bystander training.
- Expectations of a Line Manager training.
- EDI champions supporting local actions and addressing unprofessional behaviours.
- Cultural Ambassador pilot in Conduct Management.

Recommendation / Action Required

The Board/Committee/Group is requested to:

- champion the staff survey as an indicator of staff engagement
- incorporate asking staff opinions of feeling respected by colleagues (Q7c) and experience of discrimination (Q16b) into Board Go & See routines.

Accountable Lead Signature	on behalf of Jude Gray, Chief People Officer
Date	**02/05/2025**

NHS
Great Western Hospitals
NHS Foundation Trust

2024 Staff Survey Results

Trust Board | May 2025

Together we are Great

Contents

2024 Staff Survey Results

National Context

2024 Staff Survey Results

Great Western Hospitals NHS Foundation Trust

A total of **774,828** NHS staff responded to the 2024 Staff Survey
(707,872 in 2023)

210 NHS Trusts participated in the survey to give an overview of Staff Engagement for Autumn 2024

National Results

- Overall, all People Promise indicators remained stable to last year. A slight improvement in four People Promise indicators; safe and healthy, always learning, and work flexibly. Reward and recognition and team working remained unchanged, whereas compassion and inclusivity and whether staff have a voice that counts slightly declined.
- Morale saw a slight improvement, staff saying they were thinking of leaving the NHS is unchanged compared to last year and retains the improvement seen between 2022 and 2023.
- Improvements seen on health and wellbeing measures, with the proportions of staff experiencing harassment, bullying or abuse from each of patients/service users, managers and other colleagues are all at their lowest reported levels in five years.
- Key measures of staff experience remained stable to last year with staff willing to recommend the NHS as a place to work remaining similar. The percentage of staff that would recommend their organisation as a place to get care also remained similar to last year, however both measures remain below their 2020 levels.
- On equality and diversity scores were broadly stable, There remained a significant equality gap in the experience of Black Minority Ethnic staff.

GWH Staff Survey

2024 Staff Survey Results

Great Western Hospitals NHS Foundation Trust

GWH Staff were surveyed from September to November 2024

Both Substantive and Bank Staff were surveyed, with a tailored set of questions delivered to our Bank workers

GWH Response Rate: 71%

Median Response Rate: 49%

Benchmarking for 2024 is against a group of 122 comparable Acute and Acute & Community Trusts, representing a median response rate of 49% and 532,587 comparable completed questionnaires.

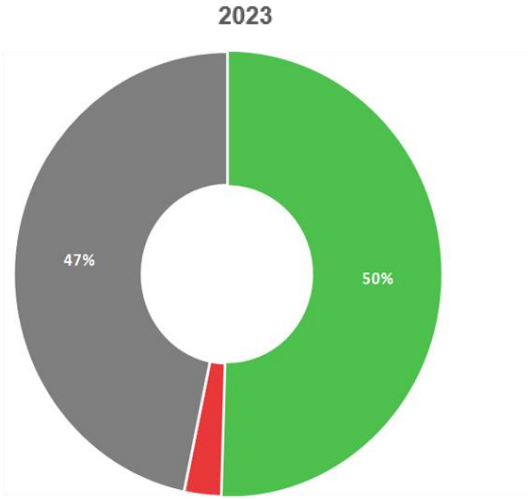
For the 2024 Survey we improved and received our highest ever response rate at **71%**. This was a considerable increase both to the median and to our 2023 response rate of 69%, and the highest response rate for Acute & Acute and Community Trusts nationally, reflective of a successful targeted comms plan and incentive programme.

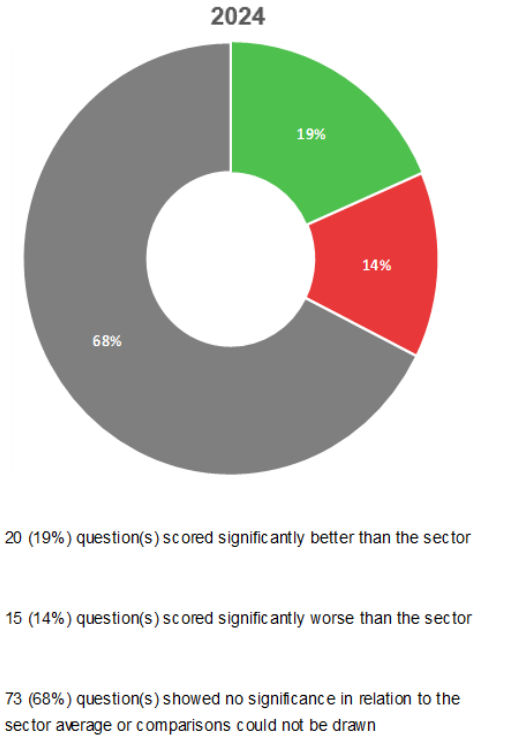
Headline Findings

2024 Staff Survey Results 2024

Great Western Hospitals NHS Foundation Trust

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
Theme - Staff engagement	6.85	Not Significant	6.81	Not Significant	6.85
Theme - Morale	5.91	Not Significant	5.93	Not Significant	5.93
People Promise 1 - We are compassionate and inclusive	7.25	Not Significant	7.23	Not Significant	7.22
People Promise 2 - We are recognised and rewarded	5.91	Not Significant	5.92	Not Significant	5.90
People Promise 3 - We each have a voice that counts	6.71	Not Significant	6.69	Not Significant	6.68
People Promise 4 - We are safe and healthy	6.11	Not Significant	6.14	Not Significant	6.09
People Promise 5 - We are always learning	5.69	Not Significant	5.71	Not Significant	5.69
People Promise 6 - We work flexibly	6.40	Not Significant	6.42	Significantly Better	6.22
People Promise 7 - We are a team	6.78	Not Significant	6.77	Not Significant	6.74

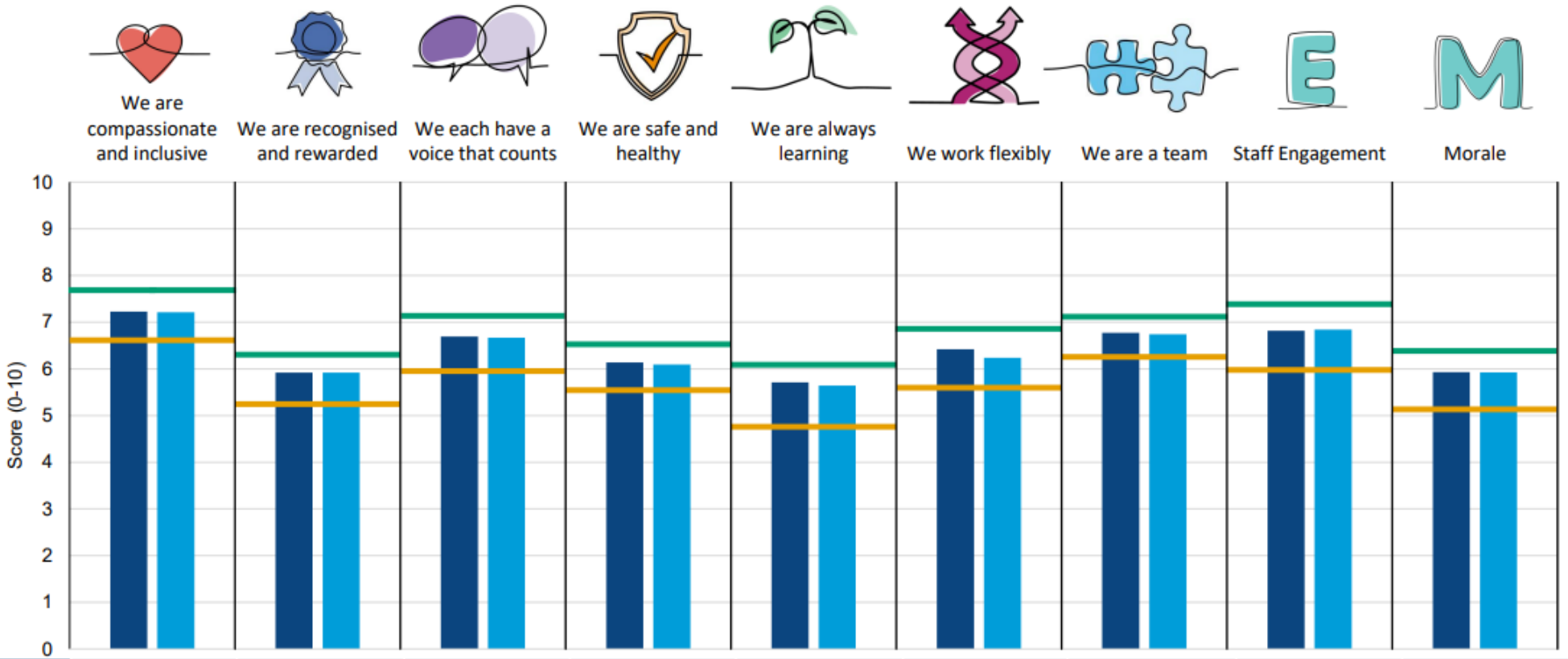




People Promises & Themes

2024 Staff Survey Results

Great Western Hospitals NHS Foundation Trust



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.23	5.92	6.69	6.14	5.71	6.42	6.77	6.82	5.93
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	4222	4219	4180	4199	4064	4188	4210	4217	4221

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Successes to Celebrate

2024 Staff Survey Results

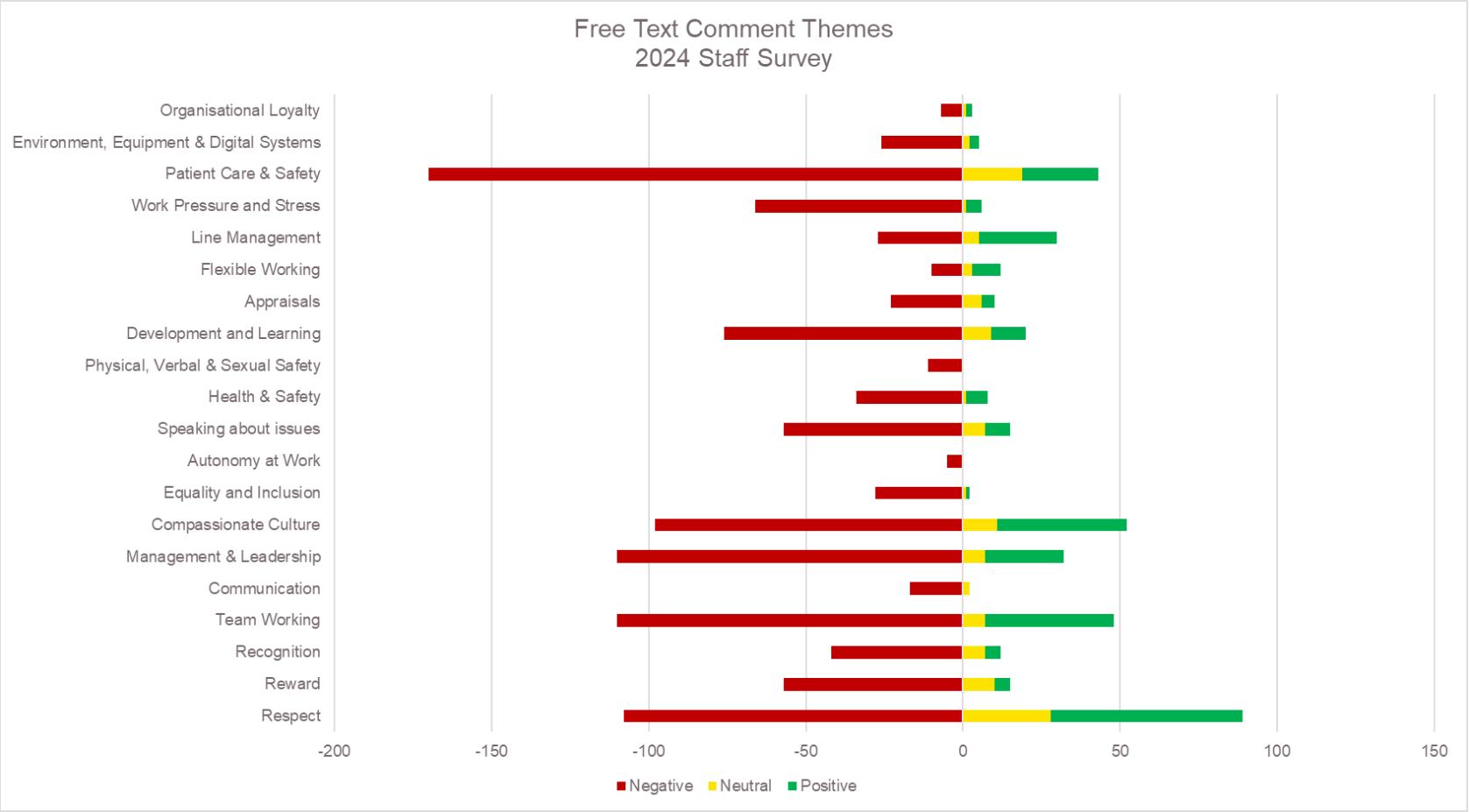
Great Western Hospitals NHS Foundation Trust

- **20** questions scored **significantly better (19%)** compared to the sector
- **47** questions **(43.52%)** showed an **improvement**, and **3** questions **(2.78%)** showed an **significant improvement** to the scores in comparison to 2023 results
- The People Promise '**We work flexibly' is significantly better** than sector scores

We work flexibly

Free Text Analysis

2024 Staff Survey Results



The Staff Survey allows our staff to provide a free text response highlighting any other comments they wish to share. For 2024, we have analysed and grouped these responses into prevalent 'themes' and reported the number of Positive/Neutral/Negative responses associated with each.

Overall, free text sentiments are:

19% Positive	18% Neutral	63% Negative

By volume, Patient Care and Safety is a prevalent theme with the negative narrative being a contributing factor between positive and negative split.

Respect is another prevalent theme although a more balanced split between positive and negative, the negative narrative being the contributing factor.

Free Text Analysis

2024 Staff Survey Results

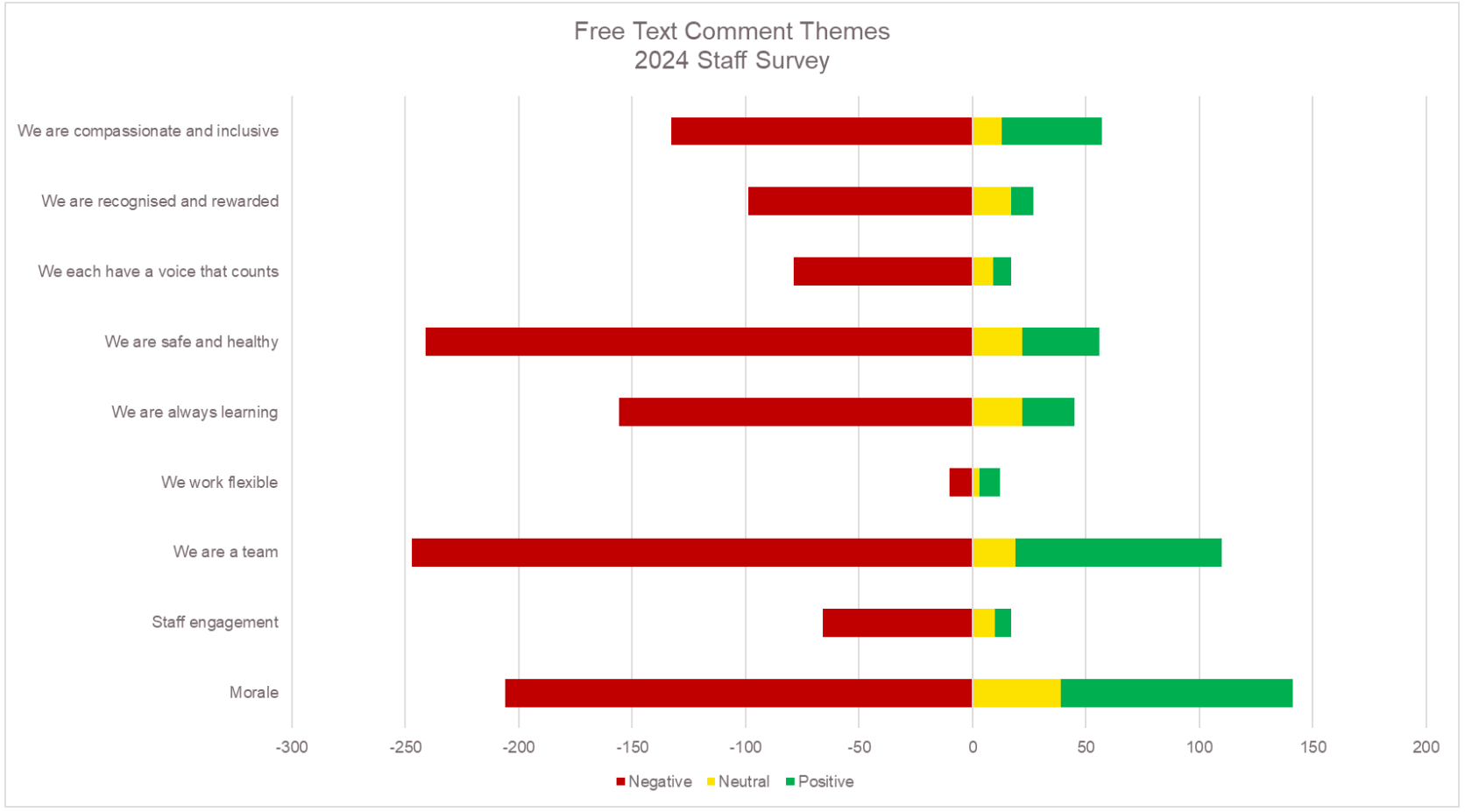
Great Western Hospitals NHS Foundation Trust

Free-text comment themes in the 2024 survey were also mapped against the NHS People Promise.

The ‘Morale’ theme and ‘We are safe and healthy’ promise are the most prevalent promises in the free-text comments, closely linked to workplace stressors, burnout, and materials/resources required to complete roles.

Teamwork was also a dominant message throughout the comments in the survey, which is largely linked to ‘respect’.

Although the above elements displayed a high volume of negative sentiment, there are promising positive messages coming through from our staff around teamwork, respect, and compassionate culture.



