Great Western Hospitals NHS Foundation Trust

TRUST BOARD

Thursday 10 July 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** Jude Gray	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 8 May 2025 (draft)	7 – 17	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	18	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	LC	-	-
6.	**Care Reflection (and film) – Improvements in care for patients with a Learning Disability, staff awareness and training** Tania Currie, Head of Patient Experience & Engagement & Jade Pearce, Learning Disability Nurse	19 – 20	TC/JP	Receive	9.45
7.	**Chair's Report** Liam Coleman, Chair	21 – 24	LC	Note	10.20
8.	**Chief Executive's Report** Cara Charles-Barks, Chief Executive Simon Wade, Acting Managing Director / Chief Financial Officer	25 – 35	CCB/ SW	Note	10.30
BREAK (10 minutes) at 10.50 to 11.00am					
9.	**Integrated Performance Report** Integrated Performance Report – Breakthrough Objective and Pillar Metric deep dive	36 – 87	Executive Directors	Receive	11.00

		PAGES	BY	ACTION	TIME
	• Performance, Population & Place Committee Board Assurance Report (May & June) – Bernie Morley, Non-Executive Director & Committee Chair	88 – 93	BM	Assurance	11.40
	• Quality & Safety Committee Board Assurance Report (May & June) – Claudia Paoloni, Non-Executive Director & Committee Chair	94 – 100	CP	Assurance	
	• People & Culture Committee Board Assurance Report (June) – Julian Duxfield, Non-Executive Director & Committee Chair	101 – 103	JD	Assurance	
	• Finance, Infrastructure & Digital Committee Board Assurance Report (May & June) – Faried Chopdat, Non-Executive Director & Committee Chair	104 – 107	FC	Assurance	
10.	**Charitable Funds Committee Board Assurance Report (May)** Julian Duxfield, Non-Executive Director and Committee Member	108 – 109	JD	Assurance	12.00
11.	**Audit, Risk & Assurance Committee Board Assurance Report (June)** Helen Spice, Non-Executive Director and Committee Member	110 – 111	HS	Assurance	12.10
12.	**Safe Staffing review for Nursing, Midwifery & AHP** Luisa Goddard, Chief Nurse *(received at Quality & Safety Committee 22 May 2025)*	112 – 138	LG	Note	12.20
13.	**Research Annual Report 2024/25** Steve Haig, Chief Medical Officer *(received at Quality & Safety Committee 19 June 2025)*	139 – 146	SH	Note	12.35
CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**					
14.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	None	CC	Approve	12.50
15.	**Committee Effectiveness Review 2024/25** Caroline Coles, Company Secretary	147 – 187	CC	Approve	-
16.	**Quality Account 2024/25** Luisa Goddard, Chief Nurse *(Approved by Quality & Safety Committee on 19 June 2025 for publication on the Trust's website)*	188 – 253	LG	Note	-
17.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-
18.	**Date and Time of next meeting** Thursday 11 September 2025 at 9.30am, Great Western Hospital, Swindon	Verbal	LC	Note	-
19.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the*	-	-	-	13.00

	PAGES	BY	ACTION	TIME
confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"				

Great Western Hospitals NHS Foundation Trust

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

Present:

Liam Coleman (LC)	Chair
Cara Charles-Barks (CCB)	Chief Executive (part meeting for item 24/150)
Julian Duxfield (JD)*	Non-Executive Director
Luisa Goddard (LG)	Chief Nurse
Benny Goodman (BG)	Chief Operating Officer
Jude Gray (JG)	Chief People Officer
Steve Haig (SH)	Acting Chief Medical Officer
Bernie Morley (BM)	Non-Executive Director
Claudia Paoloni (CP)	Non-Executive Director/Senior Independent Director
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Interim Managing Director

In attendance:

Jonathan Hinchliffe (JH)	Group Chief Transformation & Innovation Officer (Interim)
Deborah Rawlings (DR)	Board Secretary
Jenni Fry	Community Midwife (agenda item 013/25)
Dr Jon Freeman	Clinical Lead – Consultant Clinical Psychologist (agenda item 013/25)
Angela Morris	Senior People Partner (agenda item 021/25)
Lisa Marshall*	Director of Midwifery & Neonatal Services (agenda item 022/25)
Kat Simpson*	Head of Midwifery & Neonatal Services (agenda items 013/25 & 022/25)

Apologies

Faried Chopdat (FC)	Deputy Chair/Non-Executive Director
Caroline Coles (CC)	Company Secretary
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director

Number of members of the Public: None

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
008/25	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
009/25	**Declarations of Interest** There were no declarations of interest.	
010/25	**Minutes of the previous meeting (public)** The minutes of the Board meeting held in public on 13 March 2025 were adopted and agreed as a correct record.	
011/25	**Outstanding actions of the Board (public)** The Board received and considered the outstanding action list.	
012/25	**Questions from the public to the Board relating to the work of the Trust**	

Minute	Description	Action

The Board noted a question from a member of the public via Sam Pearce-Kearney, Appointed Governor on the Trust's policies and procedures for relocating wards with particular reference to the moves in November 2024.

The Deputy Director of Improvement & Partnerships had provided a response which outlined the mobilisation plan for staff, ward changes which had been subject to a full business case process, actions to ensure that quality impact and risk assessments had been undertaken with mitigations in place against identified areas of concern, and key lessons learnt as part of the project closure.

The Board **noted** the question and agreed there was no further action required.

013/25 **Staff Story – Staff Support**

Jenni Fry, Community Midwife, Dr Jon Freeman, Clinical Lead – Consultant Clinical Psychologist, and Kat Simpson, Head of Midwifery & Neonatal Services, joined the meeting to present this item.

The Board received a story from a community midwife who had been involved in a traumatic experience at work last year, following which the staff member had engaged in appropriate support pathways which had enabled her to return to work after a period of significant distress and sickness associated with the incident.

The Board reflected on some of the issues which had arisen during the incident and how these could be improved, particularly in relation to the use of satellite communications. The Board was also pleased to note that there were good mechanisms available for staff to provide feedback on the support received following incidents through Trauma Risk Management (TRiM) peer support mechanism and clinical psychology support.

The Board thanked Jenni and Jon for their presentation and for sharing her personal experiences and welcomed the support mechanisms that were available to staff within the organisation.

The Board **noted** the staff story.

014/25 **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 March and April 2025 in which the Governors participated.

The recruitment process for the appointment of two new Non-Executive Directors and two new Associate Non-Executive Directors was noted. Two vacant NED champion roles had now been filled by Julian Duxfield as Wellbeing Guardian and Claudia Paoloni as Maternity Board Safety Champion, with the latter being on an interim basis until the new NEDs were on board.

The Board noted that following the development of the Group model, work had commenced to standardise committee structures with common reporting at Joint Committee level. It was noted that it was proposed to disband the Mental Health Governance Committee and incorporate its remit into the Quality & Safety Committee (QSC). The governance and membership of the Mental Health Operational Group had also been strengthened with quarterly reports to be received by QSC and would be aligned with the other two trusts.

The Board noted the Register of Interests of the Board of Directors as at 31 March 2025 and the Board members were reminded of their obligation to register any relevant and material interests as soon as they arise, together with the requirement to declare interests at meetings.

Minute	Description	Action

It was also noted that the Fit & Proper Person Test 2024/25 had been completed and that evidence confirmed that all serving members of the Board were fit and proper. The requirements for the annual assessment had therefore been fully satisfied and that an overall summary would be submitted to the regional NHSE team confirming compliance with the framework by 30 June 2025.

The summary of Board Safety Visits from October to December 2024 was noted and that the feedback from the board safety visits continued to remain positive and that triangulation was enabling conversation in other key areas around patient engagement and safety.

Cara Charles-Barks, Chief Executive also made reference to the need to strengthen the collective voice at board level across the Group from a mental health perspective and Luisa Goddard, Chief Nurse agreed to review how mental health representation could be improved as a Group.
Action: Chief Nurse

The Board **noted** the report.

RESOLUTION:

The Board

- ***approves the proposal to disband the Mental Health Governance Committee and note that the remit will be incorporated into the Quality & Safety Committee; and***
- ***approves the Board of Directors' Register of Interests as at 31 March 2025 for submission onto the Trust's website.***

015/25 **Chief Executive's Report**

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

Laying the Foundations for Reform
The government's 10 Year Health Plan 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. The three strategic shifts related to moving care from hospital to community, sickness to prevention, and analogue to digital. Amongst the changes to reduce the cost of the current operating model of the NHS were the changes around Integrated Care Boards and how this will look in the future in terms of serving the health needs of the population.

Group Development
The Board noted that following a recruitment process for the three Managing Director roles, substantive appointments had now been made. In April, Jonathan Hinchliffe had started as Interim Group Chief Transformation & Innovation Officer and that digital reports would be received by Boards going forwards. A transitional support partner, Teneo, had also been appointed to support the Group with its set-up, design and implementation over the next 18 months.

Group Engine Room
Work had commenced with the Improving Together team to establish a Group Engine Room to align teams and help shape the approach.

Current operational pressures
It was noted that the overall waiting list for the Great Western Hospital had decreased over recent months and now stood at around 36,000 patients. The number of patients waiting

Minute	Description	Action

more than 52 weeks had fallen to 950 patients but still remained much higher than wished for. Challenges remained with the number of patients in the hospital with no criteria to reside (NCTR), along with high bed occupancy, and that actions were being taken with partners to tackle the wide issues which contributed towards this, including addressing long ambulance waits. Jon Westbrook, Interim Managing Director outlined the ongoing focus by operational teams to address the NCTR challenges being faced by the Trust and to drive improvement.

A&E Survey
An engagement programme launched by the Integrated Care Board, working with Healthwatch and this Trust, had commenced to better understand why people attend emergency departments rather than other health settings to access care.

Care Quality Commission inspections
The Care Quality Commission (CQC) had carried out unannounced inspections of our surgical wards and the Emergency Department, Children's Emergency Unit and Urgent Treatment Centre (UTC) during March and April 2025. The formal outcome of both inspections was still awaited but as per the surgery visit the CQC were very complimentary of the way the staff were responding to operational pressures and continued to welcome the CQC team.

Finance
The Trust ended the financial year with a £1.4m surplus to our planned deficit which was a credit to all our teams but still represented a deficit position for the organisation and that work continued to bring the Trust to a balanced financial position. This was particularly the case as this year's position was in part achieved through one-off measures that cannot be repeated next year. It was noted that savings of around £18.5m had been achieved last year, less than our £21.9m target but £4m more than the previous year. Around 49% of the savings we delivered were the kind which can recur each year. This year more than £32m in savings would need to be found from across the Trust, and work was underway to identify where money could be saved.

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

Shared Electronic Patient Record
It was noted that during July there was to be a series of events taking place at the Trust to demonstrate the first stage of the build of the new Shared Electronic Patient Record system to date.

Our behaviours
Let's Talk Behaviours, a staff engagement exercise to co-create a set of behaviours to support our STAR values had been launched within the organisation as part of the work to be a vision and values-led organisation.

The Board **noted** the report.

016/25 **BSW Hospitals Group Partnership Agreement and Joint Committee Terms of Reference**

The Board received and considered an updated Partnership Agreement and Terms of Reference for the Joint Committee. These had been developed by a working party of nominated non-executive and executive directors from the Group and supported by legal advisors Browne Jacobson.

Minute	Description	Action

It was noted that the document had been reviewed in private Boards in April and that the following updates had been made:

- Provision for attendance of deputies has been included, in the event of absence of a member.
- The binding nature of decisions of the Joint Committee in relation to Joint Functions is clarified.
- 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.
- 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.
- The cycle of business for the Joint Committee will include a review after six months of operation.

Liam Coleman, Chair explained that discussions had also included the equal number of Executive Directors from each Trust present at the Joint Committee to cover the key components of activity. The contribution and time commitment of the Non-Executive Directors was also discussed and Liam Coleman requested that feedback by the NEDs be provided to him on their views on additional availability for the Joint Committee.

Cara Charles-Barks, Chief Executive outlined the agenda for the first meeting of the Joint Committee on 23 May 2025 which included the development of the Group strategy and integration with local strategies, Group transformation and benefits realisation utilising Improving Together methodology, Group mobilisation and development, financial sustainability and recovery plan, Corporate Services Programme, and Digital update. There would also be a need to aggregate how data would be reported from each Trust in the future and that metrics were being developed to support this.