South-West Ranking

2024 Staff Survey Results

Great Western Hospitals NHS Foundation Trust

Ranking excluding response rate
9th in 2024
9th in 2023

Rank	Acute and Acute & Community Trusts South West Region inc. OUH	Response Rate	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale	Total Score
1	Somerset NHS Foundation Trust	51%	7.45	6.23	6.88	6.32	5.80	6.54	6.94	7.06	6.19	59.4
2	University Hospitals Bristol and Weston NHS Foundation Trust	54%	7.52	6.19	6.90	6.32	5.75	6.50	6.99	7.10	6.13	59.4
3	North Bristol NHS Trust	62%	7.44	6.12	6.86	6.23	5.94	6.37	6.89	7.08	6.14	59.1
4	Salisbury NHS Foundation Trust	59%	7.38	6.09	6.85	6.24	5.67	6.35	6.89	7.09	6.09	58.7
5	Dorset County Hospital NHS Foundation Trust	46%	7.41	6.09	6.81	6.05	5.74	6.47	6.92	7.03	5.93	58.5
6	Royal Devon University Healthcare NHS Foundation Trust	40%	7.46	6.16	6.76	6.26	5.26	6.38	6.89	6.96	6.11	58.2
7	Oxford University Hospitals NHS Foundation Trust	48%	7.34	5.96	6.76	6.16	5.92	6.25	6.91	6.98	5.92	58.2
8	University Hospitals Dorset NHS Foundation Trust	58%	7.37	5.99	6.79	6.15	5.72	6.30	6.86	6.90	5.95	58.0
9	**Great Western Hospitals NHS Foundation Trust**	71%	7.23	5.92	6.69	6.14	5.71	6.42	6.77	6.82	5.93	57.6
10	Royal United Hospitals Bath NHS Foundation Trust	54%	7.35	5.96	6.71	5.95	5.57	6.19	6.83	6.92	5.89	57.4
11	University Hospitals Plymouth NHS Trust	42%	7.16	5.89	6.62	6.02	5.60	6.30	6.64	6.74	5.86	56.8
12	Torbay and South Devon NHS Foundation Trust	39%	7.19	5.93	6.52	5.96	5.31	6.23	6.69	6.68	5.79	56.3
13	Royal Cornwall Hospitals NHS Trust	45%	7.08	5.84	6.52	5.96	5.27	6.07	6.67	6.56	5.79	55.8
14	Gloucestershire Hospitals NHS Foundation Trust	65%	7.02	5.76	6.38	6.05	5.45	5.99	6.59	6.53	5.79	55.6

Ranking including response rate
3rd in 2024
2nd in 2023

Rank	Acute and Acute & Community Trusts South West Region inc. OUH	Response Rate	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale	Total Score inc. Response Rate
1	North Bristol NHS Trust	62%	7.44	6.12	6.86	6.23	5.94	6.37	6.89	7.08	6.14	65.2
2	University Hospitals Bristol and Weston NHS Foundation Trust	54%	7.52	6.19	6.90	6.32	5.75	6.50	6.99	7.10	6.13	64.8
3	**Great Western Hospitals NHS Foundation Trust**	71%	7.23	5.92	6.69	6.14	5.71	6.42	6.77	6.82	5.93	64.7
4	Salisbury NHS Foundation Trust	59%	7.38	6.09	6.85	6.24	5.67	6.35	6.89	7.09	6.09	64.6
5	Somerset NHS Foundation Trust	51%	7.45	6.23	6.88	6.32	5.80	6.54	6.94	7.06	6.19	64.5
6	University Hospitals Dorset NHS Foundation Trust	58%	7.37	5.99	6.79	6.15	5.72	6.30	6.86	6.90	5.95	63.8
7	Dorset County Hospital NHS Foundation Trust	46%	7.41	6.09	6.81	6.05	5.74	6.47	6.92	7.03	5.93	63.1
8	Oxford University Hospitals NHS Foundation Trust	48%	7.34	5.96	6.76	6.16	5.92	6.25	6.91	6.98	5.92	63.0
9	Royal United Hospitals Bath NHS Foundation Trust	54%	7.35	5.96	6.71	5.95	5.57	6.19	6.83	6.92	5.89	62.8
10	Royal Devon University Healthcare NHS Foundation Trust	40%	7.46	6.16	6.76	6.26	5.26	6.38	6.89	6.96	6.11	62.2
11	Gloucestershire Hospitals NHS Foundation Trust	65%	7.02	5.76	6.38	6.05	5.45	5.99	6.59	6.53	5.79	62.1
12	University Hospitals Plymouth NHS Trust	42%	7.16	5.89	6.62	6.02	5.60	6.30	6.64	6.74	5.86	61.1

Below Average
At Average
Above Average

Great Western Hospitals
NHS Foundation Trust

Results Aligned to our Strategic Pillar

Improving Together A3 Approach

Together we are Great

Pillar Metrics

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

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

Two of our pillar metrics aligned to this pillar are monitored through the annual and quarterly staff surveys:

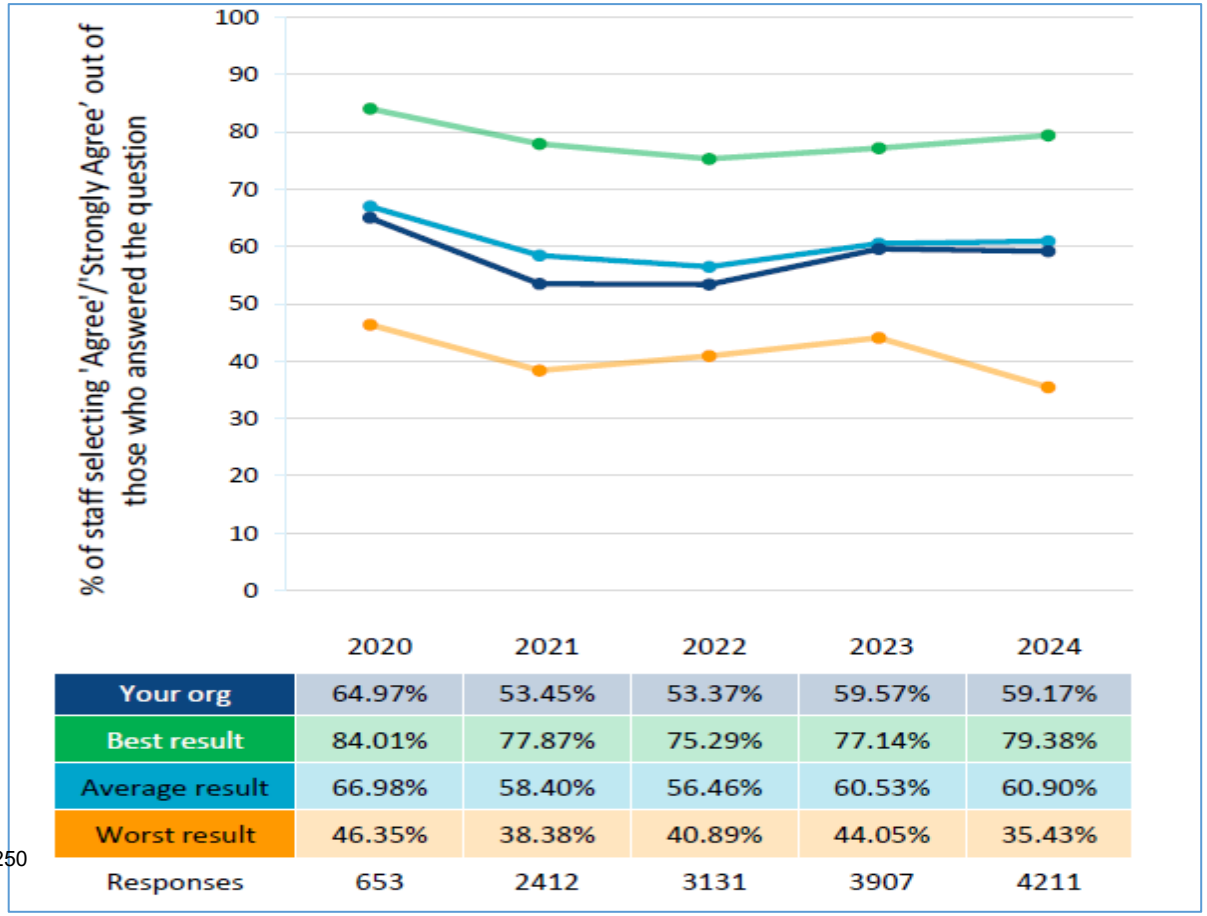
- Recommend as a place to work
- EDI – Disparity for discrimination from colleagues/managers

Our breakthrough objective focuses around respect:

- I receive respect from colleagues

Pillar Metric: "I would recommend my organisation as a place to work"

-0.4% decline



	2020	2021	2022	2023	2024
Your org	64.97%	53.45%	53.37%	59.57%	59.17%
Best result	84.01%	77.87%	75.29%	77.14%	79.38%
Average result	66.98%	58.40%	56.46%	60.53%	60.90%
Worst result	46.35%	38.38%	40.89%	44.05%	35.43%
Responses	653	2412	3131	3907	4211

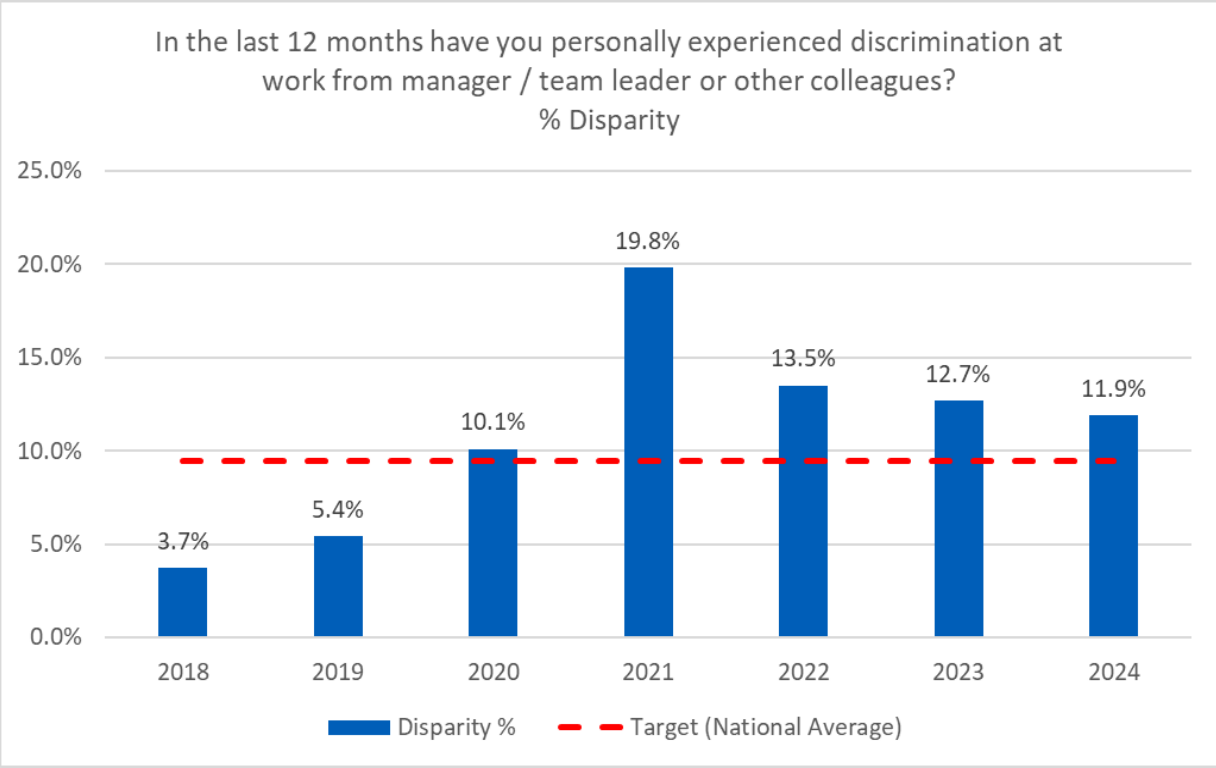
Pillar Metrics

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

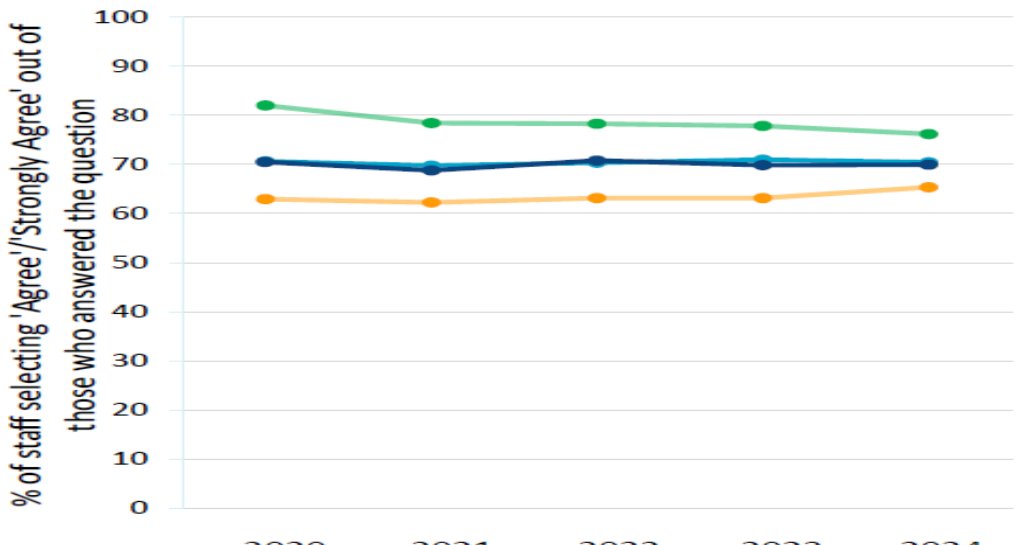
Pillar Metric:	% Disparity for "In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?"

0.81% Improvement



Breakthrough Objective:	"I receive the respect I deserve from colleagues at work"

+0.1% Improvement



	2020	2021	2022	2023	2024
Your org	70.49%	68.80%	70.81%	69.89%	69.98%
Best result	82.02%	78.45%	78.29%	77.84%	76.21%
Average result	70.63%	69.79%	70.36%	70.99%	70.44%
Worst result	62.98%	62.27%	63.14%	63.16%	65.37%
Responses	654	2415	3137	3911	4206

Pillar Metrics

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

Pillar metric: Recommend as a Place to Work

- Results remained consistent with last years' results (59.6%), demonstrating stability in a challenging year.
- The Trust is -1.3% below national average for this question.
- Breakthrough question 'Receive Respect' had a marginal increase, alongside a marginal national decrease, resulting in closing the gap between the Trust (69.8%) and national (70.4%) for this question.

Pillar metric: Disparity

- The disparity gap between white and BME colleagues reporting personal discrimination from managers/colleagues has a positive reduction of 0.8% and brings the Trust within 2% of national disparity levels.

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Results by People Promise & Theme

2024 Staff Survey

Together we are Great

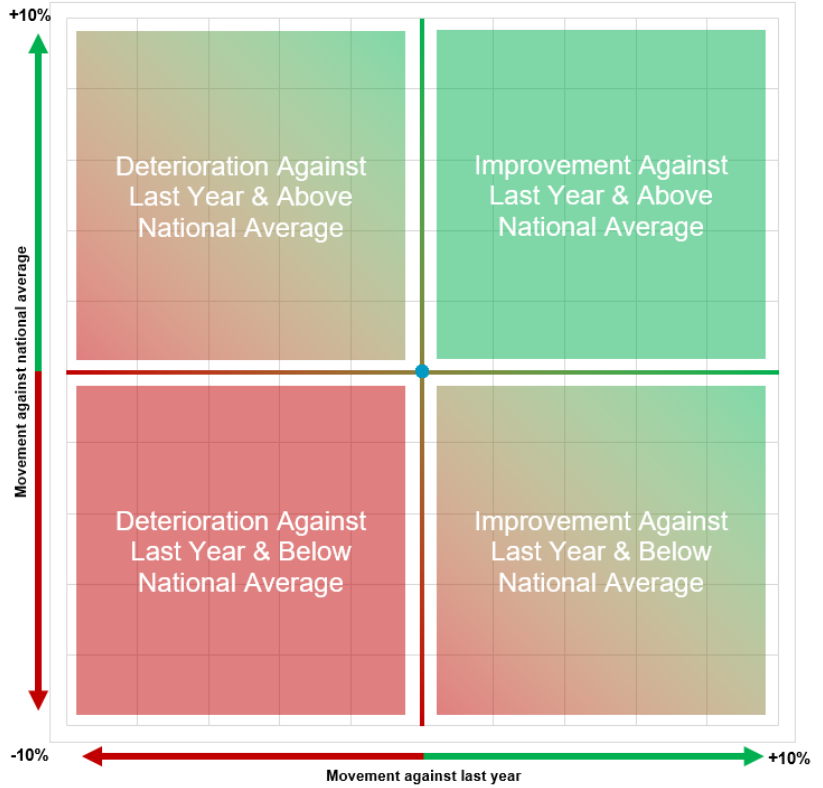
Using This Report

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

From the 2021 survey onwards, questions in the NHS Staff Survey have been aligned to the People Promise which is comprised of seven elements:

- This report breaks down performance against these People Promise elements as well as two historic 'themes' reported in previous years (Engagement and Morale).
- A quadrant graph has been created for each promise/theme, showing the relevant group of questions and their performance against last year and the national average.
- For 2024 reporting, all methodology (positive or negative scoring) continues to be aligned with the national methodology.
- Positively scored questions are denoted with a (+) and a higher result than last year/national average is good.
- Negatively scored questions are denoted with a (-) and a higher result than last year/national average is bad.



Positive/negative reporting

Variance to last year's results for GWH

Variance to national average

	Theme	Question Number	Question	2023 Result	Variance to 2022	National Average	Variance to National Average
+	Sub-Theme	ex1	Example Question 1 (Strongly Agree/Agree) Positive Reporting: Higher than LY/Average is good	67.5%	1.3%	65.0%	2.5%
-	Sub-Theme	ex2	Example Question 2 (Disagree/Strongly Disagree) Negative Reporting: Higher than LY/Average is bad	9.3%	-9.3%	9.0%	-0.3%

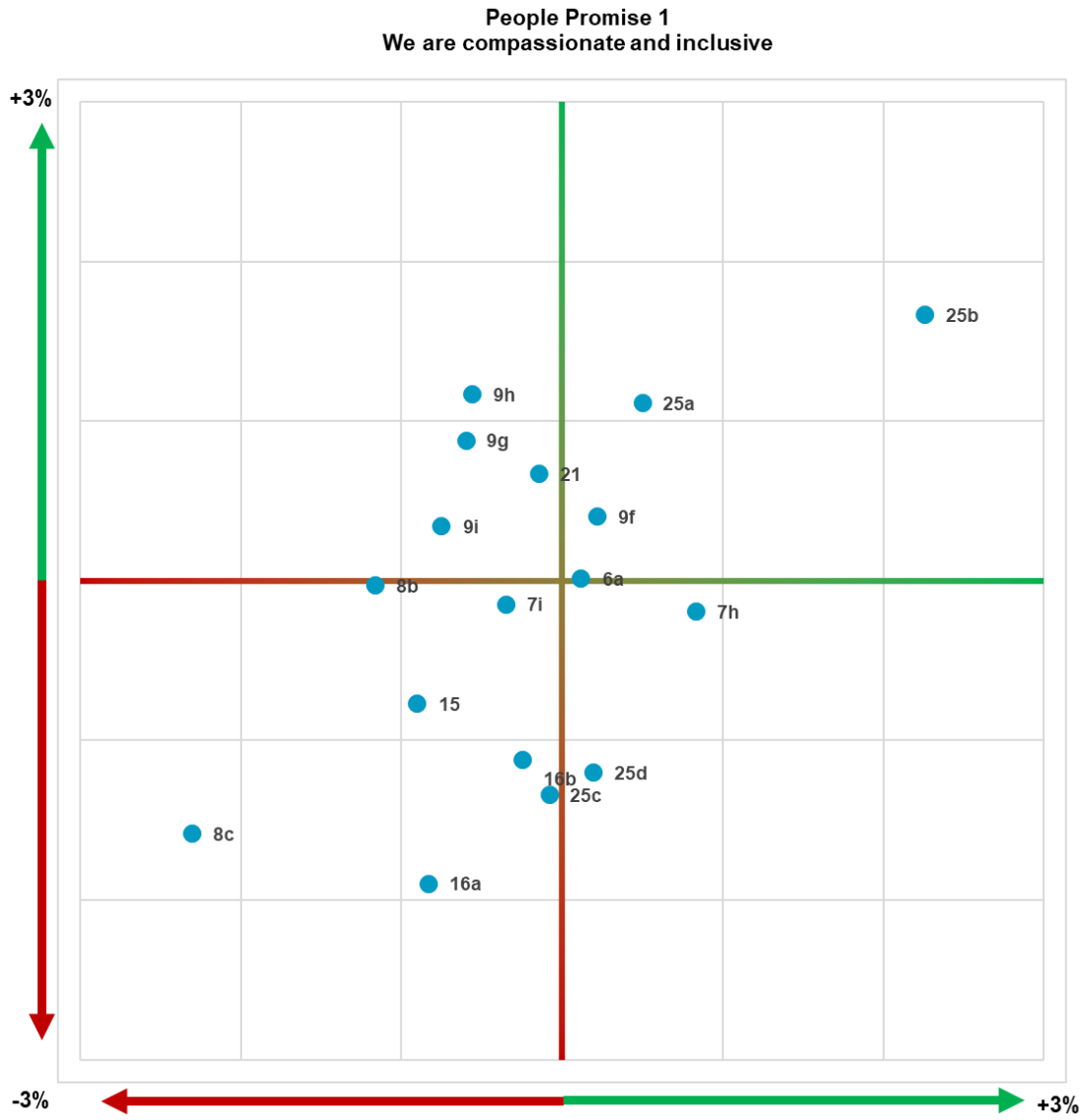
We are compassionate and inclusive

Great Western Hospitals NHS Foundation Trust

2024 Staff Survey

Questions aligned to this People Promise explore the following sub-themes:

- **Compassionate Leadership**: No significant change against 2023. Initiatives commencing in-year include civility and respect training, Leadership Behaviours framework (Oct 2023), and more recently Expectations of a Line Manager in Nov 2024. These are in early stages of roll-out and impact is expected to develop with more staff trained during 2025/6. The Just & Learning approach is embedding with 84% of line managers now completing J&L Conduct training and routinely using the 4-step J&L approach.
- **Compassionate Culture**: Questions showed overall improvement for a 2nd consecutive year demonstrating that staff lived experience is positively reflecting culture development initiatives. A success for the Trust is the above national average scores for care of patients (Q25b), and addressing concern of patients (Q25a). The 'Great Place to Work' campaign ran throughout the survey period highlighting staff stories of positive experience working at the Trust.
- **Diversity & Equality**: The question relating to fairness in career progression and promotion (Q15) has the highest decline (0.9%) and is 0.8% below national average, highlighting the need for embedding recruitment and selection equality initiatives. Recruitment Champions were introduced in Nov 2023 and unconscious bias videos shared with interviewing panels early 2024. On-going Impact measurement of this should be a focus in 2025.
- **Inclusion:** There is a continued fall in staff reporting colleagues being understanding and kind to one another (Q8b) with a 1.1% decline against 2023 and 2.5% decline against 2022. Similarly, staff reporting being polite and treating each other with respect (Q8c) declines 2.3% on 2023, and 3.9% decline on 2022. Both of these relate to the Trust breakthrough Q7c, receiving respect.



We are compassionate and inclusive

Great Western Hospitals NHS Foundation Trust

2024 Staff Survey

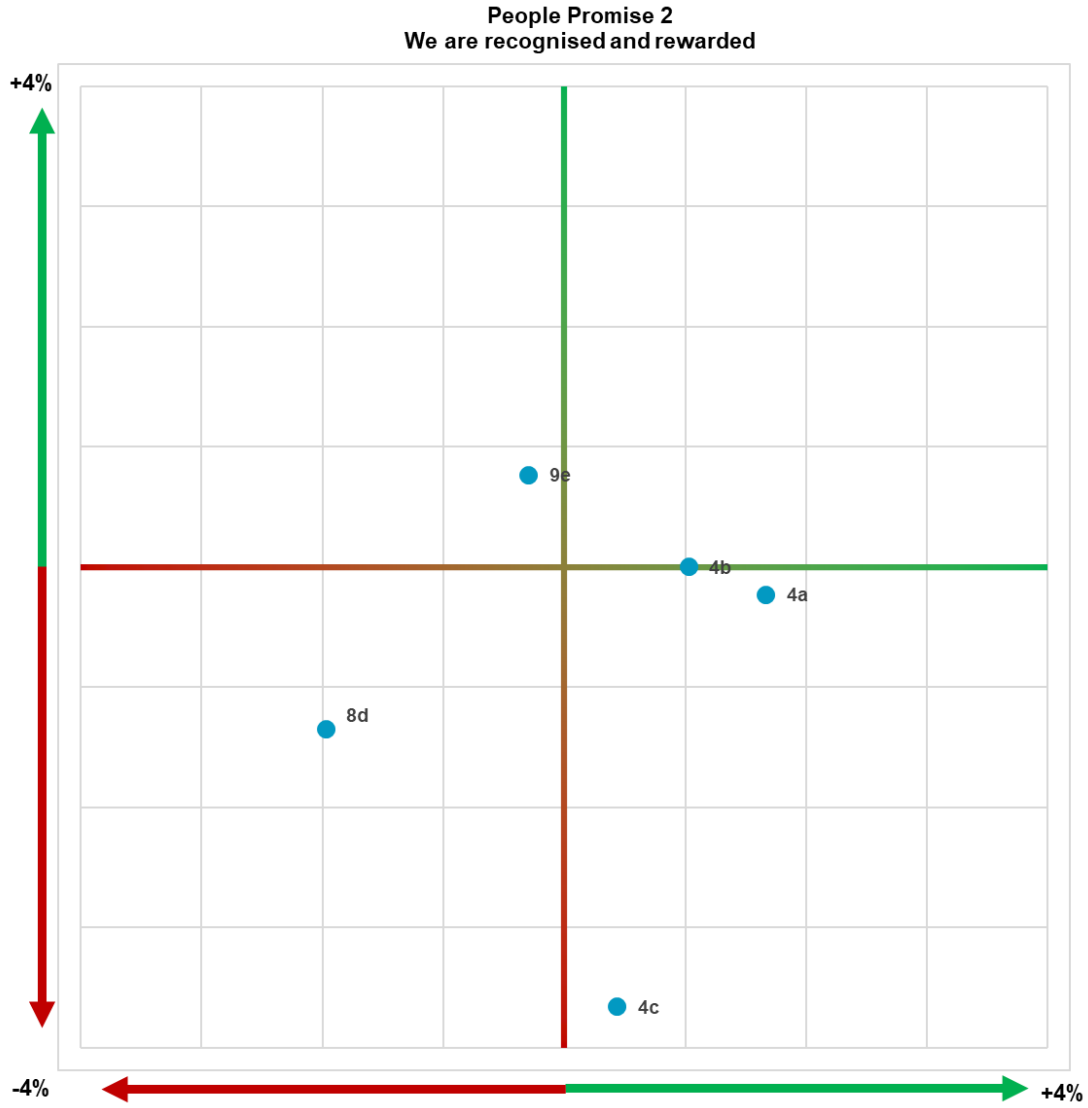
	Theme	Question Number	Question	2024 Result	Variance to 2023	National Average	Variance to National Average
+	Compassionate culture	6a	I feel that my role makes a difference to patients / service users (Agree/Strongly agree).	88.0%	0.1%	88.0%	0.0%
+	Compassionate culture	25a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	75.5%	0.5%	74.4%	1.1%
+	Compassionate culture	25b	My organisation acts on concerns raised by patients / service users (Agree/Strongly agree).	72.6%	2.3%	70.9%	1.7%
+	Compassionate culture	25c	I would recommend my organisation as a place to work (Agree/Strongly agree).	59.6%	-0.1%	60.9%	-1.3%
+	Compassionate culture	25d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	60.3%	0.2%	61.5%	-1.2%
+	Compassionate leadership	9f	My immediate manager works together with me to come to an understanding of problems (Agree/Strongly agree).	68.9%	0.2%	68.5%	0.4%
+	Compassionate leadership	9g	My immediate manager is interested in listening to me when I describe challenges I face (Agree/Strongly agree).	71.8%	-0.6%	71.0%	0.9%
+	Compassionate leadership	9h	My immediate manager cares about my concerns (Agree/Strongly agree).	70.8%	-0.6%	69.6%	1.2%
+	Compassionate leadership	9i	My immediate manager takes effective action to help me with any problems I face (Agree/Strongly agree).	67.2%	-0.7%	66.8%	0.3%
+	Diversity and equality	15	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (Yes).	55.2%	-0.9%	56.0%	-0.8%
+	Diversity and equality	16a	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (No).	89.4%	-0.8%	91.3%	-1.9%
+	Diversity and equality	16b	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (No).	89.5%	-0.2%	90.7%	-1.1%
+	Diversity and equality	21	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) (Agree/Strongly agree).	70.7%	-0.1%	70.1%	0.7%
+	Inclusion	7h	I feel valued by my team (Agree/Strongly agree).	68.9%	0.8%	69.1%	-0.2%
+	Inclusion	7i	I feel a strong personal attachment to my team (Agree/Strongly agree).	63.0%	-0.3%	63.2%	-0.1%
+	Inclusion	8b	The people I work with are understanding and kind to one another (Agree/Strongly agree).	68.9%	-1.2%	68.9%	0.0%
+	Inclusion	8c	The people I work with are polite and treat each other with respect (Agree/Strongly agree).	68.4%	-2.3%	70.0%	-1.6%

We are recognised and rewarded

2024 Staff Survey

Questions aligned to this People Promise explore staff connection to themes of Reward and Recognition.

- **Reward**: The 2023 7% increase in satisfaction on pay (Q4c) has been maintained with a further improvement to 27.5%. It is encouraging to see that the increased controls on pay (e.g. overtime reduction, system-aligned bank rates) have not had a negative impact on staff perception of pay levels. To support colleague preparation for retirement, the Trust introduced quarterly pension workshops as part of the people promise programme.
- **Recognition**: Significant increase for 2nd consecutive year in staff reporting recognition for good work (Q4a +1.7% improvement against 2023, and +5% on 2022). Similarly, there is an improvement in staff reporting that the Trust values their work (Q4b +1.1% against 2023, and +6.7% against 2022), reflecting the breadth of recognition schemes at GWH e.g. xmas hampers, tea trolley, anniversary day, Great West Fest and Staff Excellence awards.
- Peer staff recognition scheme Star of the Month continues to be promoted and there has been a 29% increase in Hidden Hero nominations with 253 received Jan-Dec 2024.
- The Trust re-introduced face-to-face long service awards during 2024. This was well received and will continue in this format through 2025/6.
- Despite the above, staff showing appreciation to one another (Q8d) falls against both 2023 and national average. E-cards were launched in August to encourage peer-to-peer recognition and will be promoted and measured for positive impact during 2025/6.



We are recognised and rewarded

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

	Theme	Question Number	Question	2024 Result	Variance to 2023	National Average	Variance to National Average
+	Reward and recognition	4a	The recognition I get for good work (Satisfied/Very satisfied).	52.8%	1.7%	53.0%	-0.2%
+	Reward and recognition	4b	The extent to which my organisation values my work (Satisfied/Very satisfied).	43.9%	1.0%	43.9%	0.0%
+	Reward and recognition	4c	My level of pay (Satisfied/Very satisfied).	27.5%	0.4%	31.1%	-3.7%
+	Reward and recognition	8d	The people I work with show appreciation to one another (Agree/Strongly agree).	64.9%	-2.0%	66.3%	-1.3%
+	Reward and recognition	9e	My immediate manager values my work (Agree/Strongly agree).	72.1%	-0.3%	71.3%	0.8%

We each have a voice that counts

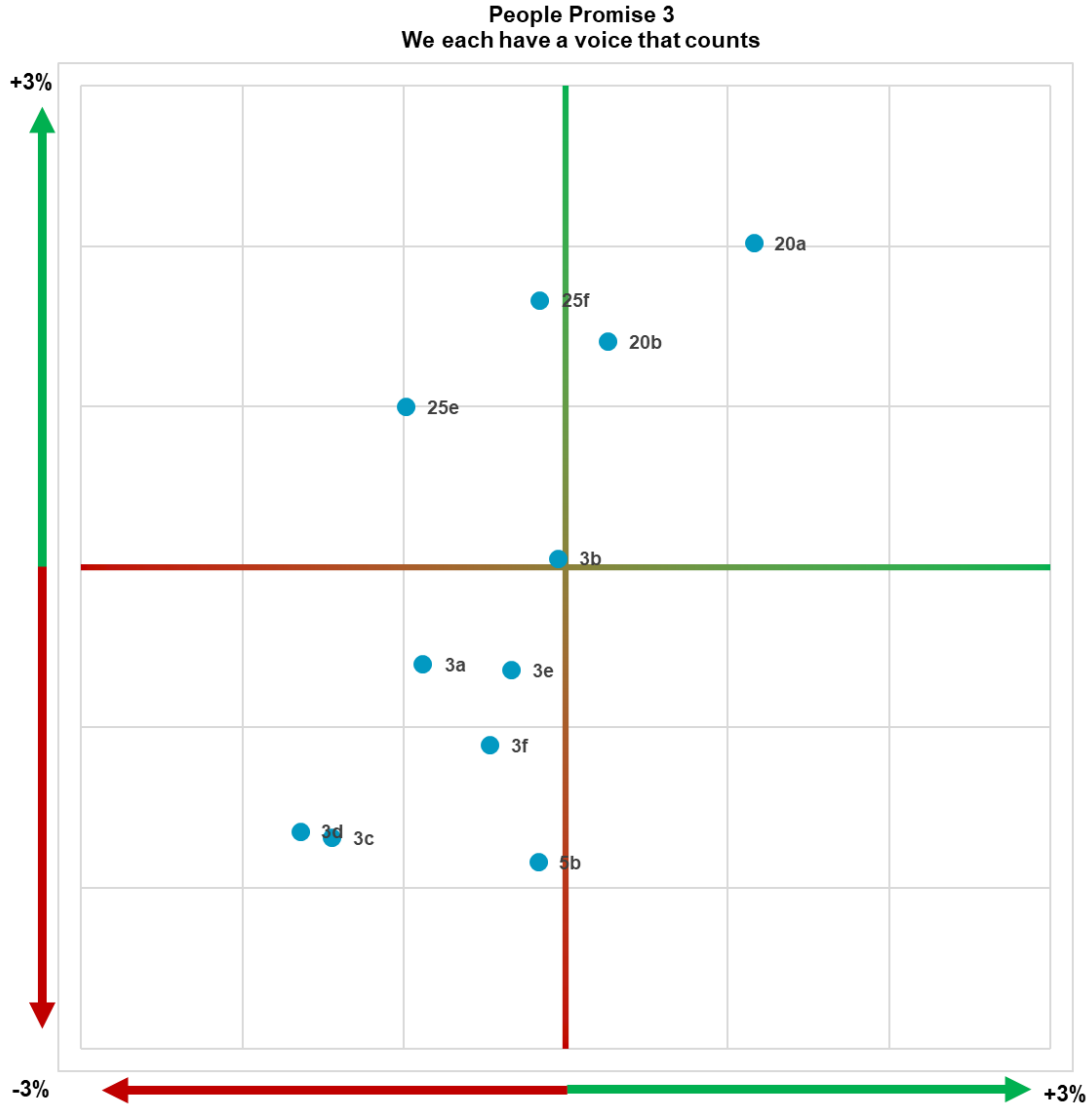
Great Western Hospitals NHS Foundation Trust

2024 Staff Survey

Questions aligned to this People Promise look at themes of Autonomy & Control and Raising Concerns (speaking up culture).

- **Autonomy and Control**: Overall, the improvement seen 2022-23 has not been sustained in 2024, with a decline in 9 of 11 questions. Staff feeling able to make suggestions and improvement, having opportunities to show initiative, and being involved in decisions about change all decline. This may reflect the Trust change of breakthrough objective in April 2024 (from making improvements happen to respect) and demonstrate that teams have not yet embedded the improvement approach as BAU.
- **Raising Concerns**: Encouraging to see better-than national improvement in staff feeling safe to raise clinical concerns (Q20a) given that it had deteriorated in 2023. Scores relating to staff feeling safe to speak up about anything that concerns them (Q25e), and confidence in them being addressed by the Trust (Q25f), have declined. The Trust is developing an embedded expectation and accountability for people to speak-up supported by Clever Together.