RESOLVED:

The Board

- ***approves the BSW Hospitals Group Partnership Agreement, agreeing the five Joint Functions and Terms of Reference of a special purpose Joint Committee';***
- ***approves the execution of the Partnership Agreement;***
- ***approves that the Chair and Chief Executive nominate members of the Joint Committee; and***
- ***approves the establishment of the BSW Hospitals Group Joint Committee in May 2025.***

017/25 **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 March 2025.

Board Assurance Reports

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meetings on 26 March 2025 and 23 April 2025 the following was highlighted:

- Referral to Treatment (RTT) figures continued to reduce but was still off target for the year to date.

Minute	Description	Action

- Ambulance handovers had decreased to 83 hours compared to 92 hours. Although this was an improvement for a second month, it was noted that this was the sixth consecutive month the target maximum average of 70 hours had not been met. However, this evidenced that improvement measures which had been introduced had now started to show results.
- NCTR continued to remain high with an increase in the number of long stay patients. Cara Charles-Barks, Chief Executive added that pressure was being put on the system to reduce demand and increased access to out of hospital care to help drive improvement and support our financial plans.
- Cancer diagnosis performance continued to show an improved position, however issues remained with the under-delivery of the Plastics Service provided at GWH via a SLA with Oxford remained a significant risk.
- Diagnostics performance remained strong and work continued to drive this improvement.

The Board **noted** the report.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (QSC) at its meetings on 20 March 2025 and 17 April 2025 and the following was highlighted:

- Two errors were highlighted within the April report to the Board which related to overall reductions in harm (159 in January) and that there was an uptick in January and February with increased cases in pressure harms.
- The complaint response rate had continued to improve with increased focus by divisions using A3 Improving Together methodology to drive improvement.
- Good assurance continues to be evidenced from Learning from Deaths reports, with improved engagement with structured judgement reviews and clear actions and outcomes from learning.
- Good progress continues to be made within the Trust through collaborative working with system partners, the introduction of quarterly Divisional GIRFT reports, creation of benchmarking reports with shared learning and project management of historical and current review findings.
- The new Electronic Discharge System went live in March 2025 which was welcomed by the Committee.

Liam Coleman, Chair reflected on the quality and availability of care information provided to patients. In response, Luisa Goddard, Chief Nurse explained that the distribution of patient information leaflets were audited, such as falls, but agreed to review the standard of information provided and how evidence of its distribution to patients could be captured to provide evidence of quality assurance.

Action: Chief Nurse

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 29 April 2025 and the following was highlighted:

- Good progress continued to be made on the development of apprenticeships, however actions were being taken to close the gap in terms of the levy spend versus the actual level being.

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- The annual report on education and training demonstrated progress against the recommendations within the 2024 review. Work was underway to ensure that all outstanding recommendations would be achieved but it was recognised that this would take time to embed.
- The final report of the 12-month People Promise Retention project was received which would implement a range of policies and initiatives to help deliver improved retention.
- A review of the national job evaluation scheme profiles for the Nursing and Midwifery bands 4-6 had been undertaken which had shown there was an annual cost risk to the Trust of approximately £10m and this was to be monitored.
- Difficulties associated with the delivery of workforce recovery targets and current processes to manage headcount did not appear to be delivering the reductions required with temporary staffing usage and that this would continue to be monitored by the committee.
- The Trust Staff Survey results had demonstrated minimal movement when compared to last year's results. The Trust had the highest response rate (71%) of any acute and community trust nationally. The committee was to receive further updates from each division during the year to monitor progress.

The Board **noted** the report.

Use of Resources

Finance, Infrastructure & Digital Committee Chair Overview

The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meetings on 24 March 2025 and 28 April 2025 and the following was highlighted:

- The BSW finance position as at Month 12 was a breakeven position. This position was after the recognition of the pro rata share of £30m deficit funding and additional funding received in Month 11. The financial risk for the system continues to escalate and remained high, with the outlook for 2025/26 forecasted as challenging, notwithstanding the actions agreed at the System Financial Recovery Board.

The Board reflected on the financial challenges ahead for the system to meet targets and actions to be taken to avoid an enforcement action. Cara Charles-Barks stressed the need to create engagement and innovation around transformation to build a sustainable model going forward and to shift a deficit model conversation. The Board acknowledged that the 2024/25 improvement plan was achieved ahead of plan with the costs saving plan being spread throughout the year.

The Board **noted** the report.

018/25 **Mental Health Governance Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Mental Health Governance Committee (MHGC) at its meeting on 25 April 2025 and highlighted the following:

- It was noted that this committee was to be disbanded following the meeting held in April 2025. The Board acknowledged the considerable work of the committee and oversight of mental health governance and safety responsibilities for the organisation together with improved partnership working.
- The Board approved the draft Use of the MHA 2024/25 Annual Report which detailed used of the Mental Health Act during 2024/25.

The Board **noted** the report.

Minute	Description	Action

RESOLVED:

The Board approves the Use of the MHA 2024/25 Annual Report.

019/25 **Trust-wide Quarterly Learning from Deaths Report Q4**

The Board received and considered the quarterly report on Learning from Deaths for the Trust.

Steve Haig, Acting Chief Medical Officer reported that that the SHMI data for the period October 2023 to September 2024 had remained within the expected range. The HSMR data for the period August 2023 to July 2024 was statistically higher than expected although continued to follow a downward trajectory. There was a continued higher volume of super spells and observed deaths with a diagnosis of R69 (uncoded activity). Data could not be fully interpreted due to lags in data, however internal data monitoring continued and was reviewed alongside Telstra Health reports. However, the Board noted that a decision had been made to cancel the Telstra Health contract as it did not add value to data analysis and that data could be gained from other available sources.

It was noted that structured judgement review (SJR) completion remained below average for Q4 and less than 2023/24. A new trial of "sifting process" to identify the most appropriate way of reviewing deaths was underway. Divisions continued to be supported with the completion of SJRs and a structured mortality review programme was to receive oversight and monitoring by the Trust Mortality Group.

It was noted that a coding/clinical review had been undertaken in relation to Pneumonia & Aspiration Pneumonia and that themes had been identified across the BSW system for further system-wide learning and action. Reviews had also been undertaken in relation to Hip Fracture and Inpatients Falls and that no further action was required from the mortality team at present but both would continue to be monitored.

Steve Haig, Acting Chief Medical Officer reflected on Learning from Deaths Board Workshop in April 2025 which provided insight and learning to the Board members.

The Board **noted** the report.

020/25 **Emergency Preparedness, Resilience & Response Annual Assurance Report**

The Board received and considered the Emergency Preparedness, Resilience and Response (EPRR) Assurance Report 2023 which outlined the continued progress of the EPRR agenda and assurance on Trust compliance with the EPRR core standards following completion of the annual assurance process.

It was noted that the Trust had been assessed as substantially compliant. Two areas that were reported as partially compliant related to the requirement to further develop business impact analysis to improve robustness, and the need to improve business continuity plans to address gaps and improve resilience.

Benny Goodman, Chief Operating Officer provided an overview of the Trust's activity to comply with the standards and priority areas for improvement in 2025/26 whilst embedding learning from the Trust's incident response processes.

The Board **noted** the report.

021/25 **Trust Staff Survey Results 2024**

Angela Morris, Senior People Partner joined the meeting for this item.

Minute	Description	Action

The Board received a report on the results of the National Staff Survey 2024. The Trust achieved a response rate 71% (4,228 colleagues), being the highest staff survey response across NHS England.

It was noted that the majority of the Trust People Promise scores in 2024 survey were in line with sector scores. The scores for *'We work flexibly'* were significantly better than similar organisations. The scores for compassionate culture and advocacy are significantly worse. The majority of the People Promise scores for 2024 Bank staff within the Trust were significantly better than the substantive Trust scores. The scores for *'We are safe and healthy'*, compassionate culture, diversity and equality were significantly better than the substantive scores. The scores for development and line management were significantly worse.

At question level, 7 scores were in the top 20% range of similar organisations and questions included 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 related to level of pay, unrealistic time pressures, and reporting physical violence at work.

An analysis of the free text comment themes provided by staff had also been undertaken and that this predominantly related to patient care and safety, and teamwork largely linked to respect. Any identified themes were to be shared with the divisions. Julian Duxfield, Non-Executive Director encouraged the Board members to further review the free text comments which provided a rich collection of views behind the survey questions, as board safety visits do not always provide such valuable insight.

It was also noted that the Trust had implemented significant change management programmes during 2024 including a new IFD and bed reconfiguration moves. These changes and the loss of community contract did not appear to negatively influence 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")*. It was particularly highlighted that the survey results from the staff going through the community services transfer was largely positive and this was a credit to the leadership of the Integrated Care & Community Division.

The questions which related to BME and Disability were noted and an overview of the work to be undertaken to drive improvement was provided.

Claudia Paoloni, Non-Executive Director commented on the negative experience result which related to staff coming into work despite not feeling well enough to perform duties and added that presenteeism could be evidenced to be more of a problem than actual sickness absenteeism because the associated loss of performance was 30% in those individuals that were attending work. Jude Gray, Chief People Officer responded that the Trust's Absence Management (Sickness) Policy had been updated and relaunched which included a section on presenteeism and that this practice was not promoted within the organisation as acceptable.

The Board **noted** the report.

022/25 **Perinatal Services 6 month summary (Q3 & Q4)**

Lisa Marshall, Director of Midwifery & Neonatal Services, and Kat Simpson, Head of Midwifery & Neonatal Services joined the meeting to present this item.

The Board received and considered the six-month update on perinatal services which provided 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. The review also

Minute	Description	Action

demonstrated the commitment to strengthen perinatal care through improved staffing, addressing health inequalities, and fostering a positive culture within the Trust's workforce.

An overview of the key highlights from the presentation was received which related to:

- Workforce and training and improved staffing, with significant progress made to address staffing gaps and support team resilience.
- Preceptorship programme supported by NHSE funding to positively impact retention of both staff locally and to the profession.
- GWH is the host trust across the BSW LMNS for the NHSE maternity support worker competency, education and career development to enable delivery of confident and capable care.
- Thematic analysis continued of all patient safety events using the Patient Safety Incident Review Framework (PSIRF) methodology to support learning and identify improvement opportunities.
- The BadgerNET maternity digital record had been successfully implemented in January 2025. An in depth review of the rollout was to be undertaken with lessons learnt to be shared within the system.
- Since January 2025, the service had successfully supported a 24-hour triage service. The service had facilitated a smooth transition with dynamic assessment of workload and overnight staffing models to sustain care, with escalation policies to support the ongoing flow of women through the service.
- Continued improvements in sustainability of location for community services.
- Following significant progress against the identified CQC Must Do and Should Do recommendations, focus was now to be shifted to sustained preparation for an anticipated revisit and subsequent evaluation.
- Compliance with the Ockenden immediate and essential actions remained a key priority and a total of seven actions were upgraded from amber to green following an in depth review undertaken in Q4. Further assurance was provided on ongoing improvement actions to move to full compliance.

The Board **noted** the report.

023/25 **Delegation of authority for approval of Annual Accounts 2024/25**

The Board was requested to delegate authority to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts 2024/25 in order to meet the deadline of 30 June 2025.

RESOLUTION:

The Board approves the delegation of authority to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts 2024/25 before the deadline of 30 June 2025.

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.

024/25 **Ratification of Decisions made via Board Circular**

None.

025/25 **Annual Self Certification – CoS7**

Minute	Description	Action

The Board received a self-certification for Board approval prior to publication. The self-certifications was:

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

RESOLUTION:

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

026/25 **Urgent Public Business (if any)**
Liam Coleman, Chair acknowledged that this was the last meeting for Claire Thompson, Chief Officer of Improvement & Partnerships before she leaves the Trust on 6 June 2025 to join an NHS organisation based in Wales and thanked Claire in terms of her contribution to the board, leadership around the community services contract, and for her health vision that spans across the wider health sector and stakeholders in respect of health inequalities.

027/25 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 10 July 2025 at 9.30am at the DoubleTree by Hilton Hotel, Swindon.

028/25 **Exclusion of the Public and Press**
The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.

The meeting finished at 13.00hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – July 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**
8 May 2025	014/25	**Chair's Report** Collective voice to be strengthened and improved at board level across the Group from a mental health perspective.	Chief Nurse	For consideration as the trust moves into a Group model. CNOs / ICB CNO meet with AWP CNO to improve collaborative working.
8 May 2025	017/25	**Quality & Safety Committee Board Assurance Report** Patient information leaflets to be reviewed to determine the quality of information distributed to patients and how evidence of distribution can be captured to provide evidence of quality assurance.	Chief Nurse	For Q&SC

Future Actions				
None				

Report Title	**Care Reflection**				
Meeting	**Trust Board**				
Date	**10/07/2025**	**Part 1 - Public**	✓	**Part 2 - Private**	☐
Accountable Lead	Luisa Goddard, Chief Nurse				
Report Author	Tania Currie, Head of Patient Experience and Engagement				
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:

The Care Reflection highlights areas for improvement in care, staff awareness and training. The staff leading this work provide information about ongoing projects to ensure we learn from this experience of care.