- Exit interview questionnaires were uploaded to ESR in October 2024 to provide the Trust with more meaningful insight into reasons for leaving. A dashboard report will share insights to divisions on a quarterly basis starting May 2025.
- A review of 'stay conversations' took place in Oct 2024 which highlighted that conversations were mainly taking place once staff had resigned, therefore less opportunity to influence remaining at the Trust. Stay conversations have now been built into the standard 1:1 template to promote conversation throughout employment.



We each have a voice that counts

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2024 Staff Survey

	Theme	Question Number	Question	2024 Result	Variance to 2023	National Average	Variance to National Average
+	Autonomy and control	3a	I always know what my work responsibilities are (Agree/Strongly agree).	85.9%	-0.9%	86.6%	-0.6%
+	Autonomy and control	3b	I am trusted to do my job (Agree/Strongly agree).	90.0%	0.0%	90.0%	0.1%
+	Autonomy and control	3c	There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	71.5%	-1.4%	73.2%	-1.7%
+	Autonomy and control	3d	I am able to make suggestions to improve the work of my team / department (Agree/Strongly agree).	69.0%	-1.6%	70.6%	-1.6%
+	Autonomy and control	3e	I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	50.2%	-0.3%	50.8%	-0.6%
+	Autonomy and control	3f	I am able to make improvements happen in my area of work (Agree/Strongly agree).	54.6%	-0.5%	55.7%	-1.1%
+	Autonomy and control	5b	I have a choice in deciding how to do my work (Often/Always).	50.2%	-0.2%	52.0%	-1.8%
+	Raising concerns	20a	I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	72.5%	1.2%	70.4%	2.0%
+	Raising concerns	20b	I am confident that my organisation would address my concern (Agree/Strongly agree).	57.3%	0.3%	55.9%	1.4%
+	Raising concerns	25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	61.3%	-1.0%	60.3%	1.0%
+	Raising concerns	25f	If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	49.9%	-0.2%	48.2%	1.7%

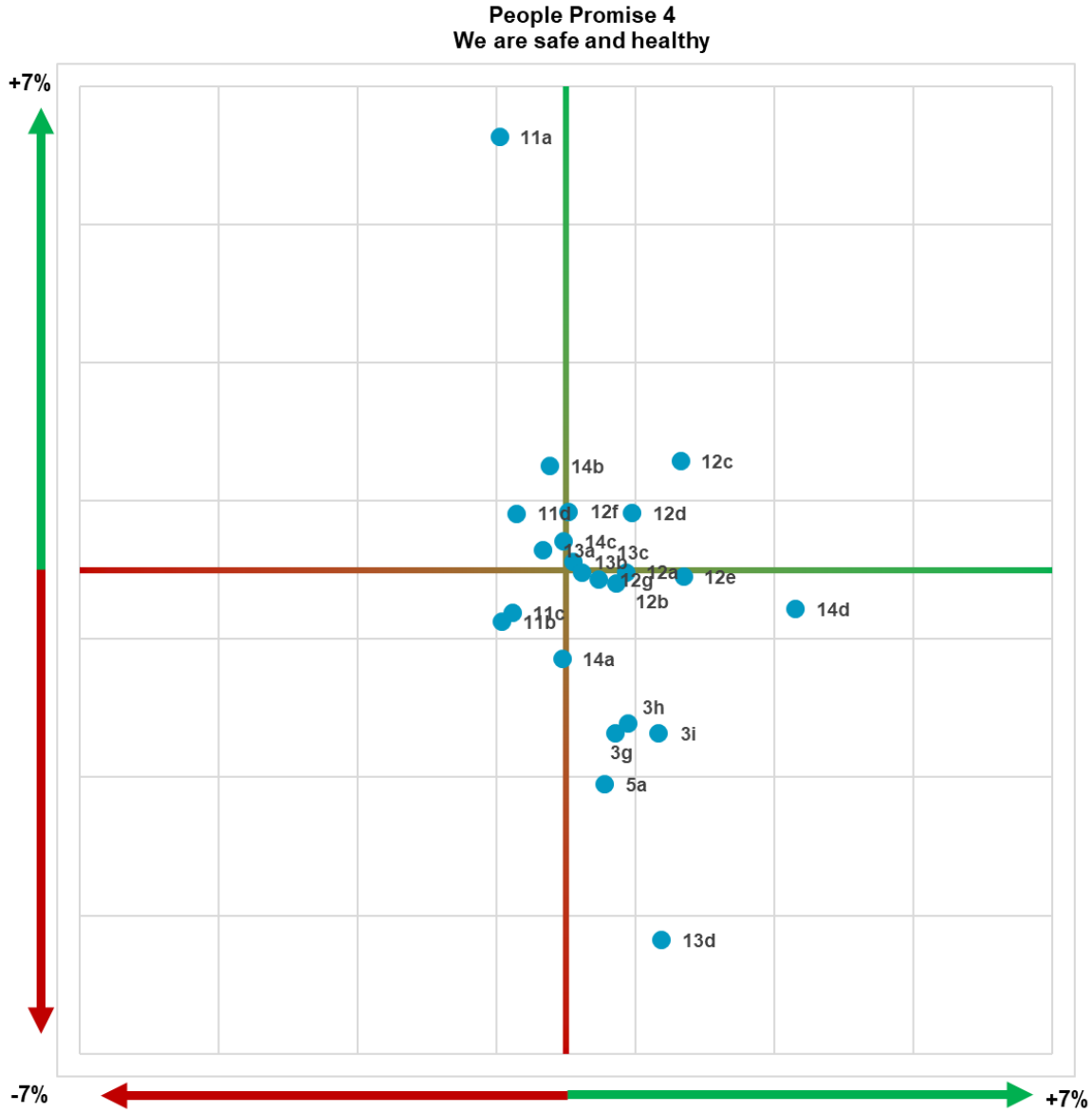
We are safe and healthy

2024 Staff Survey

This People Promise and its questions focus on sub-themes of Burnout, Negative Experience, and Health & Safety Climate.

- **Burnout questions:** All questions relating to Burnout have improved for a 2nd consecutive year and equal or better than national average. A 4% increase in staff reporting they work zero additional paid hours reflects the overtime restrictions introduced during 2024.
- **Health & Safety Climate**: The improvement in staff reporting having adequate materials (Q3h) and enough staff to do their job (Q3i) is reflected in staff feeling better able to meet conflicting demands (Q3g) and reflects further investment in safer staffing. Greater awareness of the Trust investments in equipment and staff may bring these closer to national levels.

  Encouraging improvement in staff reporting relating to incidents of physical violence, bullying or harassment. Whilst small in percentage terms, the experience of violence and aggression at work and should be explored with hotspot departments.



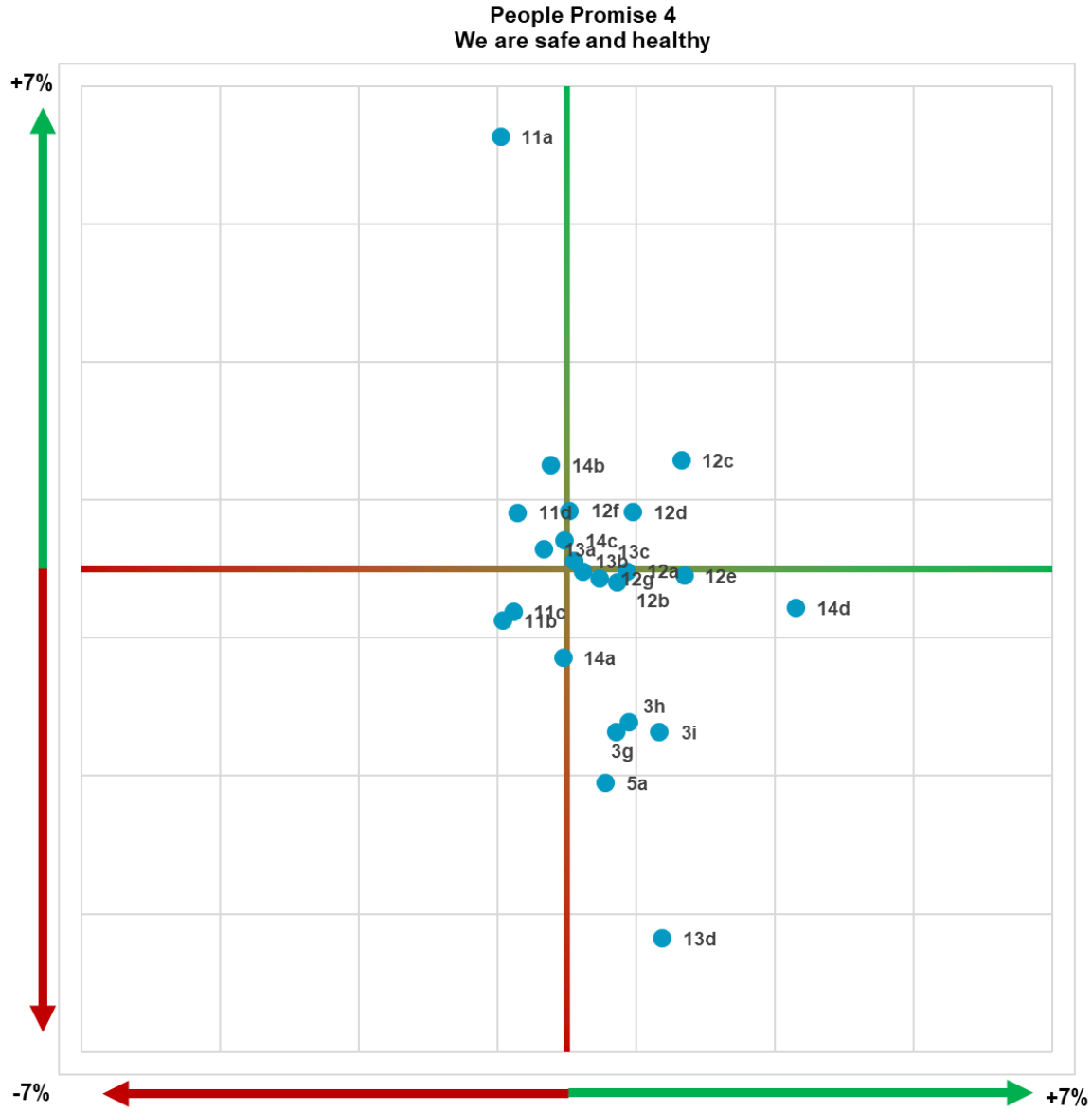
We are safe and healthy cont'd

Great Western Hospitals NHS Foundation Trust

2024 Staff Survey

This People Promise and its questions focus on sub-themes of Burnout, Negative Experience, and Health & Safety Climate.

- Staff feeling the organisation takes positive action on their health and wellbeing remains a success for the Trust at +6% above national average. Staff awareness of the broad H&WB offer is being maintained through weekly Comms signposting to H&W events and initiatives. This includes a focus on community teams with Orbital-based H&S events and tea-in-a-box recognition scheme.
- Nov 2023 the Trust signed up to the NHS Sexual Safety Charter, with an interim policy launched Nov 2024 and Sexual Misconduct Policy launched Dec 2024. 'Understanding Sexual Misconduct in the Workplace' E-learning module launched on ESR Jan 2025 which will support improvement in 2025.



We are safe and healthy

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

	Theme	Question Number	Question	2024 Result	Variance to 2023	National Average	Variance to National Average
+	Health and safety climate	3g	I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	45.1%	0.7%	47.5%	-2.4%
+	Health and safety climate	3h	I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	54.8%	0.9%	57.0%	-2.2%
+	Health and safety climate	3i	There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	30.4%	1.3%	32.8%	-2.4%
+	Health and safety climate	5a	I have unrealistic time pressures (Never/Rarely).	22.6%	0.6%	25.7%	-3.1%
+	Health and safety climate	11a	My organisation takes positive action on health and well-being (Agree/Strongly agree).	62.3%	-1.0%	56.0%	6.3%
+	Health and safety climate	13d	The last time you experienced physical violence at work, did you or a colleague report it (Yes).	65.2%	1.4%	70.6%	-5.4%
+	Health and safety climate	14d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it (Yes).	51.3%	3.3%	51.9%	-0.6%
-	Burnout	12a	How often, if at all, do you find your work emotionally exhausting (Often/Always).	33.9%	0.9%	33.9%	0.0%
-	Burnout	12b	How often, if at all, do you feel burnt out because of your work (Often/Always).	31.0%	0.7%	30.8%	-0.2%
-	Burnout	12c	How often, if at all, does your work frustrate you (Often/Always).	34.6%	1.6%	36.2%	1.6%
-	Burnout	12d	How often, if at all, are you exhausted at the thought of another day/shift at work (Often/Always).	27.3%	0.9%	28.1%	0.8%
-	Burnout	12e	How often, if at all, do you feel worn out at the end of your working day/shift (Often/Always).	42.6%	1.7%	42.5%	-0.1%
-	Burnout	12f	How often, if at all, do you feel that every working hour is tiring for you (Often/Always).	19.0%	0.0%	19.8%	0.8%
-	Burnout	12g	How often, if at all, do you not have enough energy for family and friends during leisure time (Often/Always).	29.7%	0.5%	29.6%	-0.1%
-	Negative experiences	11b	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities (Yes).	31.0%	-0.9%	30.3%	-0.8%
-	Negative experiences	11c	During the last 12 months have you felt unwell as a result of work related stress (Yes).	42.1%	-0.8%	41.5%	-0.6%
-	Negative experiences	11d	In the last three months have you ever come to work despite not feeling well enough to perform your duties (Yes).	55.1%	-0.7%	56.0%	0.8%
-	Negative experiences	13a	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (One or more	14.1%	-0.3%	14.4%	0.3%
-	Negative experiences	13b	In the last 12 months how many times have you personally experienced physical violence at work from managers (One or more times).	0.6%	0.1%	0.8%	0.1%
-	Negative experiences	13c	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues (One or more times).	1.9%	0.2%	1.9%	0.0%
-	Negative experiences	14a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public (One	26.0%	-0.1%	24.7%	-1.3%
-	Negative experiences	14b	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers (One or more times).	8.5%	-0.2%	10.0%	1.5%
-	Negative experiences	14c	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues (One or more times).	18.1%	0.0%	18.5%	0.4%

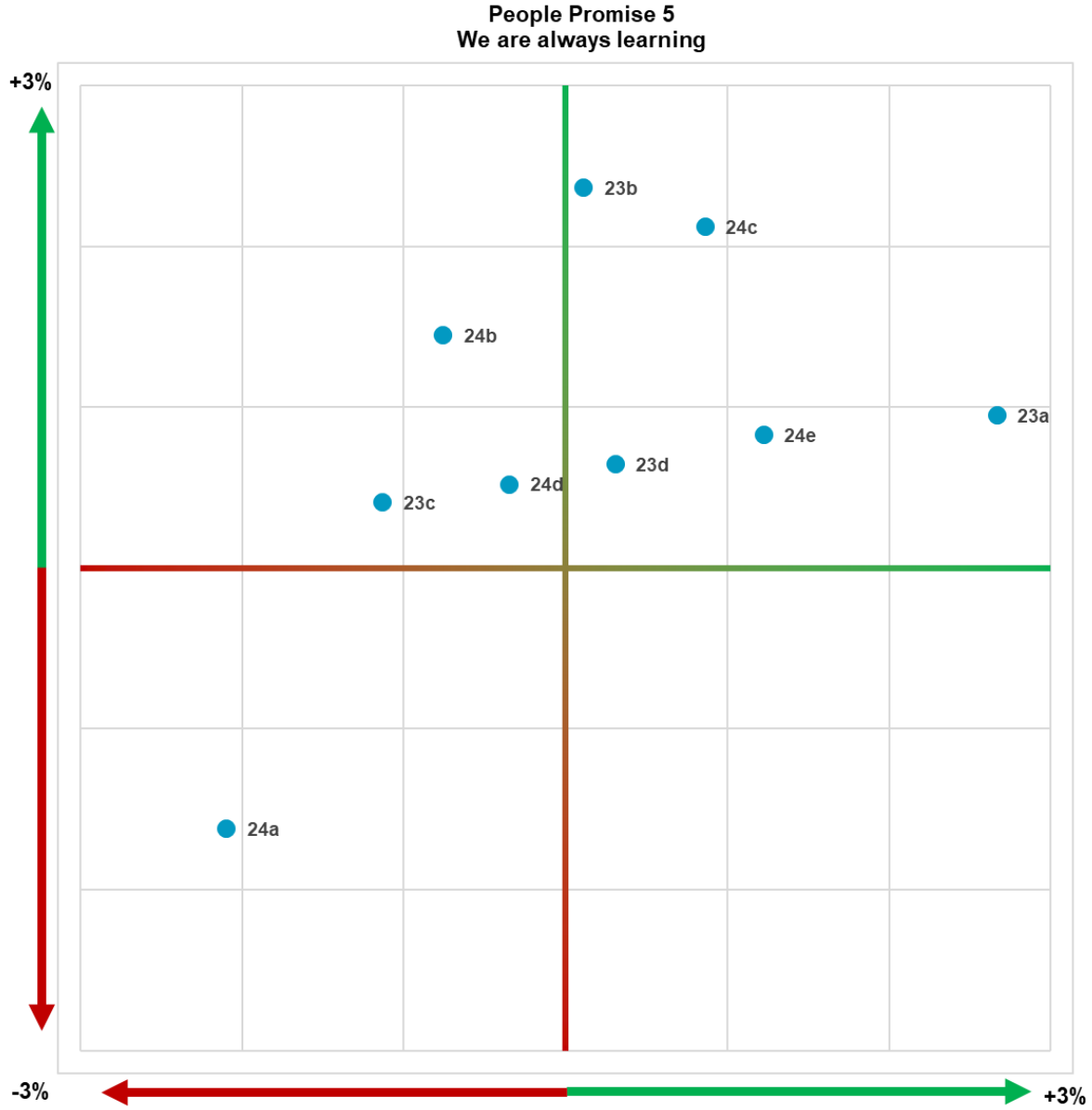
We are always learning

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

Questions aligned to this People Promise look at Development and Appraisals.

- Maintained as the most improved Trust promise in 2023 and 2024.
- **Development**: Staff report over the last 3 surveys a consistent improvement in having opportunity to improve knowledge and skills and access to development opportunities. This reflects the breadth of training and development offered at the Trust with further opportunity for improvement in 2025 provided by a new 'Leadership, Talent and Organisational Development Prospectus'.
- Expectations Of A Line Manager training launched Nov 2024 includes management accountability and resources for signposting and developing staff talent, including through Scope for Growth and career mentoring.
- April 2025 sees the launch of a Trust-wide induction workbook to support new starters. This includes introduction to the Trust, role-specific and mandatory training expectations. and incorporates a buddy system to further support early days of working at GWH. An extended induction programme was also developed in 2024 for resident doctors.
- **Appraisal:** The importance of appraisal conversations at GWH is reflected in the improved score, and is also better than national levels. This will be further supported in 2025 by the link of appraisal to pay progression, and the introduction of an ESR-based format which reinforces a focus on objective setting and STAR behaviours.
- Appraisals helping people do their job slightly improves however this isn't translating into staff being offered challenging work and links to a decline in staff having clear objectives (Q23c) and understanding each others roles (Q7d). It may also link to Q15 relating to fairness of career progression.



We are always learning

Great Western Hospitals NHS Foundation Trust

2024 Staff Survey

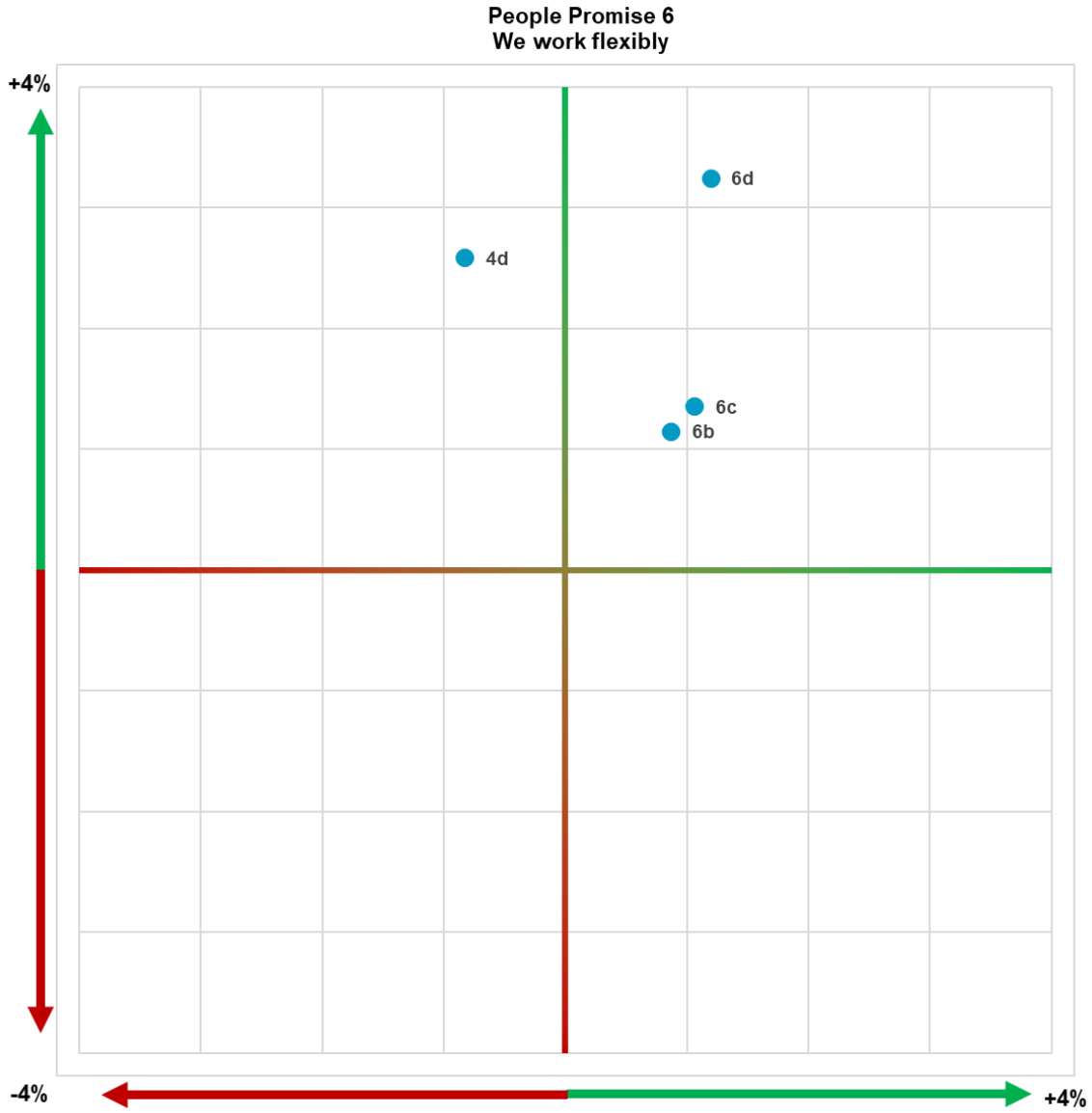
	Theme	Question Number	Question	2024 Result	Variance to 2023	National Average	Variance to National Average
+	Development	24a	This organisation offers me challenging work (Agree/Strongly agree).	66.5%	-2.1%	68.1%	-1.6%
+	Development	24b	There are opportunities for me to develop my career in this organisation (Agree/Strongly agree).	55.7%	-0.8%	54.3%	1.4%
+	Development	24c	I have opportunities to improve my knowledge and skills (Agree/Strongly agree).	71.5%	0.9%	69.4%	2.1%
+	Development	24d	I feel supported to develop my potential (Agree/Strongly agree).	56.7%	-0.3%	56.2%	0.5%
+	Development	24e	I am able to access the right learning and development opportunities when I need to (Agree/Strongly agree).	60.3%	1.2%	59.5%	0.8%
+	Appraisals	23a	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review (Yes).	86.0%	2.7%	85.1%	0.9%
+	Appraisals	23b	It helped me to improve how I do my job (Yes, definitely).	28.1%	0.1%	25.7%	2.4%
+	Appraisals	23c	It helped me agree clear objectives for my work (Yes, definitely).	36.4%	-1.1%	36.0%	0.4%
+	Appraisals	23d	It left me feeling that my work is valued by my organisation (Yes, definitely).	34.4%	0.3%	33.8%	0.6%

We work flexibly

2024 Staff Survey

This People Promise is split into sub-themes of work/life balance and flexible working.

- All questions are better than national average.
- Further evidence that the Trust has a culture of openly discussing flexible working opportunities and demonstrating a commitment to support staff balance home and work life, +0.9% against 2023, and +2.1% compared to 2022.
- The Trust embeds consistency using a standard management toolkit, 1:1 and appraisal meeting templates. Consideration of flexible working arrangements is prioritised in change management programmes where possible, for example during the bed reconfiguration moves in 2024.
- Line managers understanding of their responsibilities will be further embedded in 2025 through the Expectations of a Line Manager programme.
- Improved self-management access to roster and annual leave management was made available to staff by the introduction of Loop in June 2024.
- Retirement workshops now include a specific ‘retire and return’ workshop to support staff with flexible options on approaching retirement.
- A project run through the people promise programme highlighted that there was no application and outcome visibility at Trust level. As a result flexible working applications will be completed through ESR for AfC colleagues from March 25. This will enable oversight of compliance within policy, patterns and impact of decisions on turnover.



We work flexibly

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

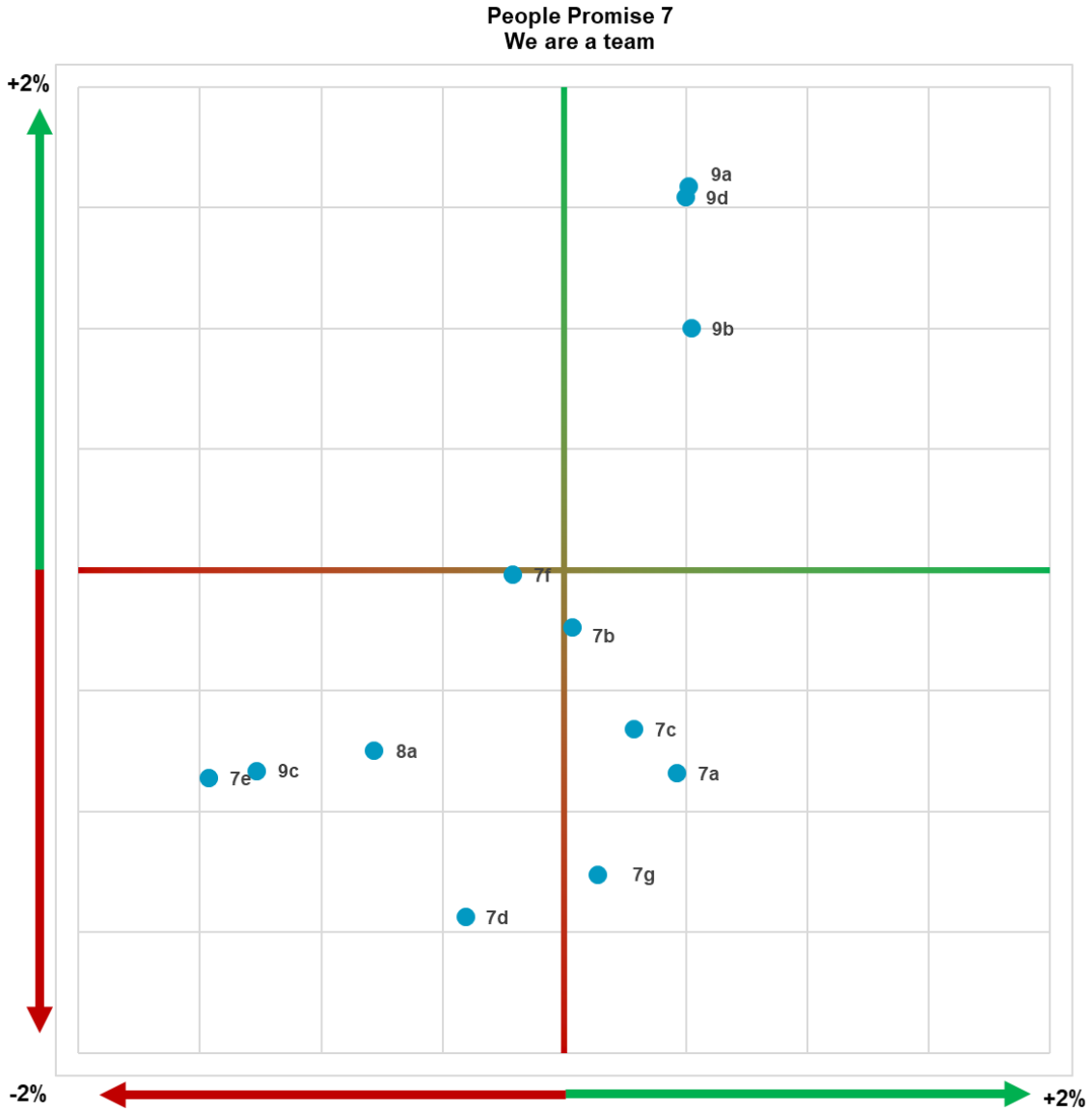
	Theme	Question Number	Question	2024 Result	Variance to 2023	National Average	Variance to National Average
+	Support for work-life balance	6b	My organisation is committed to helping me balance my work and home life (Agree/Strongly agree).	50.5%	0.9%	49.3%	1.1%
+	Support for work-life balance	6c	I achieve a good balance between my work life and my home life (Agree/Strongly agree).	57.2%	1.1%	55.9%	1.4%
+	Support for work-life balance	6d	I can approach my immediate manager to talk openly about flexible working (Agree/Strongly agree).	73.0%	1.2%	69.7%	3.2%
+	Flexible working	4d	The opportunities for flexible working patterns (Satisfied/Very satisfied).	59.0%	-0.8%	56.4%	2.6%

We are a team

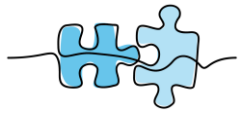
2024 Staff Survey

- Questions aligned to this People Promise examine team working and line management.

- Trust corporate projects in 2024/5 aimed at driving improvement of staff feeling respected include implementation of the national toolkit "role of the line manager“; our compassionate way; leaderships behaviours; and improved staff recognition and opportunities to thank staff.
- Pulse free text data provided a summary view that respect relates to ‘belonging to a team and culture where staff are valued, heard, and all voices matter.’ Trust and divisions will align to Q7c in 2025/6.
- **Team working:** The Trust saw significant change management programmes during 2024 with the new IFD and bed reconfiguration moves. These, and the loss of community contract do not appear to have negatively influenced staff responses to this promise.
- Wider use of the engagement and development tool (TED) will help impacting teams understand how effectively they work together and engage team members in ideas and improvement actions.
- **Line management**: An observation that there is a 7% difference in staff feeling that their line manager takes positive interest on their health and wellbeing (Q9d 70.4%) versus the organisation (Q11a 63.2%). This indicates the importance of local comms and managers providing updates to their teams.
- Questions relating to the immediate line manager see positive progress against both 2023 and national levels for a 2nd consecutive year, although the theme of staff not feeling involved in decisions is repeated.



We are a team



2024 Staff Survey

NHS
Great Western Hospitals
NHS Foundation Trust

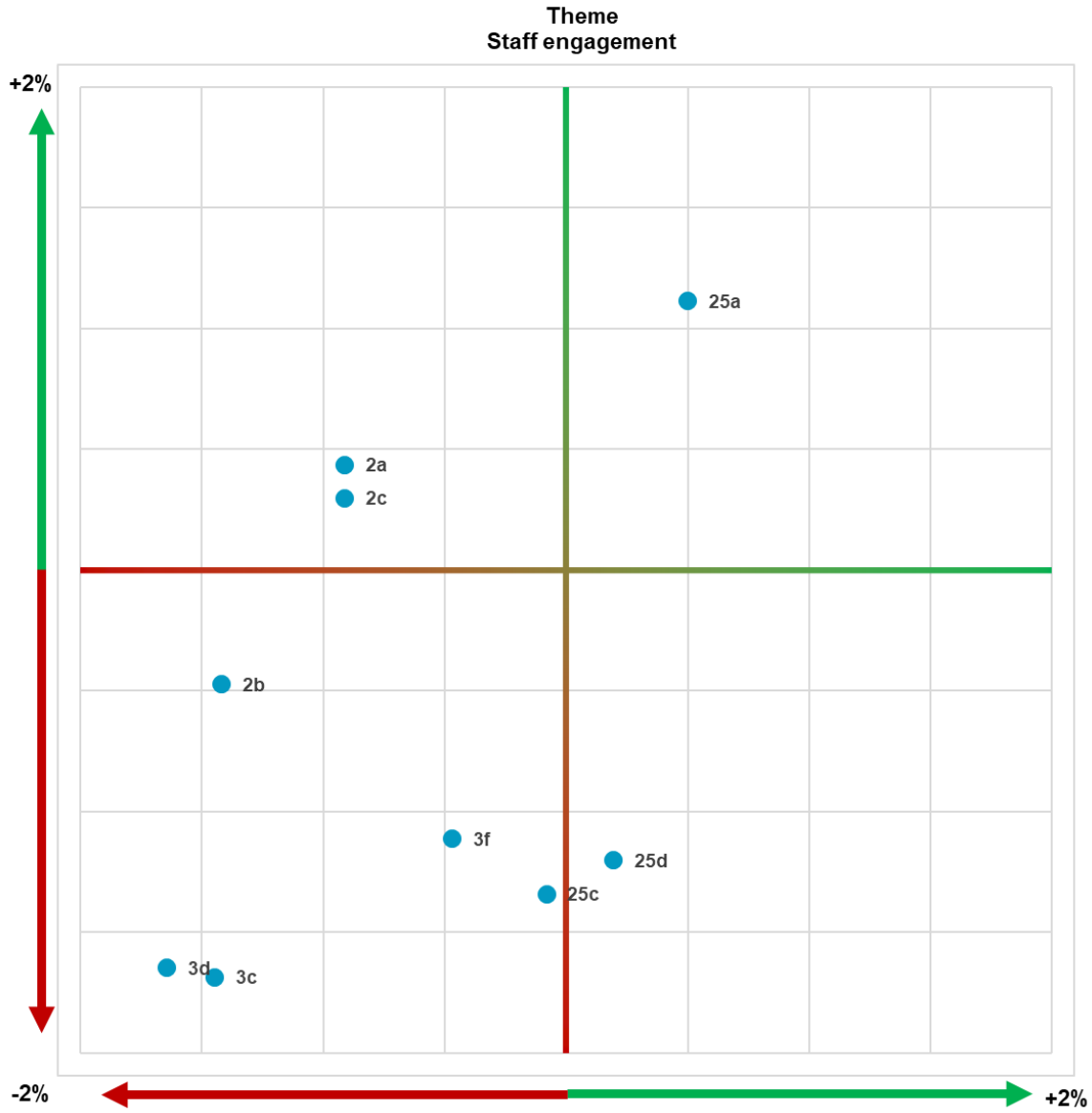
	Theme	Question Number	Question	2024 Result	Variance to 2023	National Average	Variance to National Average
+	Team working	7a	The team I work in has a set of shared objectives (Agree/Strongly agree).	72.7%	0.5%	73.5%	-0.8%
+	Team working	7b	The team I work in often meets to discuss the team's effectiveness (Agree/Strongly agree).	61.7%	0.0%	61.9%	-0.2%
+	Team working	7c	I receive the respect I deserve from my colleagues at work (Agree/Strongly agree).	69.8%	0.3%	70.4%	-0.7%
+	Team working	7d	Team members understand each other's roles (Agree/Strongly agree).	69.8%	-0.4%	71.3%	-1.4%
+	Team working	7e	I enjoy working with the colleagues in my team (Agree/Strongly agree).	79.5%	-1.5%	80.3%	-0.9%
+	Team working	7f	My team has enough freedom in how to do its work (Agree/Strongly agree).	59.5%	-0.2%	59.5%	0.0%
+	Team working	7g	In my team disagreements are dealt with constructively (Agree/Strongly agree).	55.4%	0.1%	56.7%	-1.3%
+	Team working	8a	Teams within this organisation work well together to achieve their objectives (Agree/Strongly agree).	53.5%	-0.8%	54.3%	-0.7%
+	Line management	9a	My immediate manager encourages me at work (Agree/Strongly agree).	73.0%	0.5%	71.4%	1.6%
+	Line management	9b	My immediate manager gives me clear feedback on my work (Agree/Strongly agree).	66.3%	0.5%	65.3%	1.0%
+	Line management	9c	My immediate manager asks for my opinion before making decisions that affect my work (Agree/Strongly agree).	58.0%	-1.3%	58.8%	-0.8%
+	Line management	9d	My immediate manager takes a positive interest in my health and well-being (Agree/Strongly agree).	70.9%	0.5%	69.4%	1.5%

Staff engagement

2024 Staff Survey

The Staff Engagement theme explores sub-themes of Motivation, Involvement, and Advocacy.