Report

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

This Care Reflection tells the story of Danny and is shared by his mum Maria. Danny had a Learning Disability (LD) and attended hospital on many occasions. Sadly, Danny died following cardiac surgery at Bristol hospital in 2023. During his many admissions his mum found that staff did not understand Dannys specific needs, in particular how best to communicate with him and how to support his anxieties and keep him occupied and relaxed. In response and in memory of Danny, Maria has set up a charity to provide distraction and support resources to support adults with Learning Disabilities. Maria shares her personal experience and explains the impact on Danny, his care and eventual outcome whilst sharing how care could be improved and suggesting ways in which staff can adapt their practice to support this.

Jade, one of our Learning Disability Nurses, shares examples of improvement work that is ongoing across the trust to increase staff awareness and ensure standards of care are raised for patients with LD and their families.

The film can be viewed here: https://youtu.be/JwBeDkj0Ywo

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	The learning from this care reflection will be shared widely via the departmental and divisional governance structures and more widely across the trust as part of staff training. The video will be available on the trust intranet and used as part of staff training, reflection and at various meetings.	

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:

Initiatives described in the report impact on some people more favourably in order to address the inequality they would otherwise experience.
The report identifies a number of workstreams and initiatives that are specifically aimed at ensuring we hear, involve, and understand feedback from people with Learning Disabilities and Autism. These include:
Engagement and involvement with LD groups across our local communities to identify where there may be inequalities in access to and feedback about, our services.
Implementation and promotion of services to support unpaid carers.

Recommendation / Action Required

The Board/Committee/Group is requested to:

To receive the presentation to note the patient and family experience along with the developments and improvements identified from this Care Reflection.

Accountable Lead Signature	Luisa Goddard.
Date	**23/06/2025**

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**10/07/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Liam Coleman, 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:

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
- Annual Report & Account 2024/25

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 to note the updates.

Accountable Lead Signature	Liam Coleman, Chair
Date	**23/06/2025**

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.

1. Council of Governors

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

June 2025		
Date	**Event**	**Purpose**
2 May	Briefing meeting on the BSW Hospitals Group Joint Committee	Governor briefing on BSW Hospitals Group Joint Committee proposals
2 May	Briefing meeting of Chair/Lead Governor/Company Secretary	Regular meeting to update and discuss any topical issues
20 May	Engagement & Membership Working Group	To advise and support the Trust in increasing membership and improving membership engagement.
21 May	Business & Planning Working Group	To identify key issues to address in relation to Trust finances and business planning.
21 May	Public Health Talk	The Teenage Years - a compassionate approach to understanding and supporting young people through adolescence.

5 Jun	Governor Focus Conference 2025	Govern Well National NHS governor event
6 Jun	Nomination and Remuneration Committee	To agree job description and remuneration for joint chair and vice chair roles.
9 Jun	Learning from Death's Quarterly meeting	Governor representative attendance at meeting
9 Jun	People's Experience & Quality Working Group	To identify key issues in relation to service users and staff experience and the quality of the work of the Trust.
10 Jun	Governor In-house Finance Training	Finance training ran by Johanna Bogle, Deputy CFO
17 Jun	Briefing meeting of Chair/Lead Governor/Company Secretary	Regular meeting to update and discuss any topical issues
	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 Staff Survey and CQC visits, and approved the job description and terms of conditions of the Joint Chair (GWH/RUH).
23 Jun	Informal Governor meeting	Governors met with Will Smart, NED

2. Non-Executive Directors

2.1 The recruitment process for 2 new NEDs and 2 new ANEDs continues with interviews taking place 9th July 2025 (NEDs) and 7th August 2025 (ANEDs).

3. Strengthening Board Oversight & Development

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

Date	Area	Board Member
20 May 2025	Maternity Triage	Claire Thompson, Chief Officer of Improvement & Partnerships Julian Duxfield, Non-Executive Director
11 June 2025	Neptune	Simon Wade, Chief Financial Officer Julian Duxfield, Non-Executive Director
23 June 2025	Linnet	Jude Gray, Chief People Officer Will Smart, Non-Executive Director

4. Trust Chair Key Meetings during May & June 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

Meeting	Purpose
NEDs' Meeting	Monthly meeting
Finance, Infrastructure & Digital Committee	To attend as an observer
Performance, Population & Place Committee	To attend as an observer
Audit, Risk & Assurance Committee	To sign off annual report & accounts
GWH Council of Governors	To chair meeting
RUH Bath Council of Governors	To chair meeting
Chairs & Group CEO Meeting	Network meeting
BSW Chairs' meeting	Regular meeting
BSW EPR Joint Committee	System meeting
BSW Hospitals Group Joint Committee	To chair system meeting
BSW All Board Seminar	System meeting
RUH Bath Non-Executive Directors	System meeting
ICB & Acutes – Next Steps Forward	System meeting
Meeting with Regional Director NHSE SW	System meeting re Acute Model
Chairs' Forum	National meeting
Longlisting and shortlisting for Non-Executive Directors at GWH	To review applications
Meetings with Non-Executive Director candidates	To discuss NED roles with candidates

5. Annual Reports & Accounts 2024/25

5.1 This is to confirm that the Annual Report & Accounts 2024/25 were approved by the Audit, Risk & Assurance Committee on 24 June 2025 as delegated by the Board and subsequently submitted to NHSE on 27 June 2025 ahead of the 30 June deadline. The next stage is for it to be laid to Parliament (after summer recess) before it can be published and presented at the Annual Members Meeting. A copy of the submitted report can be obtained from the Company Secretary (for Board members only).

Report Title	**CEO report**				
Meeting	**Trust Board**				
Date	**10/07/2025**	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 ☐
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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 updates
2. BSW Hospitals Group development
3. Operational position at Great Western Hospital
4. Quality improvements
5. Systems and strategy updates including the shared Electronic Patient Record, our values and behaviours, and financial position

6. Workforce, wellbeing and recognition, including the finalists in our Staff Excellence Awards, and the relaunch of our Never OK campaign

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 highlights the Trust being selected alongside Avon and Wiltshire Mental Health Partnership NHS Trust as one of 12 new partnerships across the country to help improve care for people who arrive at the Emergency Department (ED) while in an episode of crisis. Around 15 per cent of people who attend our ED have an existing mental health condition, or experience mental health crisis.

The report details the finalists for our Staff Excellence Awards, one of the categories of which is championing health equalities.

The report highlights the launch of a refreshed Never OK campaign. Many of the reported incidents in 2024-25 relate to abuse related to the protected characteristics.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	**02/07/2025**

1. National/system

1.1 Urgent and Emergency Care Plan 2025/26

The Urgent and Emergency Care Plan 2025/26 was published on 6 June 2025 and outlines how patients will receive better, faster and more appropriate emergency care as the Government sets out reforms to shorten waiting times and tackle persistently failing Trusts.

The new package of investment and reforms will improve patients' experiences this year, including caring for more patients in the community, rather than in hospital which is often worse for patients and more expensive for taxpayers.

Backed with a total of nearly £450 million, the Urgent and Emergency Care Plan 2025-2026 will deliver:

- around 40 new same day emergency care and urgent treatment centres - which treat and discharge patients in the same day, avoiding unnecessary admissions to hospital;
- up to 15 mental health crisis assessment centres to provide care in the right place for patients and avoid them waiting in A&E for hours for care, which is not the most appropriate setting for people who are experiencing a crisis. These centres will offer people timely access to specialist support and ensure they are directed to the right care;
- almost 500 new ambulances will also be rolled out across the country by March 2026.

The plan's emphasis will be on shifting more patient care into more appropriate care settings as part of the move from hospital to community under the government's Plan for Change to rebuild the NHS, while tackling ambulance handover delays and corridor care.

Further information on the Urgent and Emergency Care Plan 2025/26 can be found via https://www.england.nhs.uk/publication/urgent-and-emergency-care-plan-2025-26/

1.2 National Maternity Investigation Launched to Drive Improvements

On 23 June 2025 the Health and Social Care Secretary announced that there will be a rapid national investigation into NHS maternity and neonatal services. It is believed that the investigation will have two phases, the first will investigate up to 10 maternity and neonatal services, NHS England has yet to confirm which trusts will be involved. The second phase will undertake a system-wide review of maternity and neonatal care, bringing together lessons learned from past inquiries to create one clear plan; the terms of reference for this review are being developed by NHSE.

An overview of the current Maternity and Neonatal services across the Trust is shown below:

The Trust was rated as Requires Improvement for Maternity care by the Care Quality Commission in March 2024, highlighting triage, level 3 safeguarding training and staffing levels. The Trust is fully complaint with year 6 against the Clinical Negligence Scheme for Trusts and 94% compliant for Saving Babies' Lives Care Bundle.

A new Director of Midwifery is in post following retirement of the existing post holder, and a new Head of Midwifery is starting in July.

1.3 NHS Oversight Framework 2025/26

The new NHS Oversight Framework 2025/26 was published on 26 June 2025 and describes a consistent and transparent approach to assessing Integrated Care Boards (ICBs) and NHS Trusts and Foundation Trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

It has been developed with the engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations.

This one-year framework sets out how NHS England will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping us identify quickly where organisations need support.

Further information about the NHS Oversight Framework 2025/26 can be found via: https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/

2. Group Development

2.1 Group Electronic Patient Records (EPR) Programme Senior Responsible Officer (SRO)

The Board is formally asked to note the transfer of the SRO for the Group EPR from the interim Managing Director at the RUH to the interim Chief Transformation and Innovation Officer with effect from 28 May 2025. This change will optimise the programme leadership and governance approach to mitigate the risks associated with the EPR Programme. Thanks go to the RUH interim Managing Director for providing SRO support up to the transfer.

Updates on the EPR Programme will be provided to the Board on a regular basis.

2.2 Leadership Team – Confirmation of Managing Director Appointments

In May we confirmed the appointment of three new substantive Managing Directors across BSW Hospitals Group, each bringing a wealth of experience in leadership and a strong track record of delivering high-quality, patient-centred services. As Managing Directors, they will be responsible for the overall operational leadership of our hospitals. They will work closely with each other, their Boards and senior leadership team, and together as part of our Group leadership. The appointments are:

- Great Western Hospitals NHS Foundation Trust - Lisa Thomas. Lisa joins from Salisbury NHS Foundation Trust where she is currently the Interim Managing Director.
- Royal United Hospitals Bath NHS Foundation Trust - John Palmer. John joins from Royal Devon University Healthcare NHS Foundation Trust where he is the Chief Operating Officer.

- Salisbury NHS Foundation Trust - Nick Johnson. Nick joins from a joint role with Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust where he is Joint Chief Strategy, Transformation and Partnerships Officer and Deputy Chief Executive at Dorset County Hospital.

2.3 Interim Chair & Vice Chair Appointments

In May and June, the Trusts also held successful appointment processes for an interim Joint Chair for RUH & GWH (Liam Coleman), an interim Chair in SFT (Eiri Jones) and Vice Chairs in GWH (Faried Chopdat) and RUH (Sumita Hutchison). In coming weeks, the Councils of Governors, company secretaries and governance leads will support the establishment of a joint Nominations Committee to coordinate recruitment of a substantive Joint Chair by April 2026.

2.4 Partnership Agreement and Joint Committee Establishment

In May, Trust Boards approved our BSW Hospitals Group Partnership Agreement, including Joint Committee Terms of Reference. The Partnership Agreement was executed on 22 May, and on 23 May, Salisbury NHS Foundation Trust hosted the inaugural BSW Hospitals Group Joint Committee meeting. A full committee report to Boards from the Group Joint Committee will be issued with minutes in the fourth week of July.

The next Joint Committee meeting will be held on 16 July in Swindon and will focus on discussion and approval of the proposed Group Operating Model and Leadership Model. A new Group Integrated Performance Report (IPR) will be shared and detailed corporate services model plans will be introduced for priority services – Finance, People, Digital, Estates & Facilities and Capital Planning - plus Corporate Governance and Communications.