- No significant change to questions under the sub theme **motivation** and **involvement**. These questions largely link to the people promise 'We have a voice that counts' which highlighted a decline in staff having opportunities to show initiative, and being involved in decisions about change.
- **Advocacy** questions are considered to be a key indicator of staff engagement in a Trust. All 3 questions under the advocacy sub theme have been sustained or improved in 2024. Of particular note is improvement in the friends and family measure for a second consecutive year, with an increase staff reporting being happy with the standard of care provided by the organisation (Q25d). This closes the gap against national average given that this question saw a -1.8% reduction nationally.



Staff engagement

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

	Theme	Question Number	Question	2024 Result	Variance to 2023	National Average	Variance to National Average
+	Motivation	2a	I look forw ard to going to w ork (Often/Alw ays).	54.6%	-0.9%	54.2%	0.4%
+	Motivation	2b	I am enthusiastic about my job (Often/Alw ays).	67.5%	-1.4%	68.0%	-0.5%
+	Motivation	2c	Time passes quickly w hen I am w orking (Often/Alw ays).	71.2%	-0.9%	70.9%	0.3%
+	Involvement	3c	There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	71.5%	-1.4%	73.2%	-1.7%
+	Involvement	3d	I am able to make suggestions to improve the w ork of my team / department (Agree/Strongly agree).	69.0%	-1.6%	70.6%	-1.6%
+	Involvement	3f	I am able to make improvements happen in my area of w ork (Agree/Strongly agree).	54.6%	-0.5%	55.7%	-1.1%
+	Advocacy	25a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	75.5%	0.5%	74.4%	1.1%
+	Advocacy	25c	I w ould recommend my organisation as a place to w ork (Agree/Strongly agree).	59.6%	-0.1%	60.9%	-1.3%
+	Advocacy	25d	If a friend or relative needed treatment I w ould be happy w ith the standard of care provided by this organisation (Agree/Strongly agree).	60.3%	0.2%	61.5%	-1.2%

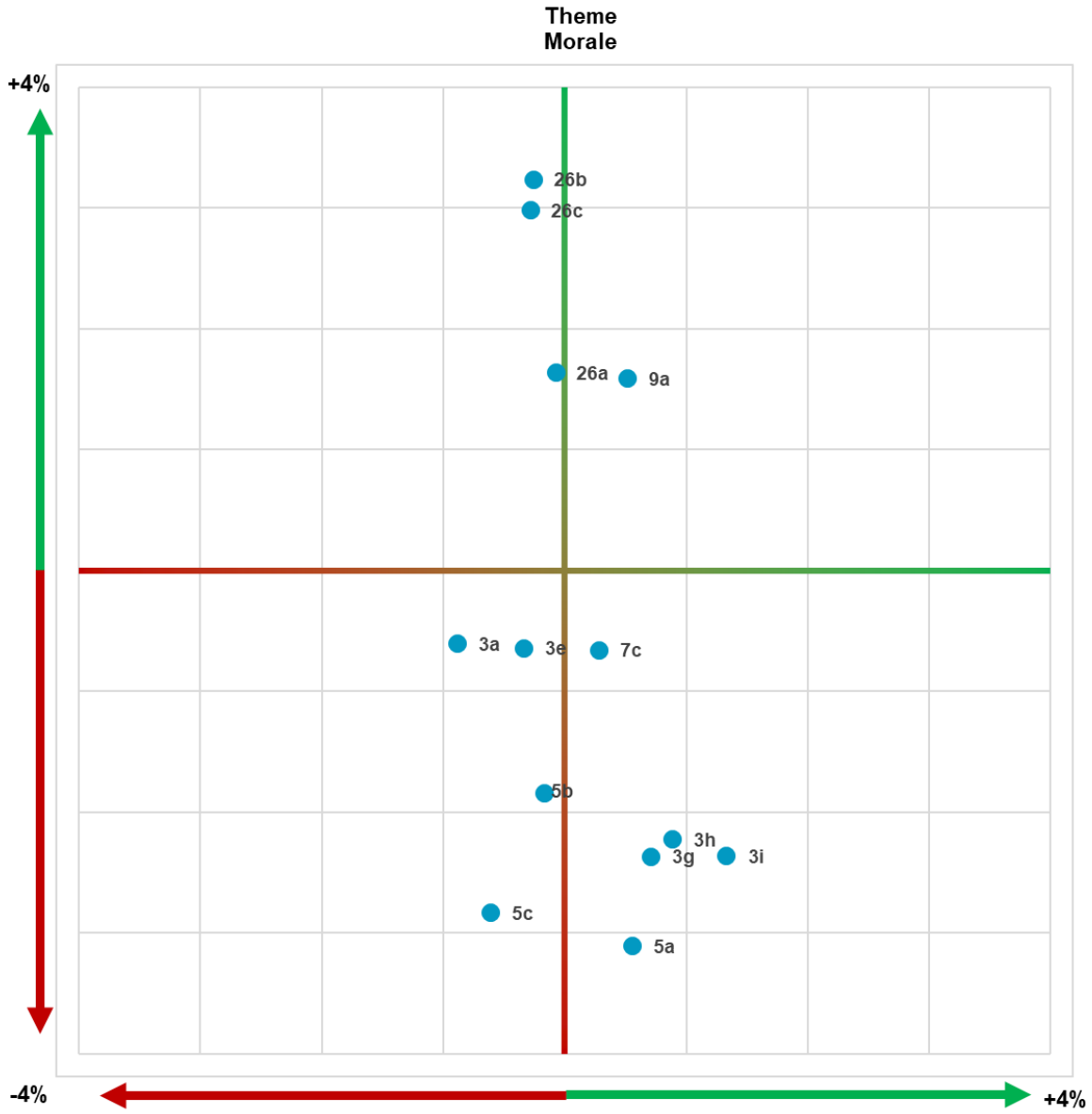
Morale

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

The Staff Engagement theme explores sub-themes of Health and Safety Climate and Burnout.

- The pattern of slow and steady improvement against the **work pressures** cluster of questions remains in 2024 with more staff feeling they are able to meet the conflicting demands on their time (+0.7%) and have adequate materials, supplies and equipment to do their work (+0.9%), however, these questions are below the national average.
- The Trust could review further ways to improve staff awareness and communicate the investments being made in staffing numbers and equipment.
- Voluntary turnover has remained at an 8.5% average over the last 12 months showing the resilience of staff response to change programmes and positive impact of Trust Retention Working group. The introduction of a People Promise Manager in 2024/5 facilitated a 30-day diagnostic and countermeasures focussed on retention in the first 12 months of employment, role of the line manager during induction, and improving leaver intelligence.



Morale

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

	Theme	Question Number	Question	2024 Result	Variance to 2023	National Average	Variance to National Average
-	Health and safety climate	26a	I often think about leaving this organisation (Agree/Strongly agree).	26.8%	-0.1%	28.4%	1.6%
-	Health and safety climate	26b	I will probably look for a job at a new organisation in the next 12 months (Agree/Strongly agree).	17.7%	-0.3%	21.0%	3.2%
-	Health and safety climate	26c	As soon as I can find another job, I will leave this organisation (Agree/Strongly agree).	12.9%	-0.3%	15.9%	3.0%
+	Health and safety climate	3g	I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	45.1%	0.7%	47.5%	-2.4%
+	Health and safety climate	3h	I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	54.8%	0.9%	57.0%	-2.2%
+	Health and safety climate	3i	There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	30.4%	1.3%	32.8%	-2.4%
+	Health and safety climate	3a	I always know what my work responsibilities are (Agree/Strongly agree).	85.9%	-0.9%	86.6%	-0.6%
+	Burnout	3e	I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	50.2%	-0.3%	50.8%	-0.6%
+	Burnout	5a	I have unrealistic time pressures (Never/Rarely).	22.6%	0.6%	25.7%	-3.1%
+	Burnout	5b	I have a choice in deciding how to do my work (Often/Always).	50.2%	-0.2%	52.0%	-1.8%
+	Burnout	5c	Relationships at work are strained (Never/Rarely).	43.1%	-0.6%	45.9%	-2.8%
+	Burnout	7c	I receive the respect I deserve from my colleagues at work (Agree/Strongly agree).	69.8%	0.3%	70.4%	-0.7%
+	Burnout	9a	My immediate manager encourages me at work (Agree/Strongly agree).	73.0%	0.5%	71.4%	1.6%

Great Western Hospitals
NHS Foundation Trust

BME and Disability Overview

2024 Staff Survey

Together we are Great

Workforce Equality Standards

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

A subset of questions in the Staff Survey contain indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

Workforce Race Equality Standard (WRES)

Q#	Responses for White Staf vs All Other Ethnic Groups for:
Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
Q14b & Q14c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
Q16b	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Workforce Disability Equality Standard (WDES)

Q#	Responses for Staff with LTC vs Staff Without LTC:
Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public
Q14b	Percentage of staff experiencing harassment, bullying or abuse from managers
Q14c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues
Q14d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
Q11e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
Q4b	Percentage staff saying that they are satisfied with the extent to which their organisation values their work
Q31b	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work
Engagement Theme	The staff engagement score for staff with LTC or illness vs staff without a LTC or illness

Race Equality

2024 Staff Survey

Successes

- We have continued to see an improvement in BME staff experiencing harassment, bullying or abuse from colleagues in last 12 months, this has reduced by 1.69% since last year, this is 1.23 percentage points lower than the benchmark average. There is no significant change for White staff, however, this has worsened by a small increase of 0.47%.

Areas for improvement

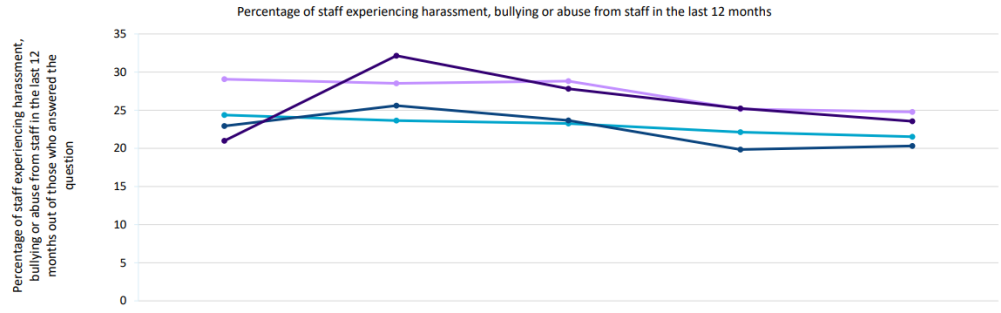
- BME staff believing that the organisation provides equal opportunities for career progression or promotion has worsened by 0.85%, notably 5 percentage points lower than the benchmark average, whilst the rate for White staff has stayed relatively the same as last year (0.32% improved) and is 1.42% better than the benchmark average. Inclusion and Recruitment Champions were introduced in November 2023 for band 8B and above. Leadership Skills training has also been delivered including interview skills for ethnic minority and internationally educated staff. Focus for 2025 will be to assess the impact measurement and the Board will engage with Staff Networks including Race Equality Network to review data in the Summer of 2025.

- BME staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months has increased slightly by 1.18%, this is marginally lower than the benchmark average (0.32% lower). There was no significant change for White staff, a reduction of 0.22% since 2023. EDI conference in November 2024 focused on allyship and included Bystander training, we will better understand the impact of this in 2025. A guide is currently being developed to support staff to address racism which will be launched during Black History Month.

- Although BME staff experiencing discrimination from a manager or colleague in the last 12 months has reduced by 0.98% to 18.57%, this remains higher than the benchmark average by 2.85 percentage points. The percentage of White staff experiencing discrimination is relatively the same as 2023 (0.15 percentage points lower) and is the same as the benchmark. The disparity between BME and white staff is 11.88% (down by 0.83%), the Trust Pillar Metric target is 9.4% (the national disparity worsened from 8.3%).

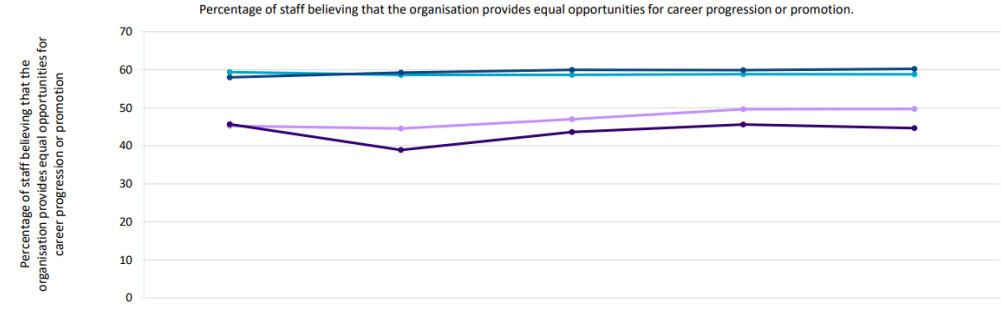
- To support EDI pillar metric question 16B, Divisional Working Groups are taking local action and over 60 EDI champions are supporting local actions and addressing unprofessional behaviours. The Cultural Ambassador has recently been introduced and will be piloted in our Conduct Management Policy to support staff that feel they are being treated unfavourably. This is in the early stages and dependent on the impact, may be extended to other Trust policies.

Great Western Hospitals NHS Foundation Trust



	2020	2021	2022	2023	2024
White staff: Your org	22.94%	25.61%	23.67%	19.84%	20.31%
All other ethnic groups*: Your org	20.99%	32.15%	27.82%	25.24%	23.55%
White staff: Average	24.37%	23.65%	23.25%	22.12%	21.53%
All other ethnic groups*: Average	29.07%	28.53%	28.81%	25.16%	24.78%
White staff: Responses	558	2023	2455	2837	2856
All other ethnic groups*: Responses	81	367	647	1030	1295

*Staff from all other ethnic groups combined



	2020	2021	2022	2023	2024
White staff: Your org	58.01%	59.25%	59.96%	59.92%	60.24%
All other ethnic groups*: Your org	45.68%	38.90%	43.63%	45.60%	44.65%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%
White staff: Responses	562	2032	2455	2824	2842
All other ethnic groups*: Responses	81	365	644	1022	1290

*Staff from all other ethnic groups combined

Disability Equality

2024 Staff Survey

Successes

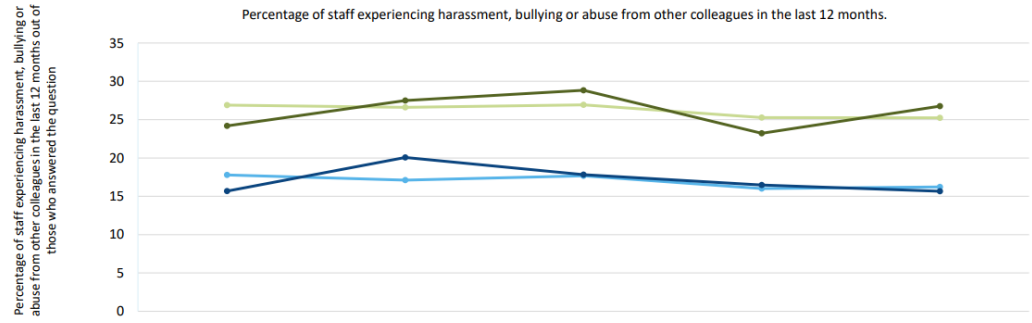
- The percentage of staff with LTC or illness who have experienced harassment, bullying and abuse from patients has reduced by 0.81%, this is 4.51% higher than the benchmark average, and is a continuing downward trend for the third year in a row. The percentage for staff without LTC or illness remains relatively the same since last year (0.8% higher than the benchmark average).

Areas for improvement

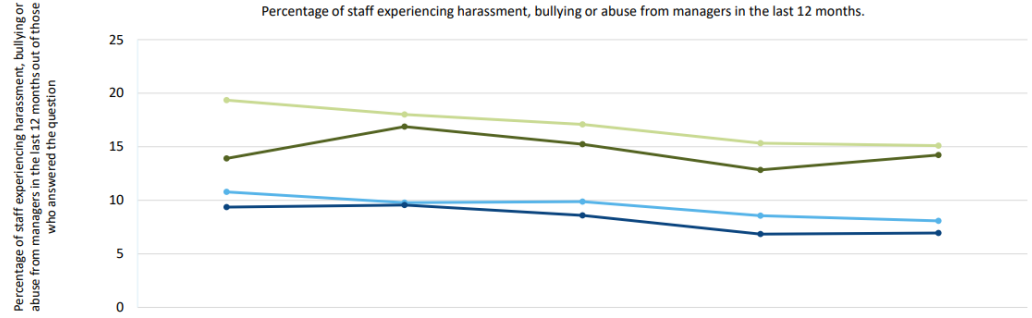
- The percentage of staff with LTC or illness experiencing harassment, bullying and abuse from a manager has increased by 1.38% (0.88% lower than the benchmark average), the percentage for staff without LTC or illness remains relatively the same as last year (1.13% lower than the benchmark). Civility & Respect training has been implemented, and Leadership Behaviours were introduced in October 2023, more recently Expectations of a Line Manager training was introduced in November 2024 with further training sessions planned for 2025, the impact of this will be measured over the coming months. EDI Champions include disabled staff, and the Differently Abled Network were instrumental in shaping the programme and oversight in its delivery.

- The percentage of staff with LTC or illness experiencing harassment, bullying or abuse from colleagues in the last 12 months has increased by 3.54%, in contrast to having reduced by 5.61% the year before. This is higher than the benchmark average by 1.52%. The percentage of staff without LTC or illness who have experienced harassment, bullying or abuse has decreased by 0.81%. This is slightly better than the national average. However, the number of staff with LTC who went on to report it has improved by 5.93% indicating staff are more likely to speak up.

- The percentage of staff with LTC or illness who believe the organisation provides equal opportunities for career progression or promotion has reduced by 1.33%, similar to the benchmark average. The disparity between this group and staff without LTC and illness is 4.69% (the non-LTC/illness group is 1.29% lower than the benchmark average). Inclusion and Recruitment Champions sit on interview panels for 8B and above roles and the Board engaged with disabled staff in December 2024 to understand their lived experiences. The feedback from these listening events were reviewed at a People Services Workshop to identify actions and a ‘you said, we did’ document will be published in new financial year.