2.5 Board to Board Development

On 4 June the RUH hosted the latest of our Board-to-Board development days. Discussion generated a series of areas for focused work – including on potential Target Operating Model and development of our Governance and Accountability Framework. A report on proposed next steps is included in July Board papers. Further Board-to-Board sessions are planned in October and next February.

2.6 Operating Model/Leadership Structures/Corporate Services

Work to establish our new operating model has continued in May and June, supported by colleagues from Teneo. Corporate services will be an important element of the new operating model. A comprehensive joined-up corporate services programme is now in place. A Project Director funded by NHS England has recently joined, and a Steering Group has been established to oversee the programme.

2.7 Group Engine Room

In June, Improving Together Leads confirmed plans with the Managing Directors to establish a Group Engine Room meeting monthly from July, to help us align teams across the Group around our biggest problems and priority programmes.

2.8 Mutually Agreed Resignation Scheme (MARS) across GWH, RUH, and SFT

Following agreement in the Joint Committee on 23 May, BSW Hospitals Group introduced a MARS scheme. MARS enables our Trusts to support staff to leave their organisation on a voluntary basis and support Trust corporate service savings. The scheme ran between 2 and 20 June 2025. An update on the take-up rate and impact of the MARS scheme will be shared in August.

Great Western Hospitals NHS Foundation Trust update

3. Operational update

3.1 Latest operational position

In May we delivered 99 per cent of the elective and outpatient operational activity we planned to, which is equal to 105 per cent of our 2019/20 activity and 92 per cent of our 2024/25 activity.

Our overall waiting list continues to fall and now stands at 37,476. We remain focused on reducing the amount of time patients are waiting for treatment.

The number of patients staying in hospital for 21 days or longer remains a challenge, as does the number of patients who are in hospital without a clinical need to be there.

We continue to work closely with our partners to tackle the underlying issues that cause patients to stay longer than needed.

3.2 Mental health transformation

We have been selected alongside Avon and Wiltshire Mental Health Partnership NHS Trust as one of 12 new partnerships across the country to help improve care for people who arrive at the Emergency Department (ED) while in an episode of crisis.

Around 15 per cent of people who attend our ED have an existing mental health condition, or experience mental health crisis.

Admissions for mental health conditions in under 18s across Bath and North East Somerset, Swindon and Wiltshire, as well as admissions for those who intentionally self-harm, are also consistently higher than the national average.

Many of these patients have complex physical, mental health and social care needs, which require a multi-disciplinary approach to care, to ensure their needs are met.

The new partnership will look at improving the overall patient experience, as well as the waiting time for assessments, referrals or further community-based care.

Collaborative improvement will be delivered by NHS Confederation in partnership with NHS England's Mental Health Improvement Support Team.

The programme seeks to strengthen and encourage cross system working by supporting practical, real-time testing of improvement ideas.

4. Quality

4.1 Patient Safety Award

Our Medicines Safety Specialist Susanne Pidduck has been short-listed for a Health Service Journal Patient Safety Award.

This is great recognition for work Susanne undertook on a quality improvement project to explore change in the process for intravenous medicines, using human factors principles. The winner of the award will be announced at a ceremony in September.

4.2 Recognition for Pad Project

The Pad Project, a Trust improvement initiative, has been showcased in the Nursing Times.

Focused on reducing the inappropriate use of continence pads on hospital wards, the Pad Project is proving to have a big impact on the comfort, safety, and recovery of patients, while saving the Trust thousands of pounds each year and reducing environmental damage.

It was introduced to Woodpecker, Jupiter, and Saturn wards as part of an initial audit in 2023, resulting in a 50 per cent increase in patients with the correct pads and a 20 per cent increase in the number of patients wearing only one pad on one of the wards. Previously, patients were found to be wearing multiple pads, rather than a single pad of the correct type. There was also a reduction in moisture-associated skin damage.

The Pad Project is encouraging wards to review their stock to ensure they have an appropriate variety of continence options and to use underwear when the patient is continent.

Alongside improving the safety and quality of care for patients, the Pad Project is a great example of how we can achieve financial savings at the same time, with a £1,500 decrease in spending across the three wards in one quarter, and a projected annual saving of more than £6,000 across the same area for 12 months.

There is also a positive environmental impact through the reduction in waste.

5. Systems and strategy

5.1 Shared Electronic Patient Record

Implementing a new Shared Electronic Patient (EPR) across our Trust, along with the Royal United Hospital and Salisbury NHS Foundation Trust is a top priority for the BSW Hospitals Group.

This is a highly complex piece of work, and this month we were able to demonstrate the initial version of the EPR to staff, to help them understand how the system will work across clinical areas and gain their feedback.

These sessions will enable us to better understand how the many benefits of an EPR will be realised, ahead of further work taking place on the system.

5.2 Way Forward Programme building award

Our new Integrated Front Door was a winner at the Swindon Building Control Local Awards 2025.

The project team attended the ceremony to receive the 'Best non-residential extension or alteration' award.

The award is recognition of the work to build and successfully open the doors on the new Emergency Department, Children's Emergency Unit and Medical Assessment Unit – which became operational in the autumn and was officially opened by Her Majesty The Queen in January.

5.3 Sustainability

We marked the national Great Big Green Week locally at Great Western Hospital with a number of activities, events and talks for staff to get involved with.

The week involved bike MOTs, sustainability conferences, educational talks and electric car demonstrations to encourage staff, patients and the wider community to go green.

We have also now welcomed 25 new staff Sustainability Champions to our network, meaning we currently have more than 130 champions to support teams with sustainable initiatives in the workplace.

5.4 Our values and behaviours

We have been running an engagement exercise as part of our work to agree with our teams the kind of behaviours we expect from one another while at work.

Staff made more than 4,000 contributions to help shape what our behaviours should be as part of this process.

The engagement exercise follows the launch of our new strategic direction, and aims to create one simple set of behaviours to support our STAR values.

We have refined the proposed behaviours based on the feedback we have received and tested these with members of our Trust Management Committee and our staff networks. The new set of behaviours will be launched later in the year.

5.5 Finance

Across the BSW Hospitals Group we have a deficit of £16.7m. For our Trust, our deficit position is £5.6m.

Key to delivering our plan for the year is achieving our efficiency savings target of £32.4m. After month two of the current financial year (May), we have delivered £1.8m which is a shortfall of £3.6m on where we should be at this point in the year.

We have put in place several financial controls including tightened expenditure controls, enhanced scrutiny of recruitment and agency use, stricter sign-off procedures for non-essential spending, and robust divisional accountability frameworks.

6. Workforce, wellbeing and recognition

6.1 Staff Excellence Awards

Our annual Staff Excellence Awards ceremony will take place on Friday 18 July. Congratulations to everyone who has been nominated.
The finalists are as follows:

Team of the Year:
- Dove Unit and Brighter Futures
- Access Team
- Integrated Front Door Project Team
- Children's Unit

Leader of the Year:
- Anjana Jalaja
- Jennifer Kear
- Lucie Edwards
- Satinder Mann

Improving Patient Experience:
- Jade Pearce
- Kathyrn Rix
- Suprita Dewan
- Susan Ellingham

Patient Choice:
- Caroline Critchley
- Helen Good
- Tim Maughan and Charlotte Perry-Bennett
- Sandra Greenwood

Hero: Beyond the Call of Duty:
- Katherine Tydeman
- Sarah Churchill
- Sharon Northwood
- Susan Knowlton-Bush

Improving Together:
- Angela Morris
- Holly Andrews and Eleanor Tindall
- Mark Bryant and Gary Crisp
- Sharon Lay

Sustainability:
- Charlotte Goode
- Kiera Kolasinski
- Endoscopy team
- Green ED team

Star of the Year:
- Antenatal Day Assessment Unit

- Kim Johns and Shannon Henson
- Luis Pedro
- Rosie Howell

Lifetime Achievement:
- Alison Culley
- Anthony McCluskey
- Kash Aujla
- Sharon Keene

Championing Health Equalities:
- Jennifer Woods
- Katherine Appelby
- Kelly Whitworth
- Lisa Daniel

GWH Rising Star:
- Emma Barnes
- Febbie Nyakwawa
- Oluwaseun Adedeji
- Sarah Coxon

6.2 Never OK campaign

Last month we launched a refreshed campaign to stop the abuse of our staff – Never OK.

This campaign seeks to reduce verbal, physical and sexual abuse towards staff.

In 2024/25, there were 383 reported incidents of abuse against staff, including physical, verbal, racial abuse and sexual harassment, but we know there are many more incidents that have gone unreported.

Wiltshire Police joined members of the health and safety team on site visiting wards and departments to hand out new resources and speak to staff about the campaign.

6.3 Mutually Agreed Resignation Scheme

Last month we launched a Mutually Agreed Resignation Scheme across BSW Hospitals Group.

The scheme is a form of voluntary severance, designed to enable employees, in agreement with their employer, to choose to leave their employment voluntarily in return for a severance payment. It should not be confused with voluntary or compulsory redundancy.

This scheme will help us to look at how we can transform our services and reduce the number of employees needed to run those services.

The applications submitted will be taken forward with those staff who made them.

6.4 Non-fiction award

Rachel Clarke, specialty doctor in palliative care, won the national 2025 Women's Prize for Non-Fiction, with her book 'The Story of a Heart'. The story explores the human experience behind organ donation.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**10/07/2025**	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	Use of Resources: • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

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 May (April for Cancer) are as follows:

STRATEGIC Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

May's performance shows the total number of patients waiting over 52 weeks at 764, a 6.3% reduction from the 816 reported in the previous month. The current 52 week PTL stands at 2.04% of the overall wait list size against the target of 1% for March 2026.

The overall RTT PTL continues to reduce and overall RTT performance within 18 weeks was 59.56%, increase by 1.77% percentage points from the previous month. Patients waiting over 65 weeks at the end of May were 31, with five patients over 78 weeks (all with next steps in place).

Overall good progress continues on reducing the RTT waiting list size but there remain challenges in eliminating long waits over 65 week waits in the Planned Care and Surgery Division. These issues are concentrated in Plastics, T&O (Foot and Ankle surgery) and within Urology and General Surgery where outpatient capacity remains a constraint and where risks remain in relation to requirement for surgery. Recovery planning remains in place to eliminate 65 week waits by the end of June.

- 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 at 80.4%.

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.

62-day performance for urgent suspected cancer referral to treatment was slightly below operating plan at 70.9% in April. Tumour site trajectories are most challenged within Urology, Colorectal and Plastics.

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. Further discussions on alternative outsourcing options are taking place in May and BSW Hospitals Group is also assessing mutual aid capacity for the future.

Cancer 31-day performance was at 93.2% in April. Outsourcing, waiting list initiatives and tumour site pathway reviews continue as part of improvement work to deliver the 96% standard.

- Time in Emergency Department

4-hour performance (type 1 and 3) improved from 69.6 to 70.3%. This is 7.7% below the 25/26 national target. The reduction in performance relates to type 1 performance reducing and impacting our overall position, with some fluctuation to Type 3.

The number of ambulances conveyed during April-May remained consistent at 1485. May saw a mild elevation in the number of daily hours lost from 86 to 88., however arrival to triage within 15 minutes has significantly improved to 87.4% supporting rapid assessment and safety checks of patients. Overall patient attendances continue to be higher than in Q4 at around 5000.

The total attendance mean time wait for a patient in May 2025 was 162 minutes against the national standard of 240 minutes. This has remained consistent from 163 mins in April. Staffing and acuity challenges have led to periods with longer LOS, sometimes with 4hrs wait TBS although discharge has then been prompt.

An average of 86 hours lost per day was reported for ambulance handover delays during May. This is an increase of 10 minutes on April and 64 minutes outlying from the target 33 minutes on June trajectory. However, May was a month of 2 halves weeks 1 & 2 impacted by poor performance across May bank holiday (Mean 2:02:21) vs week 3&4 (mean 00:56:03). This performance improvement corresponds directly to the implemented remedial action plans during May, and the removal of 11 winter escalation beds from the bed base. . Early indications for June is that UEC maintain and improve on week 3&4 performance working towards achieving June trajectory target for ambulance handovers.

The UEC and Flow transformation plans short term plans have been implemented during May, with additional pilot's run to access benefits of proposed medium term and strategic improvement plans within the IFD and wider Hospital bed base. 2 IFD Streaming Hub pilot days were delivered and highlighted learning has been added to the action plans for continuous improvement. Improvements are all focused on delivering <33 mins ambulance handovers and >70% 4-hour performance.