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	24.18%	27.49%	28.83%	23.22%	26.76%
Staff without a LTC or illness: Your org	15.68%	20.07%	17.83%	16.47%	15.66%
Staff with a LTC or illness: Average	26.89%	26.60%	26.93%	25.26%	25.24%
Staff without a LTC or illness: Average	17.79%	17.11%	17.67%	16.01%	16.22%
Staff with a LTC or illness: Responses	153	553	711	857	908
Staff without a LTC or illness: Responses	491	1804	2373	2951	3193



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	13.91%	16.88%	15.23%	12.84%	14.22%
Staff without a LTC or illness: Your org	9.37%	9.56%	8.58%	6.84%	6.95%
Staff with a LTC or illness: Average	19.35%	18.00%	17.09%	15.33%	15.10%
Staff without a LTC or illness: Average	10.78%	9.77%	9.88%	8.56%	8.08%
Staff with a LTC or illness: Responses	151	557	709	857	907
Staff without a LTC or illness: Responses	491	1810	2388	2952	3193

NHS
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Responding through Improving Together

2024 Staff Survey

Together we are Great

2024 Trust Breakthrough Objective

Improving Together

Great Western Hospitals NHS Foundation Trust

Breakthrough Objective	To reach a target score of 75% in the main 2024 staff survey national staff survey question: I receive the respect I deserve from my colleagues at work

2018	69.4%
2019	75.4%
2020	70.4%
2021	68.9%
2022	70.8%
2023	69.5%
2024 Q1	70.7%
Q2	71.1%
2024	69.8%
Q4	64.30%

Trust Wide A3

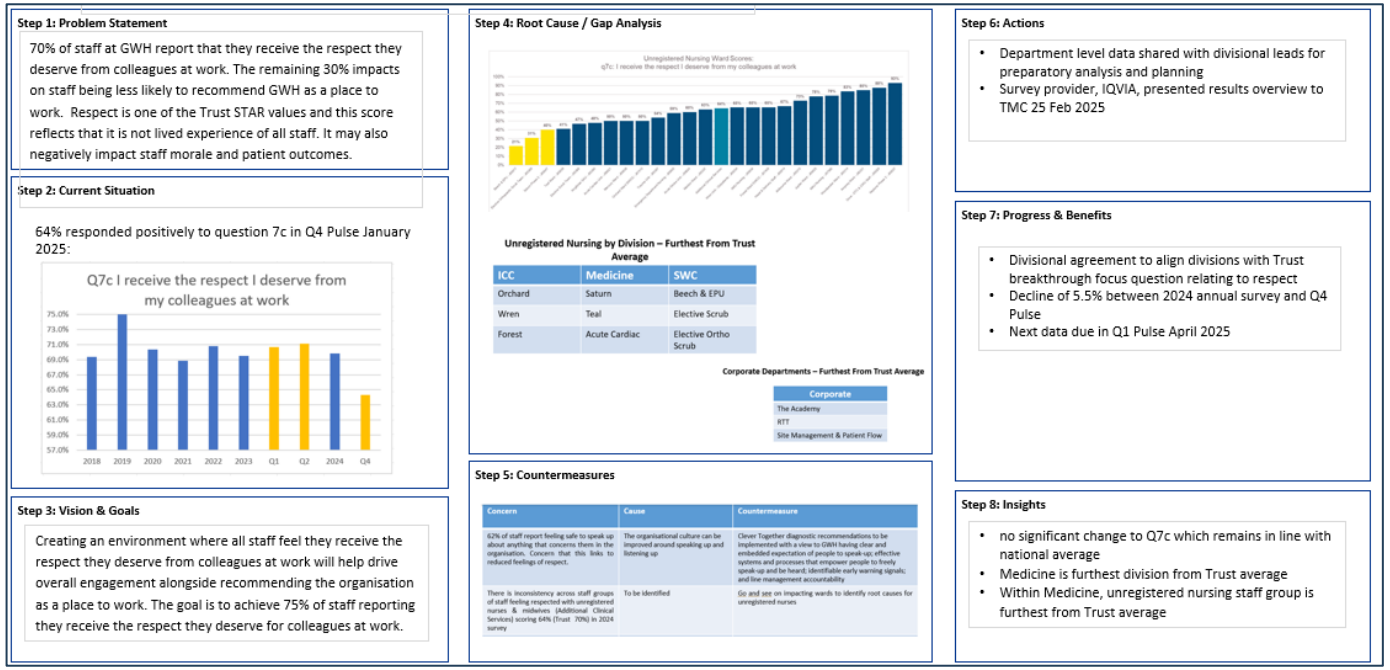
2024 Breakthrough Objective

Great Western Hospitals NHS Foundation Trust

An A3 analysis has taken place highlighting the impacting departments and staff groups.

All divisions will align with the Trust breakthrough focus in 2025/6:

Q7c "I receive the respect I deserve from my colleagues at work."



Step 1: Problem Statement

70% of staff at GWH report that they receive the respect they deserve from colleagues at work. The remaining 30% impacts on staff being less likely to recommend GWH as a place to work. Respect is one of the Trust STAR values and this score reflects that it is not lived experience of all staff. It may also negatively impact staff morale and patient outcomes.

Step 2: Current Situation

64% responded positively to question 7c in Q4 Pulse January 2025:

Q7c I receive the respect I deserve from my colleagues at work

Step 3: Vision & Goals

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. The goal is to achieve 75% of staff reporting they receive the respect they deserve for colleagues at work.

Step 4: Root Cause / Gap Analysis

Unregistered Nursing by Division – Furthest From Trust Average

ICC	Medicine	SWC
Orchard	Saturn	Beech & EPU
Wren	Teal	Elective Scrub
Forest	Acute Cardiac	Elective Ortho Scrub

Corporate Departments – Furthest From Trust Average

Corporate
The Academy
RTT
Site Management & Patient Flow

Step 5: Countermeasures

Concern	Cause	Countermeasure
62% of staff report feeling safe to speak up about anything that concerns them in the organisation. Concern that this links to reduced feelings of respect.	The organisational culture can be improved around speaking up and listening up	Clever Together diagnostic recommendations to be implemented with a view to GWH having clear and embedded expectation of people to speak-up; effective systems and processes that empower people to freely speak-up and be heard; identifiable early warning signals; and line management accountability
There is inconsistency across staff groups of staff feeling respected with unregistered nurses & midwives (Additional Clinical Services) scoring 64% (Trust 70%) in 2024 survey	To be identified	Go and see on impacting wards to identify root causes for unregistered nurses

Step 6: Actions

- Department level data shared with divisional leads for preparatory analysis and planning
- Survey provider, IQVIA, presented results overview to TMC 25 Feb 2025

Step 7: Progress & Benefits

- Divisional agreement to align divisions with Trust breakthrough focus question relating to respect
- Decline of 5.5% between 2024 annual survey and Q4 Pulse
- Next data due in Q1 Pulse April 2025

Step 8: Insights

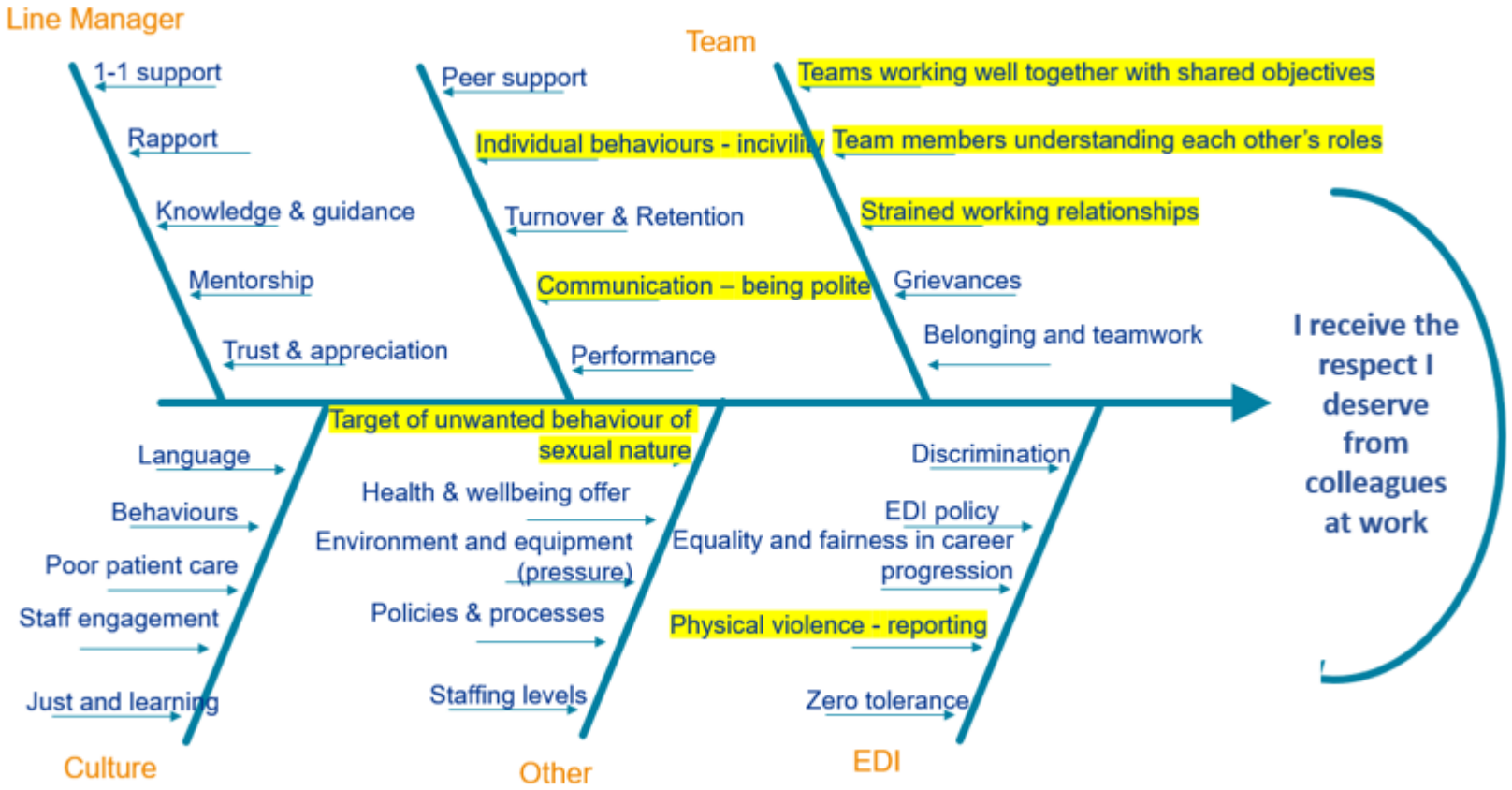
- no significant change to Q7c which remains in line with national average
- Medicine is furthest division from Trust average
- Within Medicine, unregistered nursing staff group is furthest from Trust average

Root Cause Analysis

2024 Breakthrough Objective

Great Western Hospitals NHS Foundation Trust

Q7c "I receive the respect I deserve from my colleagues at work."



Trust Breakthrough Objective

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

Q7c “I receive the respect I deserve from my colleagues at work.”

Timeline

- Align divisions with the Trust focus question receiving respect (Q7c)
- A3 and countermeasure refresh
- TMC Trust Wide presentation in March
- People and Culture Divisional presentations in April
- Divisions to review senior survey leads within the new division structure
- Monthly Trust Wide Staff Survey Working Group to provide joined up working, share good practice ideas, and encourage momentum

Trust-Wide Action

- Expectations of the line manager
- Clever Together – Values based culture
- Clever Together – Speaking up Culture
- A3 refresh by Division to understand biggest contributing factor and build countermeasures to support front line staff develop plans to improve.

Risks

- Q4 quarterly pulse survey results have declined
- Lead time from impact of countermeasure
- Financial challenge (workforce reduction/redundancy will not have a positive impact)
- Division restructure following TUPE to HCRG
- Group model, gap in senior leadership posts

Staff Survey 2024 Timeline

2024 Staff Survey

Great Western Hospitals NHS Foundation Trust

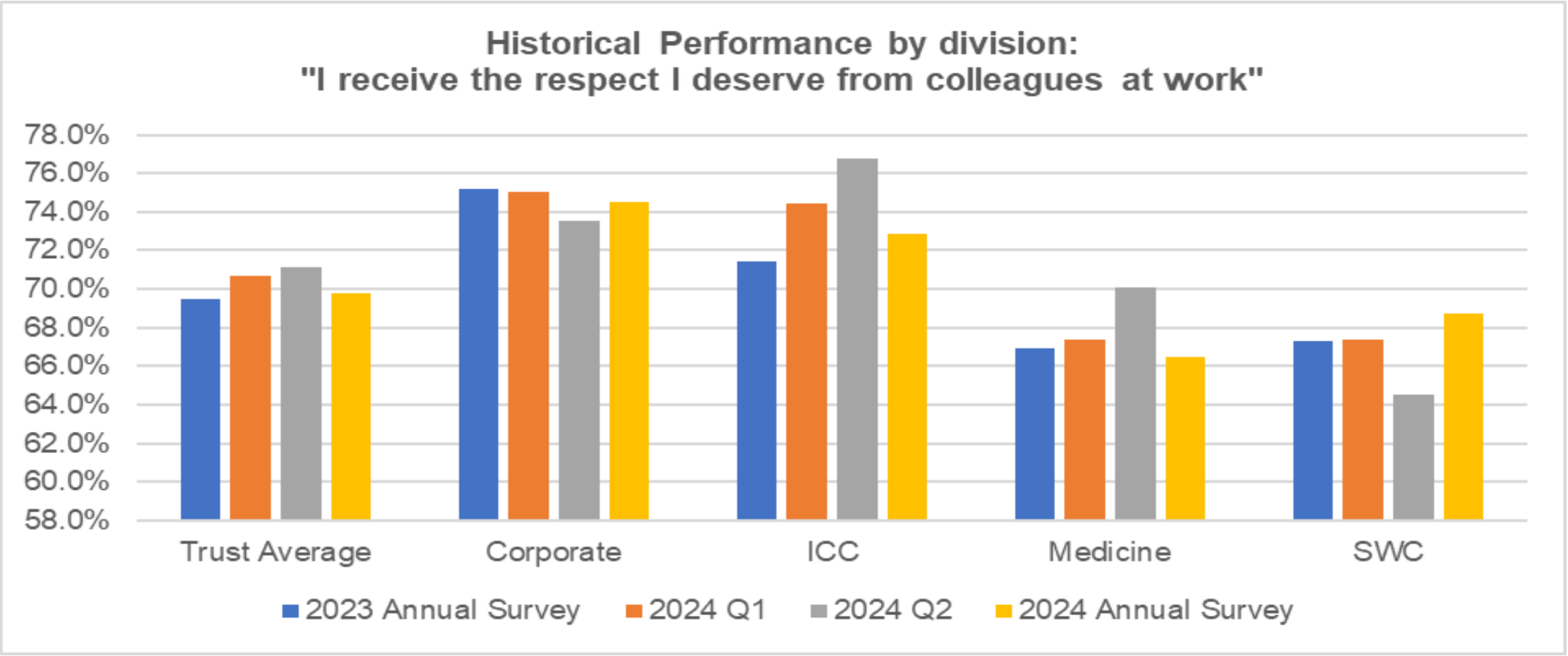
March 2025	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025
		Divisional countermeasures in progress to support Divisional Breakthrough Objectives				
Trust wide results shared with TMC – refreshed Trust A3 and countermeasures	Divisions to present at April SP&C and P&CC – refreshed A3s and countermeasures	Trust wide countermeasures in progress to support Trust Breakthrough Objective Trust Wide Staff Survey Group receive divisional escalations and drive improvement in the Trust Breakthrough Objective Progress monitored by quarterly Staff Survey live in April, July and January				Annual Staff Survey 2025 Launch

Progress to be monitored via monthly Trust Wide Staff Survey Working Group, divisional performance reviews, reported via TMC (monthly), SP&C, and P&CC

Divisional Breakthrough Objective

Great Western Hospitals NHS Foundation Trust

2024 Staff Survey



Any questions?

Report Title	**Perinatal Services Six Month Summary (Q3 & Q4)**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Luisa Goddard, Chief Nurse				
Report Author	Kat Simpson, Head of Midwifery and Neonatal Services Laura Little, Project Coordinator				
Appendices	N/A				

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 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 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 processes embedded to provide assurance of senior oversight of any identified risks and mitigating actions in place.

Report

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

This six-month update on perinatal services provides a comprehensive overview of progress mapped against key priorities, including CQC must-do and should-do actions, the Three-year Plan for Maternity and Neonatal Services, and the recommendations from the Ockenden Report. This review demonstrates the commitment to strengthening perinatal care through improved staffing, addressing health inequalities, and fostering a positive culture within our workforce.

Our roadmap for the coming months includes further improvements in staffing levels and ongoing collaboration with the NHSE Perinatal Culture and Leadership Program to strengthen our culture of safety and quality, with the continued aim to provide safe, inclusive, and high-quality perinatal services for all families

Strategic Alignment – select one or more		✓ Outstanding care		✓ Valued teams		✓ Better together		✓ Sustainable future

Link to CQC Domain – select one or more	**Safe**	✓	**Caring**	✓	**Effective**	✓	**Responsive**	✓	**Well-led**	✓

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	593 - There is a risk that patient safety will be compromised across Maternity Services because of insufficient midwifery staff to fill roster requirements	9
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?	☐	✓	☐
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	✓	☐	☐

Explanation of above analysis:

The service focusses on the co-production of a perinatal 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:

Note the progress within the service against the Three-Year Maternity & Neonatal Delivery Plan and the impact on the development of the perinatal services to make care safer, more personalised and more equitable.

Accountable Lead Signature	Luisa Goddard.
Date	**30/04/2025**

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Perinatal Service Summary

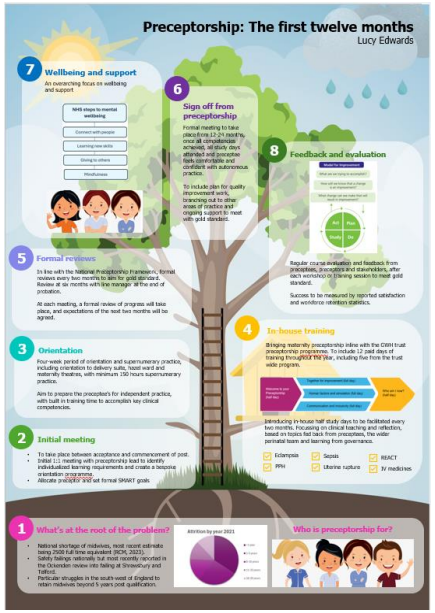
October 2024 - March 2025 (Q3 & Q4)

Overview of Perinatal Service Summary

- This presentation provides an update on perinatal services with a comprehensive overview of progress
- Progress across the service has been mapped against key national and local priorities including:
  - CQC must-do and should-do actions for Great Western Hospital
  - Three-year Delivery Plan for Maternity & Neonatal Services
- All CQC Must Do and Should Do actions are underpinned by detailed improvement action plans with dedicated senior management ownership. An action summary position mapped against the service priorities is included throughout this perinatal review.
- This review demonstrates the commitment to strengthening perinatal care through improved staffing, addressing health inequalities, and fostering a positive culture within our workforce
- Our roadmap for the coming months includes further improvements in staffing levels and ongoing collaboration with the NHSE Perinatal Culture and Leadership Program to strengthen our culture of safety and quality, with the continued aim to provide safe, inclusive, and high-quality perinatal services for all families

MD1	•The service must ensure staff are up to date with maternity mandatory training modules.
MD2	•The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night.
MD3	•The service must ensure non-compliant audits are acted upon and improvement plans put in place
MD4	•The service must ensure incidents are managed well, including but not limited to effective sharing of learning, using learning to effect change and improvement in practice.
MD5	•The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, consistent use of SBAR, consistency and accuracy over several record-keeping systems
SD1	•The service should ensure that staff are compliant with MEOWS and ensure effective audit programme is in place
SD2	•The service should ensure all incidents are monitored by ethnicity. In order to identify potential health inequalities

Workforce & Training



- Since September 2024, the perinatal service has embedded a refreshed preceptorship programme supported by NHSE funding which is anticipated to positively impact retention of staff both locally and to the profession.
  - 17 preceptors transferred to the newly designed programme and 13 Newly Qualified Midwives (NQM) have joined directly since September
- Broad workforce strategy in place to ensure accessible pathways into careers within service, including pipeline for newly qualified midwives, midwifery apprenticeships pathways and T level student support
- There is continued focus on the neonatal nursing workforce which now has a dedicated nurse on each shift for transitional care. There is further investment in development opportunities which is enabling more staff to achieve the Qualified in Speciality (QIS) certificate for intensive care and access to Advanced Neonatal Nursing training.

- Progress in Partnership (Joint Co-Chair Visit) took place at GWH on 21st February with representatives from the Royal College of Obstetricians & Gynaecologists, Neonatal Nursing Association and Royal College of Midwives. This provided an opportunity for an external objective insight into our perinatal culture and team working.
- Continued engagement with system wide development of a labour ward coordinator programme with all relevant band 7 clinical staff allocated attendance at the training & education day
- The maternity service are in the process of introducing rotational posts for newly qualified midwives in the first three years of their career.

Three Year Delivery Plan

CQC GWH Actions

Objective 4 Grow Our Workforce

Objective 5 Value & Retain Our Workforce

Objective 6 Invest In Skills

MD1 - Training Action Summary

- Continued focus on recruitment to enable a split rota between Neonatal and Paediatric services with interviews taking place on 24th and 25th April.

Maternity Support Worker BSW Project

- Great Western Hospital are the host Trust across the BSW LMNS for the NHSE Maternity support worker competency, education and career development framework which aims to realise the potential within the band 2, 3 and 4 workforce and enable delivery confident and capable care

- Since September 2024, the project team have:
  - Undertaken mapping of MSW workforce across all three Trusts and reviewed existing education arrangements for MSW workforce to identify additional provision required
  - Completed a comprehensive review of Trust job descriptions against the MSW framework criteria and developed a generic roles and responsibilities appendices for BSW job descriptions mapped against the MSW and Trust level competencies
  - Developed education and training programmes to target MSW compliance against framework and Trust specific competencies with these sessions being delivered during Q4 (24/25) and Q1 (25/26)

- All three Trusts embraced the opportunity for collaborative working and are developing robust plans for sustaining the current workforce training compliance rates and providing new starters clinical skills and competencies once the project has completed.

Three Year Delivery Plan

CQC GWH Actions

Objective 4 Grow Our Workforce

Objective 5 Value & Retain Our Workforce

Objective 6 Invest In Skills

CareQuality Commission

MD1 - Training Action Summary

Quality & Safety

- The Patient Quality, Safety and Assurance team have undertaken thematic analysis of all patient safety events over the past six months using the PSIRF methodology to support learning and identify improvement opportunities for the service.
- Through this thematic analysis GWH identified an opportunity to improve our rates of patients with post partum haemorrhages with an output greater than 1.5L
- A multi-disciplinary working group was established and initial priorities identified to inform the required deep dive. Detailed data analysis has commenced and was used to produce an improvement action plan

- Identified improvements were focussed on exploration of preventative actions alongside embedding processes that continue to mitigate the risks associated with PPH. These include:
  - Cell salvage training provided to all theatre teams to optimise usage for all patients
  - Education & practice development midwifery team leading on utilising Improving Together methodology with our front-line clinical teams to understand root causes for increased PPH rates
  - Increased visibility of Tranexamic Acid to support early use prior to reach 1L blood loss
  - Increased access to 'grab bags' for all clinical staff
  - All PPH >1L are reported via Datix and reviewed as part of PSIRF to identify learning for the multi-disciplinary team
  - All birthing people with previous PPH >1L follow a high dependency care pathway to support early recognition of any deterioration of deviations from normal
  - PPH management remains part of the MDT mandatory training curriculum

Three Year Delivery Plan

CQC GWH Actions

Objective 1 Care that is Personalised

Objective 3 Work with Service Users to Improve Care

Objective 7 Develop A Positive Safety Culture

Objective 8 Learning & Improving

Objective 9 Support & Oversight

Objective 10 Standards to Ensure Best Practice

CareQuality Commission

MD3/SD1 - Audit Action Summary

CareQuality Commission

MD4 - Incidents Action Summary

Digitalisation of Services

- In January the maternity service implemented BadgerNet as a new maternity digital record.
- The maternity digital team and the Trust IT service have worked collaboratively with our digital system providers to support our clinical workforce during the implementation and will continue to focus on data reporting structures and resolving challenges throughout Q4 and Q1 (2025/26).
- The Trust are currently in “Go Live” status and continue to work with System C to develop fixes for all issues and challenges raised, with the digital team ensuring alternate processes are in place to ensure clinical safety is maintained

- The rollout of BadgerNet to clinical teams has been extremely successful, influenced by some of the following strategies
  - Production & availability of written “how to” guides for all staff to reference when using the new system interface
  - 24-hour assistance from trained floor walkers and increased presence from the maternity digital team to support the transition
  - Named “super-users” on all clinical shifts to support across the unit
  - Additional access to iPads and mobile computer devices for direct patient care recording, positively impacting clinical staff experience as data entry time is greatly reduced due to system design
- The team continue to roll out the Badger Notes App which provides all service users access to digital maternity notes
- An in-depth review of the rollout will be undertaken with lessons learnt feedback session to be held to aid future planning

Three Year Delivery Plan

CQC GWH Actions

Objective 2 Improve Equity for Mothers & Babies

Objective 10 Standards to Ensure Best Practice

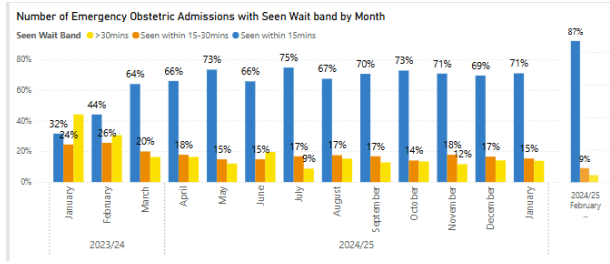
Objective 11 Data To Inform Learning

Objective 12 Make better use of digital technology

CareQuality Commission

MD5 - Digital Action Summary

Continued Service Improvements from Service User Feedback



- Since Monday 13th January 2025 the service has successfully supported a 24-hour triage service. The service has facilitated a smooth transition with dynamic assessment of workload and overnight staffing models to sustain care. The team have proactively utilised escalation policies to support the ongoing flow of women through the service.
- In February 2025 96% of women were triaged within 30 minutes with an average time from admission to triage of 12.8 minutes.
- Examples of positive improvements as a direct result of service user feedback are;
  - Little boxes of calm now implemented in Delivery Suite & Hazel ward for neurodivergent service users
  - Visual floor signage installed on second floor of GWH to help service users locate their required destination easily and quickly

Maternity & Neonatal Voices
Working in partnership to improve services

- To improve experience for neonatal patient families the infant feeding team have focussed improvements on providing food options for parents on the unit
  - Since summer 2024 parents have access to order snack packs (free of charge)
  - The “parents pantry” on the unit have a variety of snacks available 24/7 (funded by Tiny but Mighty)
  - Carer passports are issued to parents to access discounted rates in the hospital canteen
  - Scoping funding opportunities for hot meal provision on the unit using an i-wave microwave system

Three Year Delivery Plan

CQC GWH Actions

Objective 1 Care that is Personalised

Objective 2 Improve Equity for Mothers & Babies

Objective 3 Work with Service Users to Improve Care

Objective 5 Value & Retain Our Workforce

Objective 8 Learning & Improving

Objective 11 Data to Inform Learning

Care Quality Commission

SD2 - Inequality Action Summary

Ongoing Focus

- Following significant progress against the Must Do and Should Do actions identified by the CQC, throughout 2025 the Trust will be shifting improvement focus to sustained preparation for anticipated re-visit and subsequent evaluation
- The Trust have undertaken a divisional restructure with Perinatal Services to move from Surgery, Women & Children's to the newly formed Family & Specialist Services division. Perinatal Services to undergo senior leadership transitions due to retirement, with a newly appointed Director of Midwifery & Neonatal Services and subsequent Head of Midwifery recruitment process.
- Divisional driver metric focus on staff survey question “I receive the respect I deserve from colleagues at work” in line with Trust breakthrough objective.

- Maternity Capital Prioritisation proposal to upgrade Theatre ventilation in progress.
- Continue improvements in sustainability of location for community services.
- Launch date for #mycaesareanbirth project
- Plans are being prepared by Trust Estates team to revise footprint through Day Assessment Unit and Triage area to improve environment and flow for ongoing care.
- Continued progress to establishing transitional care supporting babies from 34 weeks gestation at birth.
- The Trust anticipates the release of national reports from the Thirlwall inquiry and Nottingham hospital review and will undertake action as appropriate to meet the recommendations

Ockenden Report GWH Progress Summary

- A total of seven actions were upgraded from amber to green following an in-depth review undertaken in Q4 of 2024/25
  - Established orientation package embedded for labour ward coordinators led by intrapartum matron alongside practice development & education team.
  - Escalation policy updated to reflect escalation routes to senior management, obstetric leads and executive team when staffing levels across the perinatal service do not meet agreed levels. Ongoing management of policy updates to take place via Maternity governance route.
  - Embedded process for monitoring middle grade competencies alongside RCOG portfolio and education supervision details
  - Specialist cohort of midwifery staff dedicated to work and accommodate women with multifetal pregnancies alongside consultants to cover multifetal clinics.
  - Updated information within the Diabetes in Pregnancy Management SOP reflects evidence-based advice and relevant national recommendations. Joint discussions between clinicians and service users are documented in maternity records.
  - Established detailed annual operational risk assessments for White Horse Birth Centre in line with national guidance.
  - Enhanced systems & processes for ensuring consultant review of all postnatal admissions and unwell postnatal women (including those on a non-maternity ward) with updated operating procedures, documentation and audit programme.
- Continued progress against identified improvements for Immediate and Essential actions following focussed engagement with clinical teams for the ‘amber’ actions.
- Trust continues to have no ‘red’ actions within the Immediate and Essential Actions.
- No operational risks identified within the remaining amber actions.
- Continued consideration of Ockenden improvement actions was given during the 2025/26 business planning cycle.
- Currently no identified actions that require additional investment.

Ockenden Ongoing Improvement Actions

IEA				Ongoing Improvement Actions
1	0 =	5 ↓	6 ↑	• Engagement with workforce planning across Local Maternity & Neonatal System (LMNS) • Development of in-house training provision for High Dependency maternity care • Development of Perinatal succession planning strategy in line with GWH Scope for Growth programme
2	0 =	1 ↓	9 ↑	• Review of opportunities for supernumerary clinical skills facilitator roles within funded establishment
3	0 =	1 ↓	4 ↑	• Review ongoing opportunities for Obstetrics and Gynaecology workforce with consideration of Ockenden requirements
4	0 =	0 =	7 =	• No continued improvement actions identified
5	0 =	1 =	6 =	• Embedding assurance process for local action plans from serious incidents meet Ockenden criteria for completion within six months
6	0 =	0 =	3 =	• No continued improvement actions identified
7	0 =	0 =	7 =	• No continued improvement actions identified
8	0 =	0 ↓	5 ↑	• Ratification of local audit program with associated improvement plans where indicated • Engagement with national agencies to understand the requirements for a specialist midwifery team for multifetal pregnancies
9	0 =	0 =	4 =	• No continued improvement actions identified
10	0 =	2 ↓	4 ↑	• Audit of newly introduced pathway for women birthing in the community to ensure practice and documentation embedded • Operational review of escalation policy for Induction of Labour pathway in progress
11	0 =	5 =	3 =	• Continued engagement with anaesthetic national bodies to understand next steps with implementation of Ockenden recommendations
12	0 =	2 ↓	2 ↑	• Implementation of improvement actions identified for consultant review of post-natal readmissions
13	0 =	1 =	3 =	• Enhanced training and education for midwives undertaking post-mortem consent supported by the Ockenden funded bereavement role
14	0 =	3 =	5 =	• Continued engagement with our Operation Delivery Network for Neonatal Care (ODN) to promote access to shared learning and experiences. • Development of a model for rotation with the ODN • Business planning has directed investment to Neonatal workforce to enable split rota between Neonatal and Paediatric services with ongoing recruitment
15	0 =	3 =	0 =	• Embedding practice of the OCEANS psychological support service • Delivery of specialist training sessions throughout the three-year education programme

Any questions?

Report Title	**Delegation of Authority for approval of Annual Accounts 2024/25**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Simon Wade, Chief Financial Officer				
Report Author	Caroline Coles, Company Secretary				
Appendices	n/a				

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 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 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 Trust is required to comply with the guidance in the Annual Reporting Manual for Foundation Trusts for 2024/25 and submit a set of audited annual accounts including an Annual Report by the national deadline of 30 June 2025.

The process for the completion of Trust's Annual Report & Accounts is outlined below and in line with guidance from NHS England for the NHS accounts timetable and year-end arrangements.

Date	Action
8 May 2025*	Trust Board delegates authority to Audit, Risk & Assurance Committee to approve accounts and the Annual Report.
*No Board meeting held in public in June 2025 as Board Seminar	
24 June 2025	Audit, Risk & Assurance Committee receives annual report, audited accounts, certificates and audit opinion and approves accounts and annual report
30 June 2025 (12 noon)	NHS FTs submit (electronically) audited accounts, the external auditors ISA 260 report, the external audit opinion on the accounts, and the Annual Report to NHSE.
Date to be confirmed	Laying NHS foundation trust annual report and accounts before Parliament.
7 October 2025	Annual Members Meeting

In order to meet the submission deadline, the Trust requires delegation of authority to approve its Annual Report and Accounts to the Audit, Risk & Assurance Committee.

Strategic Alignment – select one or more		☐ Outstanding care		☐ Valued teams		☐ Better together		☐ Sustainable future

Link to CQC Domain – select one or more	**Safe**	☐	**Caring**	☐	**Effective**	☐	**Responsive**	☐	**Well-led**	✓

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	n/a	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	n/a	
Next Steps	Final approval at Audit, Risk & Assurance Committee before submission of Annual Report & Accounts 2024/25	

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?	☐	☐	✓
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	☐	☐	✓
Explanation of above analysis:			

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to delegate authority to the Audit, Risk & Assurance Committee to sign-off the Trust's Annual Accounts and Annual Report for 2024/25.

Accountable Lead Signature	Simon Wade, Chief Financial Officer
Date	**28/04/2025**

Great Western Hospitals NHS Foundation Trust

Report Title	**Annual Self Certification – CoS7**				
Meeting	**Trust Board**				
Date	**08/05/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Simon Wade, Chief Financial Officer				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Self Certification CoS7				

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 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 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):

NHS providers are required to complete self-certifications for publication which provides assurance that providers are compliant with the conditions of their NHS provider licence.

With the introduction of a refreshed provider licence in 2023 the self-certification for G6 (3) and FT4 has ceased to remove duplication with the annual report. However the Trust is still required to self-assess against the following:-

Declaration	Detail
CoS7 (3)	Providers providing Commissioner Requested Services (CRS) have to certify that they have a reasonable expectation that required resources will be available to deliver designated services. (For NHS Foundation Trusts only)

This report invites the Board to review and confirm the attached statement in line with its provider licence CoS7.

Once the return has been agreed, the CEO and chair will sign. These are published on the Trust's website.

Strategic Alignment – select one or more		✓ Outstanding care		☐ Valued teams		☐ Better together		✓ Sustainable future

Link to CQC Domain – select one or more	Safe	☐	Caring	☐	Effective	☐	Responsive	☐	Well-led	✓

Risk + Oversight	Risk Score
Key risks – risk number & description (Link to BAF / Risk Register)	-
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Chief Financial Officer
Next Steps	Publish on Trust website.

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

Explanation of above analysis:

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board are requested to approve the self certification CoS7 for publication on the Trust website.

Accountable Lead Signature	Simon Wade, Chief Financial Officer
Date	**09/04/2025**

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Confirmed

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

• The 2024/25 annual accounts are prepared on a going concern basis.

• Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the cost improvement plans are achieved.

• The year to date and the annual financial position are detailed in the following reports presented to the Trust Board and relevant Board committee and Executive Led Groups:
- Monthly Financial Performance Report
- Monthly Integrated Performance Report

• The Trust is working to achieve the best possible financial position for 2025/26 in agreement with the ICS and NHSE however the emergent nature of the financial settlement for 2025/26 including system wide schemes and the impact of the ERF cap for example mean that the operational plan will be a challenge to meet full delivery across all (financial, operational performance, quality and workforce) domains.

Signed on behalf of the board of directors:-

Signature		**Signature**	
Name		**Name**	
Capacity		**Capacity**	
Date		**Date**	