A leadership exchange has also been scheduled with South West Ambulance Service and GWH Clinical and Operational Leads to share best practice on clinical pathways with a view to making significant recovery towards the 33 min handover trajectory in June. Additionally, NHS@Home clinical leadership has been working closely with GWH. Clinical specialty leads to increased awareness and understanding of clinical capabilities across the region to support early discharge.

- Proportion of Outpatient First Appointment Pathways Waiting <18 Weeks

The number of non-admitted (Outpatient) pathways waiting for a first appointment under 18 weeks has increased. Performance in May was 66% against the minimum 67% target in the operating plan. Since the November baseline collection, performance has consistently improved each month. With this continued progress, it is anticipated that the 67% target will be achieved by the end of the first quarter.

In January, the "Improving Together" methodology helped identify the largest specialty opportunities across the trust by volume, including Paediatrics, ENT, Gynaecology, Pain, Neurology, Urology, and Respiratory. The SPC chart highlights that the formation of a multi-specialty working group, comprising these specialty leads and meeting fortnightly, has

generated effective countermeasures supporting the breakthrough objectives and improved performance.

The group has identified three key areas for prioritizing process interventions:

- Straight-to-test pathways
- Booking in date order (simplifying triaged pathways)
- Clinic room prioritization

These sub-groups have been supported by a mandate from the Chief Operating Officer, ensuring that specialty operational leads prioritize capacity to facilitate the booking of all new patient pathways exceeding 40 weeks.

ALERTING WATCH METRICS

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

Diagnostics – May validated DM01 performance was 85.0%, improving slightly from 84.8% in April.

Changes to DM01 reporting guidance came into place from 1st April 2025 with the inclusion of additional waiting list types for Audiology contributing towards an expected reduction from that date. CT has recovered in May as expected but there has been a slight deterioration in NOUS. Performance in May remains just above the operating plan trajectory overall (84.9%).

Temporary Escalation Spaces (TES) – The use of TES reduced in May with the closure of 11 spaces in Dorcan. Accelerated discharge planning with partners has contributed to this effort, and the objective to avoid all medical outliers and close the discharge lounge at night is a priority for June. This remains dependent upon progress of actions to reduce the no criteria to reside wait list on the back door, especially for Pathway 1 patients in Wiltshire and Pathway 2 patients in Swindon.

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.

The number of harms has increased in May to 146 compared to 136 in April.

The number of falls in month has remained unchanged at 104 in May. The number of falls with moderate harm or above has increased to two in month.

The number of healthcare-associated infections have remained stable, with a decrease in Klebsiella and Pseudomonas matched by rises elsewhere, most significantly in C.Difficile.

Breakthrough Objectives
The Breakthrough Objective for 2025/26 has changed from reducing harm associated with pressure ulcers to reducing harm from inpatient falls.

Aim for 2025/26

- Reduce inpatient Falls by 10% each year over a 3-year programme
- Reduce inpatient falls resulting in moderate harm by 10% each year
- Reduce inpatient falls resulting in severe harm by 10% each year

The numbers of patients who experienced falls that resulted in moderate harm or above has increased to two in month. The number of patients with two or more falls has increased to twelve in month, compared to nine in April.

Alerting Watch Metrics

The number of complaints received in month has increased to 71 in month, compared to 44 in April. The number of complaints re-opened has also increased slightly to five (four in April).

Non-alerting Watch Metrics
The Emergency Department and Urgent Treatment Centra positive response rate has increased to 79.9% and is just above the internal target of 79.6%.

C.*difficile* numbers has risen by four in month to nine, putting the Trust over trajectory. Four of the nine patient had received chemotherapy. A look back has identified the same peak in trend for May 2023. A similar rise has been noted at the Royal United Hospital Bath, although the reasons are unclear.

The overall Family and Friends positive response rate for April is 82.8% a decrease from last month and likely impacted by the data issue with the providers.

Methicillin-Sensitive Staphylococcus Aureus (MSSA) numbers have increased in month to three compared to two April. Not all cases for May have been fully reviewed as they occurred at the end of the month. Despite this cannula care continues to be an area of focus as part of the A3 work in the Division of Medicine and Surgery & Planned Care.

There continues to be zero Methicillin-resistant Staphylococcus aureus (MRSA) cases reported in month. The numbers of *E. coli* infections has decreased to seven, compared to ten in April.

The number of hospital-acquired pressure ulcers has increased in month to 13, compared to six in April. The 13 harms affected ten patients. The majority were category two harms, but there were four category three harms and one category four harm.

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

- Safer staffing fill rates remain above the National target of 85%.
- Three Patient Safety Incident Investigation have been declared in May.

Our People

This section of the report outlines workforce performance in alignment with the pillars of the Trust's *People Strategy*: Workforce Planning, Opportunity, Employee Experience,

Development, and Leadership. Each pillar is evaluated through a combination of Key Performance Indicator (KPI) achievement scores and self-assessment ratings based on monthly progress.

The Trust's overarching strategic goal is:
"Staff and volunteers feel valued and involved in improving the quality of patient care."

To monitor progress against this goal, performance is assessed using the following key metrics:

- **Staff Survey – Recommend as a Place to Work**
  Target: 63%
  2024 Staff Survey score: **59.6%** (no change from the previous year)
  Q1 pulse survey: **54.7%** (improvement compared to Q4)
- **Staff Sickness Absence**
  Target: 3.5%
  April 2025 figure: **4.1%**, (improvement from previous month 4.5%)
- **Equality, Diversity & Inclusion (EDI) – Disparity in Experience**
  Target: 9.4%
  2024 Staff Survey: **11.9%** (improvement from previous year 12.7% last year)
  Q1 pulse survey: **5.0%**, (improvement of 12.1% from Q4 however due to smaller response within BME staff)

Breakthrough Objectives

Following a comprehensive review of the 2024 Staff Survey results, a key area of opportunity has been identified to further our strategic aim of improving staff experience and engagement. The Trust's A3 has been updated accordingly, with 'Teamwork' recognised as a critical lever for driving performance against our Pillar Metric: *'Recommending as a place to work'*. As a result, the breakthrough objective for 2024/25 will continue to focus on Staff Survey question 7C: *"I receive the respect I deserve from my colleagues at work."* This will be the second consecutive year targeting this question, to ensure continued and sustained improvement in this area.

Q1 Pulse Survey Highlights
"Receive respect" Target 75%
Slight decline of 0.5% in overall Trust score. The Unregistered Nursing group continues to impact results, scoring 54.4%, down from 64.3% in the 2024 survey.

Vacancy Rate
In May the vacancy rate is 215WTE (4.29%) which is the same as previous month. There is still work on rationalising the establishment against ledger due to budget setting and tupe.

Bank Spend
Banks spend in June was £2.18M this is a reduction from last month of £300k.

Agency Spend
The Trust agency spend is £0.64M, which is an increase of £40k.

Workforce Recovery
In May, workforce usage was 5,201WTE, slightly under the plan of 5,208WTE, delivering a favourable variance of -7WTE.

To remain on track a further 47 WTE reduction in temporary staffing is required in June. This must be driven by reduction of bank and agency use. The required reduction for month 3 is 41 WTE from Bank and 6 WTE from Agency, making immediate action essential.

Based on the current temporary staffing run rates for Nursing and Medical this month;

- **Nursing**: Current run rate is 102 WTE; the target is 93 WTE.
- **Medical**: Current run rate is 60 WTE; the target is 40 WTE.

Achieving this will require a strong and collective focus on bank usage and control throughout the month.

Use of Resources

For M02 2025/26 the Trust has an adjusted deficit position of £5.6m, which represents a £5.6m adverse variance to plan.

Income is £1.5m behind plan, the key driver being the removal of the Trust's deficit funding of £1.6m as a result of being overspent. It should be noted that if the Trust were receiving the deficit funding, the variance to plan would reduce to £4.1m, reflecting the tangible gap the Trust needs to bridge. ERF income associated with scenario 2a is £0.2m favourable to plan, offset by a £0.1m underperformance against private patients.

The pay position is £2.7m adverse to plan. Undelivered CIP accounts for £1.9m, with ongoing use of temporary staffing, particularly in front door areas, driving the remainder. Work will focus on reducing temporary staffing spend, particularly in areas where substantive staffing is near or at full establishment levels, noting that enhanced care and escalation costs remain high, up 41% from M02 24/25.

Non-pay is £1.5m adverse to plan. While passthrough drug costs offset with income, there is an underlying £0.2m pressure due to an overperformance on ICB related drugs, resulting in lower transitional funding. The non-pay undelivered CIP target is £1.3m with the remaining £0.1m spread across other non-pay lines. Non-pay savings will focus on areas where run rate is trending upwards, along with broader grip and control measures such as stock control on the wards and reducing discretionary spend. Lower-level approval limits are being reviewed with the aim of allowing requisition authorisation at senior manager levels only, while initial meetings between materials management and Finance have taken place to roll out stock labelling in clinical areas. These will be reported on and measured as a breakthrough objective for 2025/26.

Key to breaking even with plan in 2025/26 is delivery against the efficiency savings target of £32.4m. At M02 the Trust has delivered £1.8m against a target of £5.4m, giving a shortfall of £3.6m. Divisions and services must focus on finding recurrent schemes to reduce the deficit position. It should be noted that £20.0m of the total £32.4m target relates to pay savings, and in parallel with reducing temporary staffing spend the Trust must also reduce substantive headcount by 135 WTE, of which 104 WTE is expected to be in Corporate and admin roles.

Breakthrough Objectives

The financial breakthrough objective for 25/26 is to improve the non-pay run rate, in order to contribute towards the delivery of the £32.4m efficiency savings programme.

As at M02 the Trust is £5.6m overspent against budget. The key driver of this is an underperformance of £3.5m against the efficiency savings programme, delivering £1.8m year-to-date against a target of £5.3m. Of the £1.8m delivered, 72% was recurrent. Our underlying position remains challenging and the objective for all divisions and specialties is to find recurrent saving schemes.

For non-pay, the immediate focus is to implement Trustwide controls to help stabilise and reduce run rate. Key measures being implemented are:

1. Review of P2P approvers – removing authorisation for staff to approve requisitions <£10k
2. Freeze/restrict use of codes relation to discretionary spend eg. Stationery
3. Stock labelling – including posters in ward/clinical areas highlighting produce usage, associated cost and lower cost alternatives
4. Wastage bins – placed in ward areas so Materials Management team can more accurately quantify stock expiry and wastage levels

Task & finish groups including Finance, Procurement and Specialty leads are continuing for Theatres (SPC) and Cardiology (Medicine). The plan is to roll these out for further specialties with higher trending run rate as the year progresses.

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	PPPC & Trust Board
Next Steps	

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	✓	☐	☐
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	**03/07/2025**

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

June 2025

May 2025 & April 2025 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

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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	13-17
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Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Target/Thres.	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Percentage of RTT patients treated within 18 weeks		52.4%	52.5%	51.5%	51.4%	52.1%	53.1%	54.2%	54.8%	56.9%	58.0%	57.8%	59.6%
Percentage of RTT patients waiting over one year		4.5%	4.5%	4.8%	4.5%	3.9%	4.1%	3.5%	3.2%	3.1%	2.5%	2.2%	2.0%
Estimated time it would take to clear the waiting list if no new patients were added		26.9	28.9	29.1	28.1	25.4	23.7	24.1	24.3	23.5	22.5	21.7	32.5
Percentage of patients treated for cancer within 62 days of referral	85% (Nat)	69.4%	68.1%	70.3%	70.8%	78.1%	70.4%	73.4%	75.3%	72.7%	82.1%	70.8%	Reported one month behind
Percentage of Emergency Attendances within Four Hours	95% (Nat)	74.8%	77.2%	79.4%	77.2%	72.6%	74.0%	72.1%	73.4%	72.3%	69.9%	69.5%	70.1%
Percentage of Emergency Attendances over Twelve Hours	2% (Nat)	7.1%	5.1%	2.8%	3.8%	5.8%	7.3%	7.9%	10.1%	8.9%	8.3%	9.0%	8.5%
Planned surplus/deficit		1766	-1339	-1033	-801	-200	-683	-610	-482	74	690	-2149	-3525
Rate of productivity		-15%	-17%	-15%	-13%	-11%	-14%	-15%	-14%	-13%	-14%	-11%	Waiting for data
Readmission rate		15.1%	14.7%	16.0%	14.8%	13.7%	14.0%	14.5%	15.0%	14.6%	15.4%	15.3%	16.0%
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
Average number of days between planned and actual discharge date		2.4	4.9	2.5	2.0	1.9	2.2	2.4	2.3	2.7	2.7	2.6	2.4
Percentage of inpatients referred to stop smoking services		11.2%	11.4%	13.0%	12.5%	12.2%	12.5%	12.5%	11.3%	10.0%	11.1%	11.5%	11.9%
Percentage of people waiting over six weeks for a diagnostic procedure or test	99% (Nat)	71%	71%	76%	80%	88%	89%	85%	86%	88%	91%	85%	Reported one month behind
CQC safe inspection score		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Rates of MRSA		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.5	Two month behind	Two month behind
Rates of C-Difficile		41.1	23.6	11.8	48.8	55.5	17.2	38.8	22.2	24.6	27.7	Two month behind	Two month behind
Rates of E-Coli		58.7	59.1	29.5	42.7	55.5	40.1	33.3	16.6	43.0	33.3	Two month behind	Two month behind
Number of Emergency Attendances over Twelve Hours, with a Chief Complaint OR Diagnosis = Mental Health		72	51	31	40	49	89	71	95	86	89	88	77
Percentage of NHS Trust staff to leave in the last 12 months	14.8% (Int)	11.0%	9.6%	11.0%	10.6%	11.0%	9.7%	9.9%	9.0%	10.4%	10.9%	10.3%	One month behind
Sickness absence rate	3.5% (Int)	4.6%	5.2%	4.5%	4.3%	4.9%	4.9%	4.9%	5.1%	4.9%	4.5%	4.1%	Reported one month behind
Percentage of Emergency Attendances with Discharge Destination of Admit to Inpatient Ward, and Age > 65		8.5%	8.6%	9.9%	9.5%	9.1%	9.1%	9.7%	10.0%	9.5%	8.9%	9.3%	9.5%
Percentage of Emergency Attendances with Discharge Destination of Admit to Inpatient Ward, and Age < 18		2.8%	2.7%	2.2%	2.7%	2.8%	2.9%	2.4%	2.7%	2.7%	2.8%	2.0%	2.7%
Rate of annual growth in under 18s elective activity		12.4%	17.8%	17.9%	20.0%	23.3%	32.6%	31.5%	31.9%	30.9%	27.7%	16.4%	11.8%

Key Indicators

Great Western Hospitals NHS Foundation Trust

The below metrics are also included in the 25/26 SOF Measures. However, publication of the final guidance documentation for the 2025/26 NHS Oversight Metrics is required to clarify the definitions to ensure aligned reporting with the National Metrics.

Metrics
CQC inpatient survey satisfaction rate
NHS staff survey engagement theme score
Staff survey safety culture score

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 2025/26 continues to focus on improvement work to reduce harm from inpatient falls.

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

Trust Overall Complaint Response Rate
For 2025/26 this is a new pillar metric replacing the Friends and Family Test for the Patient Experience metric.

The Trust's objective is to maintain a consistent Trust-wide complaint response rate of 80% and upwards.

This metric reflects the Trust's commitment to learning from patient feedback and ensuring timely, high-quality responses to concerns raised.

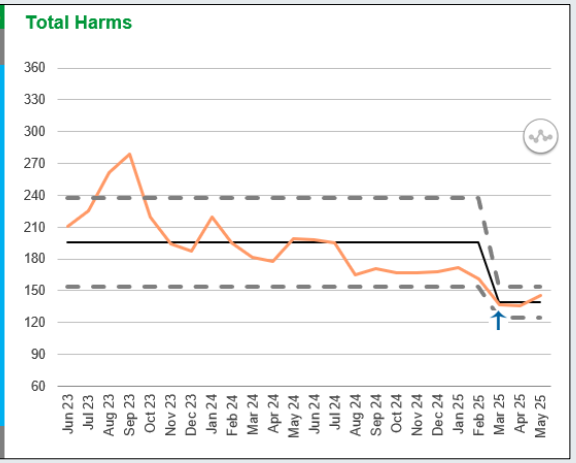
The monthly performance figure is based on the percentage of complaints responded to within the agreed timeframe, which begins at 25 (working) days and can be extended to 40 days and then a final 60 days.

Complaints response rate is tracked each month against timescale.

Total Harms

To achieve and sustain zero avoidable harm.

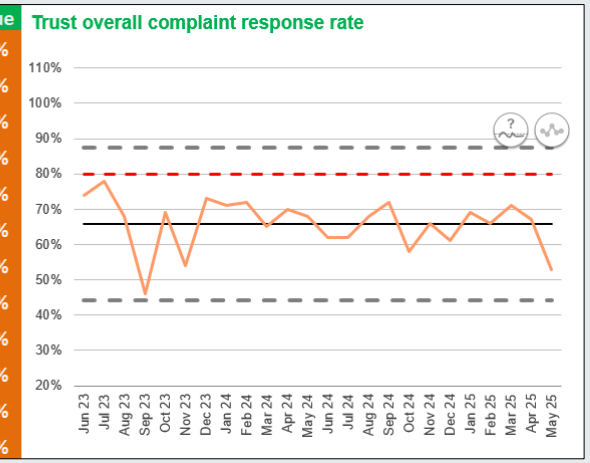
Timescale	Value
Jun 24	198
Jul 24	195
Aug 24	165
Sep 24	171
Oct 24	167
Nov 24	167
Dec 24	168
Jan 25	172
Feb 25	161
Mar 25	137
Apr 25	136
May 25	146



Trust Overall Complaint Response Rate

To achieve consistent Trust overall complaint response rate of 80%.

Timescale	Value
Jun 24	62%
Jul 24	62%
Aug 24	68%
Sep 24	72%
Oct 24	58%
Nov 24	66%
Dec 24	61%
Jan 25	69%
Feb 25	66%
Mar 25	71%
Apr 25	67%
May 25	53%



Counter Measures

The total number of harms has increased slightly for May, 146 compared to 136 in April.

There was a slight rise in the number of healthcare-associated infections, largely driven by an increase in *C. diff* cases which outweighed reductions seen in other infections. There were 10 hospital acquired Pressure Ulcers this month, with a slight increase in the level of harm seen.

The number of falls has remained the same in May as April, 104. There has been two falls with moderate harm or above in month.

The Trust's complaint response rate for May was 53%, reflecting a decrease from April's rate of 67%.
At a divisional level, performance was as follows:
Surgery and Planned Care: 65%, Family and Specialist Services: 40%, Division of Medicine: 58%. A total of 57 complaints were closed with 30 completed within the expected timeframe.
The presence of a backlog of overdue cases will take time to resolve and only timely responses to newly received complaints can impact the monitored Key Performance Indicators (KPI).
A3 complaints improvement work:

- Weekly Complaint Clinic sessions - dedicated time for Investigating Managers to seek support and advice.
- July Complaint Writing sessions scheduled
- Enhanced monitoring and reporting on extension requests has begun

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 April, there were 48.0 breaches in total, with 65% 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 (41% 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 March Plastics was responsible for 16% of breaches, without these performance would have been 75.1%

RTT: Number of patients waiting over 52 weeks

RTT performance increased by 1.77% in May delivering 59.56% compared to 57.9% in April. (The interim target for March 2026 is 60%). The total number of patients waiting over 52 weeks in May was 764, with a reduction of 52 from the previous month.

There were 31 patients reported at 65 weeks at the end of May. 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.

There were 5 x 78-week breaches reported in May 2025 including 2 Plastics (incorrect clock stop, plastic capacity); 1 General Surgery patient with a complex diagnostic pathway, 1 x ENT (continuation of care, late transfer to ENT) and 1 x Dermatology (late return from CHEC) Next steps and plans are in place for the ENT, Dermatology and General Surgery patients. An alternative provider was also sought for the Plastics patient.

A level of risk remains for June across a few specialties including Plastics, Corneal Grafts, Foot & Ankle surgery and the potential conversion risk in Urology and General Surgery.

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

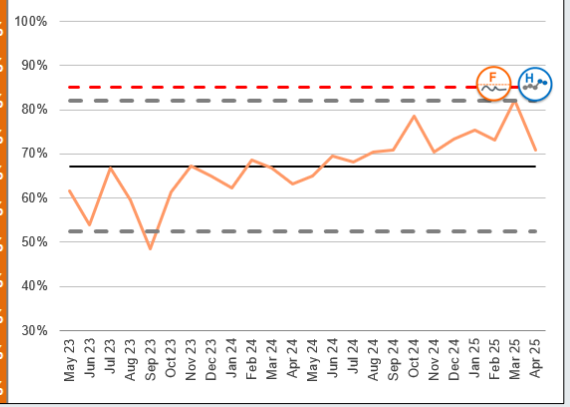
Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

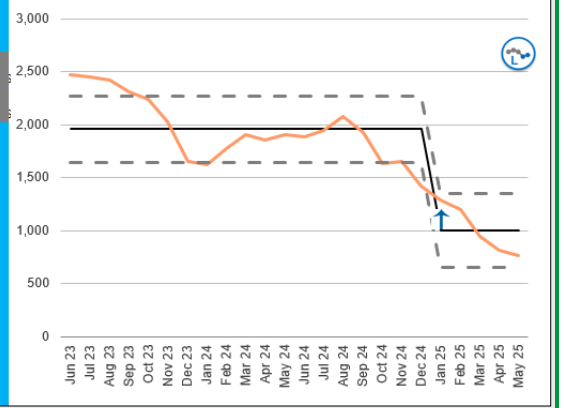
Timescale	Value
May 24	65.1%
Jun 24	69.4%
Jul 24	68.1%
Aug 24	70.3%
Sep 24	70.8%
Oct 24	78.5%
Nov 24	70.4%
Dec 24	73.4%
Jan 25	75.3%
Feb 25	73.1%
Mar 25	82.1%
Apr 25	70.9%



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
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
Apr 25	816
May 25	764



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. Recruitment of radiology clinical team over summer 25 will improve reporting turn-around times
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 can be 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 May 2025 was 433 minutes against the national standard of 240 minutes. Mean LOS has been impacted by increased delays for admitted Majors Trolley patients, with high numbers in 'Chairs' Area.

May continues to present high attendance rates across front door areas , with noted increase in patients attending with high acuity and complex care needs. Proactive decisions on escalation bed space within the ward base supported improved flow which enabled GWH to maintain its position but did not enable the expected improvements, additional focus on alternative to admission pathways are part of the ongoing counter measures.

Emergency Care – Urgent Treatment Centre - Mean Stay

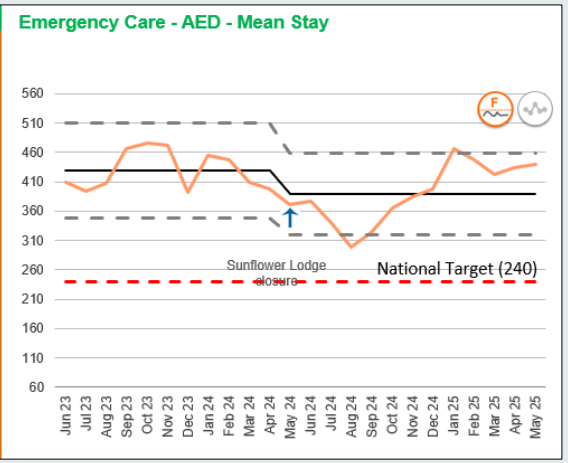
The total attendance mean time wait for a patient in May 2025 was 162 minutes against the national standard of 240 minutes. This has remained consistent from 163 mins in April. Staffing and acuity challenges have led to periods with longer LOS, sometimes with 4hrs wait TBS although discharge has then been prompt.

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.

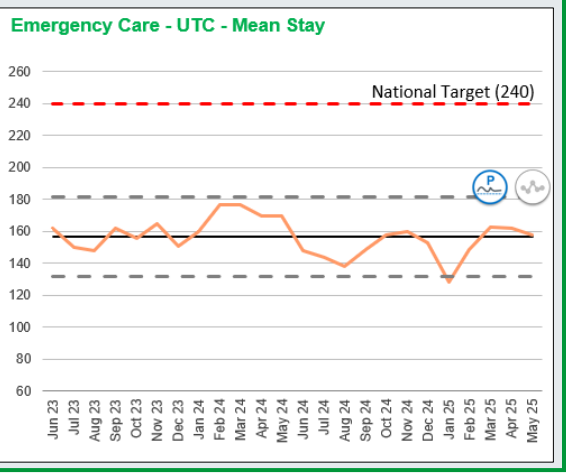
Timescale	Value
Jun 24	377
Jul 24	340
Aug 24	299
Sep 24	324
Oct 24	365
Nov 24	384
Dec 24	397
Jan 25	467
Feb 25	447
Mar 25	423
Apr 25	433
May 25	440



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
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
Apr 25	162
May 25	158



Counter Measures

- Full review of Medical & ACP model completed; increased staffing approved
  - Recruitment strategy for ED Registrar vacancy - ongoing
- Joint approach to IFD 'management' and daily operational oversight – IFD Silver & huddles.
- Rapid Assessment Area process revision – minimise delays and onward movement.
- Process change for patient management in 'Chairs' - identify quick discharges and re-reviews of patients with results -
  - Maximize early discharge for non-admitted cohort
- Review 'Internal Professional Standards' - Early transfer to Specialty Wards
- "Streaming Hub" Trials – Early intervention front door assessment
- Review/increase alternate capacity
- Review of UTC shift supportive Senior Lead role
- Recruiting into newly budgeted Medical & Practitioner roles
- ICB support to reduce attendances to UTC - increased community clinic places - Pharmacy 1st, Paediatric Acute Respiratory Hubs.
- Full utilisation of MAU/SDEC pathways
- Drive to maintain early review / maintain UTC 95% performance

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

ED Attendance as a Percentage of Population by Deprivation Quintile

We are developing a this as a new measure for the 2025/26 Strategic Planning Framework. We want to understand whether our population's level of deprivation effects the use of emergency services. The metric shows that there is a difference in the percentage of the population who utilise ED/UTC that correlates with deprivation quintile. The populations in the most deprived quintile nationally (group 1) access ED/UTC slightly more frequently than less deprived populations (groups 2-5); this difference has remained consistent throughout the last year.

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 104 patients per day occupying the bed base. 21 days LoS decreased significantly to 9.81 patients on average within the Trust for May.

May was inclusive of two 'May Bed Blitz' days to focus on Back Door Flow and ED Streaming to focus on the Front Door. **LoS reviews twice weekly to commenced in April system wide and continues**

NCTR breakdown/performance:

PW0's - 83% leaving on day 0 – remained the same as last month

PW1's – 24% leaving on day 1 – decrease on Aprill. . **Home first 114 which is decrease of 8% on last month.**

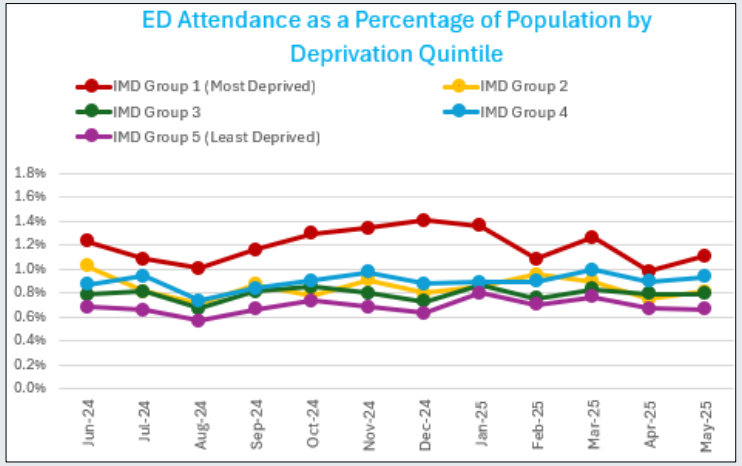
PW2's – 42% leaving on day 2 - this is a significant decrease. There is continued improvement needed with community providers and processes

PW3's – 36% discharged on day 3 – this is an increase of **4%** on last month's performance. PW3's have been a real success in low numbers going through CTH as no long term decision is being made in the acute setting.

Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

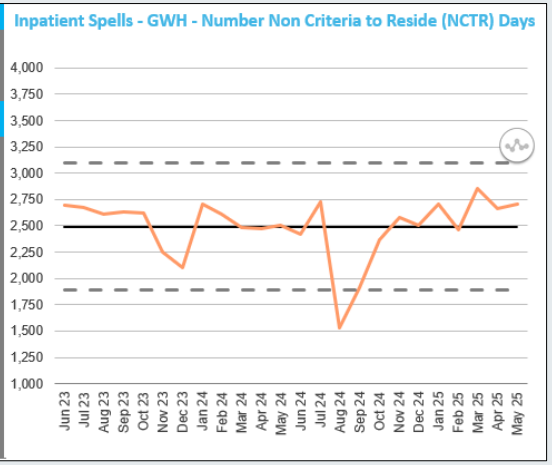
Emergency Care – Emergency Department & Urgent Treatment Centre - Emergency Attendances



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
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
Apr 25	2,663
May 25	2,710



Counter Measures

We are seeking to understand the impact deprivation may have on our population's access to emergency services in order that we can work with people to provide alternative and earlier access to care where appropriate. We are in the early stages of understanding how deprivation might affect access to care. We will seek to identify a single measure that we can track overtime to assess whether inequality of access is reducing.

Current work including linking to the Swindon locality urgent & emergency care plan and to review outputs of the ICB BIG A&E survey. We are also looking to breakdown the data further so that we can understand reasons for different patterns of access to urgent care. We will seek to do this with our partners across Swindon Integrated Care Alliance and in partnership with people in the most effected populations.

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 meetings with Out of Area providers remain in place.
- Trajectories for NCTR to commence June reporting into System
- 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 Discharge Lounge being used in escalation for overnight beds May continued use. Targeted improvement planned for May.
- Pre-empting discharges 24 hours in advance & preparing TTAs in advance – 15:30 calls introduced mid-March to close partner actions and plan for tomorrow's discharges. This is to further progress to an integrated NCTR for all areas to be launched start of June.
- Process mapping of Admission to DRD – DRD to CTH underway.

Reflections:

- Applying improving together methodology to change initiatives.
- Workforce planning to improve alignment of Acute Medical clinical Workforce to demand.
- Reverse Boarding has been enacted to support decompression of ambulance queue and ED internal queues – site/divisional understanding to be respond to risk in delayed access to urgent care.

Executive Summary

NHS Great Western Hospitals NHS Foundation Trust

Sickness Absence (rate)

The Trust's ambition is to create a healthy, supportive, and inclusive work environment where staff feel empowered to manage their wellbeing, are supported through periods of illness, and are encouraged to return to work safely.

Nationally there has been an increase to staff sickness since 2020, with an average rise of 0.8%, and we have seen a similar increase to our absence rates within GWH.

Sickness absence has a high impact on staff morale and engagement, whilst also impacting on our overall workforce levels; increasing the levels of high-cost temporary staffing within services.

Our target for sickness absence is 3.5%, and performance in March 2025 was 4.1%.

Staff Recommendation as a Place to Work

The Trust recommend a place to work target is 63% which is 2% higher than National Average for 2023 staff survey results (61%).

In 2023 and 2024 the Trust achieved 60% performance.

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.

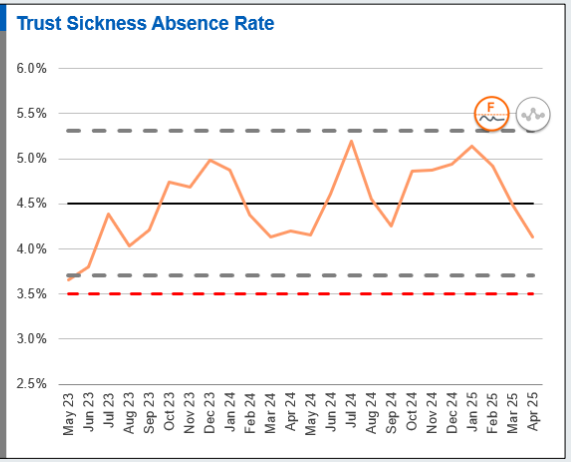
Whilst a small decline was seen in this metric throughout the year, the 2024 Annual Staff Survey results show a sustained result at 59.6%. In Q4 this declined to in Q4 to 51.7% but has increased in Q1 55%

Jude Gray
Director of Human Resources (HR)

Trust sickness absence rate

To achieve and maintain a maximum Trust sickness absence rate of 3.5%.

Timescale	Value
May 24	4.2%
Jun 24	4.6%
Jul 24	5.2%
Aug 24	4.5%
Sep 24	4.3%
Oct 24	4.9%
Nov 24	4.9%
Dec 24	4.9%
Jan 25	5.1%
Feb 25	4.9%
Mar 25	4.5%
Apr 25	4.1%



Staff % recommend the organisation as a place to work

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

Counter Measures

- In-month sickness absence for April decreased further to 4.1% (compared to 4.5% in March). Short-term absence was 2.0% and long-term absence was 2.1%.
- Intensive support focussed in hotspot areas for sickness absence continues, with the People Operations team working in departments with managers to improve department level short-term sickness rates. Departmental actions are being recorded on a central work plan with updates, escalations, and shared learning being discussed at the monthly Improving Attendance working group.
- Stress/Anxiety/Depression remains the most prevalent reason for absence in April. Training in response to this for May continued, with 11 staff being trained in Mental Health First Aid, 5 in Suicide First Aid, and 6 managers in Mental Health Skills for managers.
- Q1 Pulse Survey results showed an improvement to the number of staff who would recommend the organisation as a place to work, increasing to 54.7% (51.8% in Q4). The next update will be following the Q2 survey which launches in July.
- 635 staff shared 5,200 contributions to the 'Lets Talk Behaviours' big conversation on-line platform. Summary and findings will be presented to TMC on 10th June.
- In May, we delivered a range of wellbeing initiatives including wellbeing boxes, free staff breakfasts from Kellogs, a Schwartz Round, and multiple mental health training sessions, all aimed at supporting staff connection and emotional resilience. In June, we are launching creative and financial wellbeing sessions, reflexology appointments, and a bespoke session for senior medical staff to further enhance staff experience and engagement.

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.

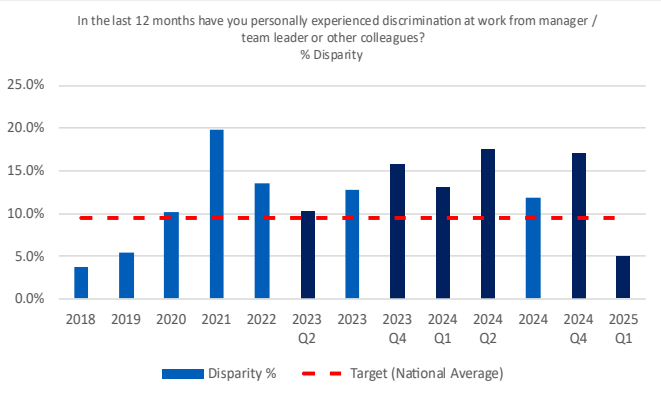
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

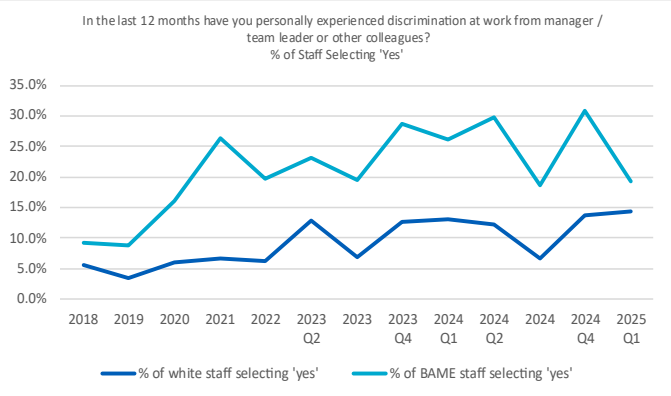
The Trust ambition is to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

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)

% 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 immersive training pilot will come to an end on the 30 June. 180 staff have registered to use the A.I. driven training platform (plus IHISC members), approximately 38% were BME. However, there were only 28 active users, with 110 sessions attended – equating to 2897 training minutes. Top modules attended are 'Public Speaking and Presentation Skills', 'Understanding Conflict' and 'Active Listening'. Before and after surveys indicate significant improvements including 'Staying calm, focussed and in control' increasing from 15% to 67%; 'listening demonstrably and with full attention' from 42% to 80%; 'summarising key points of the message' from 42% to 80%. Other workshops attended included Navigating angry conversations, Talented teamwork and Employability: 2 strategies for answering any questions. The training has the potential to help improve the Trust's WRES and WDES metrics for bullying and harassment, discrimination and equal opportunities if targeted. A full report will be presented to IHISC who will consider the future of this or similar programmes.
- The mentoring programme, hosted on the Guider platform, continues to grow slowly, with 31 mentors (32% BME, 3% LGB, 26% disabled) and 22 mentees (68% BME, 18% disabled) registered, and there are 12 active relationships and 68 goals created. To date there have been 420 mentoring minutes and the most sought-after skills are career direction, leadership, performance management and difficult conversations. A speed mentoring session will take place 23 June to promote the opportunity and enable staff to meet a potential mentor.
- The Trust is developing a Guide to addressing racist incidents and an accompanying workshop in response to 2024 staff survey and NETs survey data. The guide will be launched in July 2025 and will help staff to respond to racism from staff and patients. In addition, engagement is planned for June and early July to understand staffs' experience of bullying, harassment and abuse from patients, which includes the Safe to Speak survey: Bullying, harassment and abuse from patients and visitors.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

For M02 2025/26 the Trust has an adjusted deficit position of £5.6m, which represents a £5.6m adverse variance to plan.

Income is £1.5m behind plan, the key driver being the removal of the Trust's deficit funding of £1.6m as a result of being overspent. It should be noted that if the Trust were receiving the deficit funding, the variance to plan would reduce to £4.1m, reflecting the tangible gap the Trust needs to bridge. ERF income associated with scenario 2a is £0.2m favourable to plan, offset by a £0.1m underperformance against private patients.

The pay position is £2.7m adverse to plan. Undelivered CIP accounts for £1.9m, with ongoing use of temporary staffing, particularly in front door areas, driving the remainder. Work will focus on reducing temporary staffing spend, particularly in areas where substantive staffing is near or at full establishment levels, noting that enhanced care and escalation costs remain high, up 41% from M02 24/25.

Non-pay is £1.4m adverse to plan. While passthrough drug costs offset with income, there is an underlying £0.2m pressure due to an overperformance on ICB related drugs, resulting in lower transitional funding. The non-pay undelivered CIP target is £1.3m with the remaining £0.1m spread across other non-pay lines. Non-pay savings will focus on areas where run rate is trending upwards, along with broader grip and control measures such as stock control on the wards and reducing discretionary spend. Lower level approval limits are being reviewed with the aim of allowing requisition authorisation at senior manager levels only, while initial meetings between materials management and Finance have taken place to roll out stock labelling in clinical areas. These will be reported on and measured as a breakthrough objective for 2025/26.

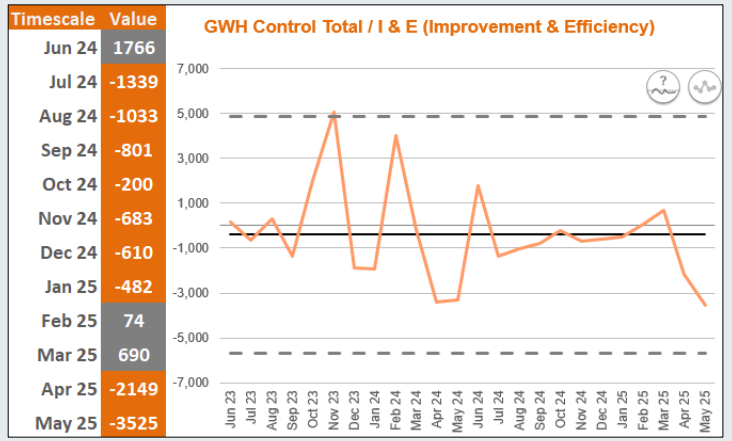
Key to breaking even with plan in 2025/26 is delivery against the efficiency savings target of £32.4m. At M02 the Trust has delivered £1.8m against a target of £5.4m, giving a shortfall of £3.6m. Divisions and services must focus on finding recurrent schemes to reduce the deficit position. It should be noted that £20.0m of the total £32.4m target relates to pay savings, and in parallel with reducing temporary staffing spend the Trust must also reduce substantive headcount by 135 WTE, of which 104 WTE is expected to be in Corporate and admin roles.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
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
Apr 25	-2149
May 25	-3525



Counter Measures

- Efficiency savings were £1.3m below target in month. Actual savings delivered were £1.5m against a plan of £2.8m. Pay was £0.7m under plan and non-pay £0.6m. Recurrent delivery was 72% in month and is 72% year-to-date. Divisions and services are included in financial recovery workstreams such as substantive workforce, temporary staffing and better buying to focus on delivery recurrent cash out savings.

Executive Summary

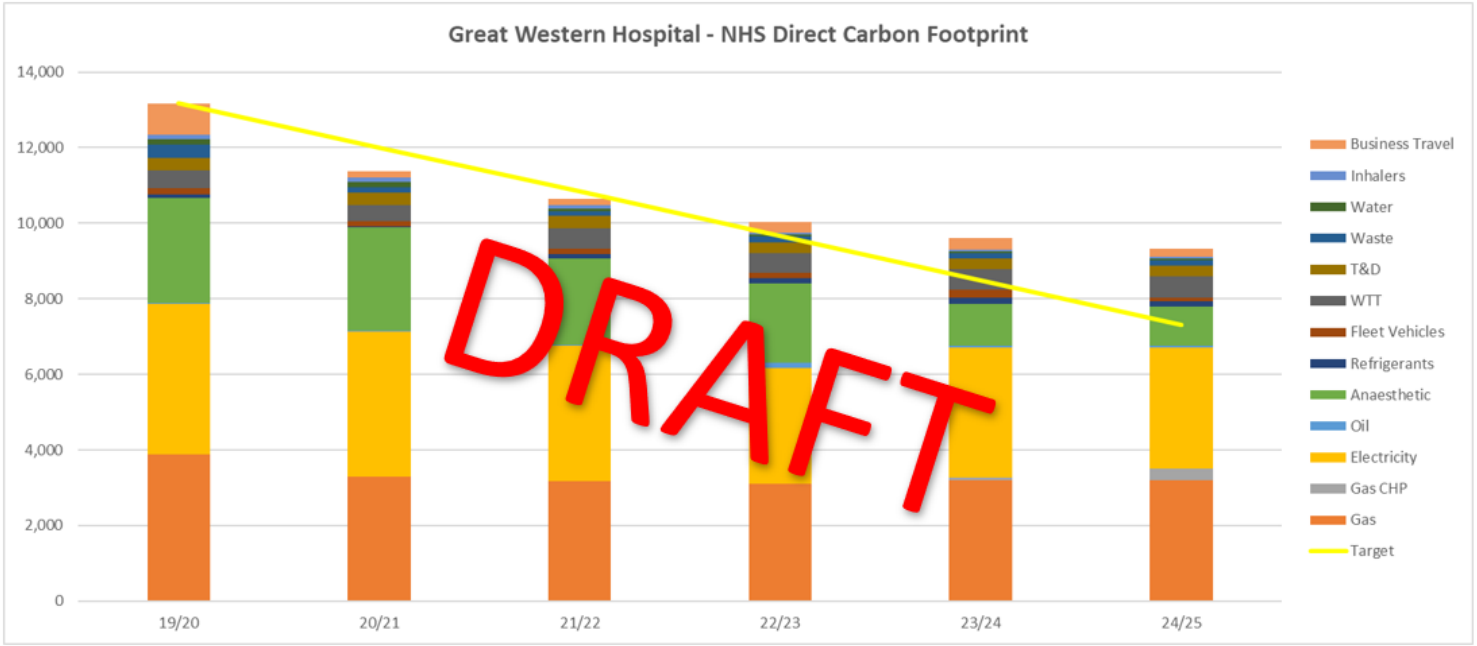
NHS
Great Western Hospitals
NHS Foundation Trust

Carbon Footprint / Sustainability

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

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

Note: Data for the latest financial year is still in draft.



Counter Measures

Great Western Hospitals NHS Foundation Trust's Green Plan has been drafted for 2025-2028 and currently being ratified. The 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.

Please see the Green Plan for the full list of actions proposed.

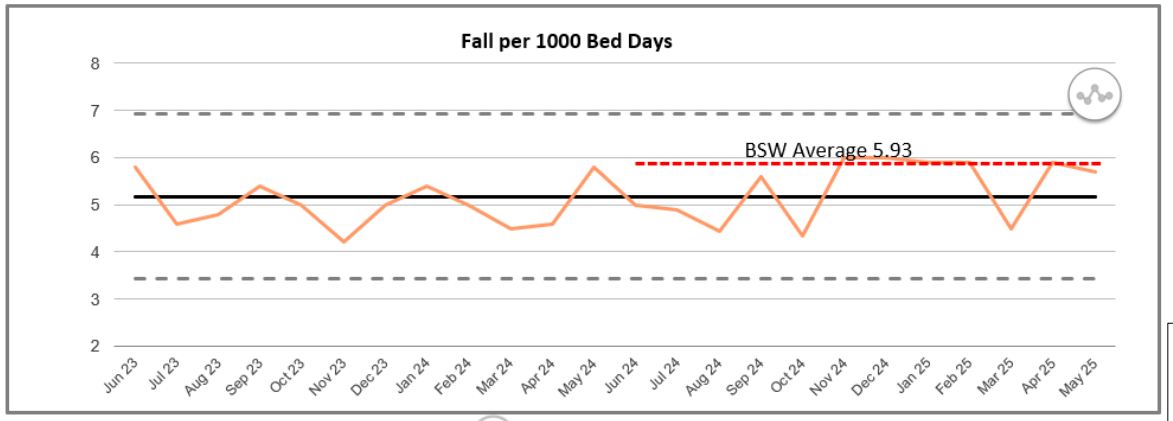
Simon Wade
Chief Financial Officer

2025/26 Breakthrough Objectives

Reducing Falls & Falls With Harm

Great Western Hospitals NHS Foundation Trust

Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
5.0	4.9	4.4	5.6	4.3	6.0	6.0	5.9	5.9	4.5	5.9	5.7



Common cause - no significant change

Understanding the Data

Falls per 1000 bed days will be monitored quarterly to provide benchmarking data. There has been an increase in the rate from the previous month.

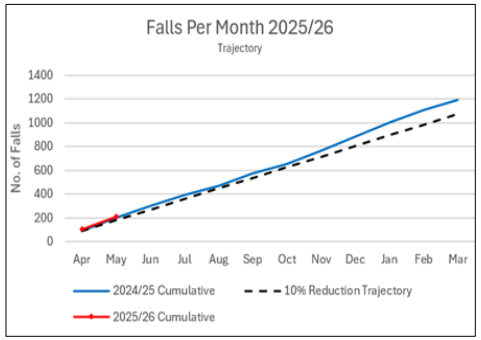
Aim for 2025/26

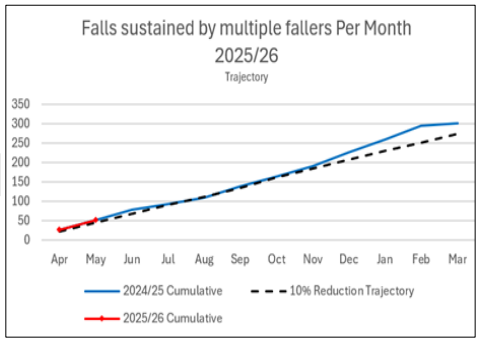
Reduction in the number of Total Falls by 30% over 3 years.
Reduction in the number of patients experiencing moderate harm or above by 10% each year
Reduction in the number of patients that fall more than once by 20%

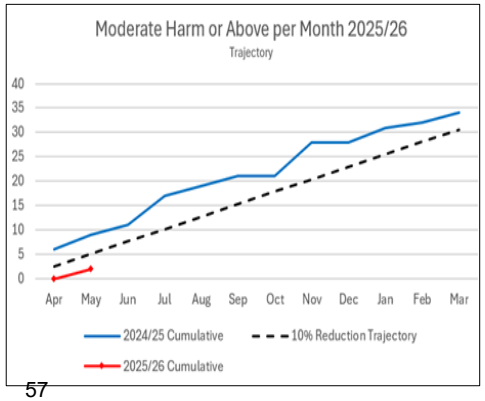
We are driving this measure because…

Analysis shows that inpatient falls are a top cause of moderate and above harm in the Trust. Between April 24- March 2025, 1192 Falls were reported, 22 resulted in moderate harm, 11 resulted in severe harm, and one 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 remained the same at 104 for the month. The number of falls with moderate harm or above has increased two in month, compared to zero for last month.

Falls sustained in patients who have fallen more than once has increased to twelve in month (nine in April).

Improvement Actions completed:
To improve post falls debriefs and support all inpatient areas to take on this approach a Toolkit for post fall incident reporting and debrief has been drafted and shared with ward managers for initial feedback.

A review of the bathroom alarms has been completed, with replacements ordered and a training and auditing plan developed to ensure future sustainability of the project.

A hot topic of the month has been developed. For May this covered safe use of bedrails. June will focus on lying and standing blood pressure.

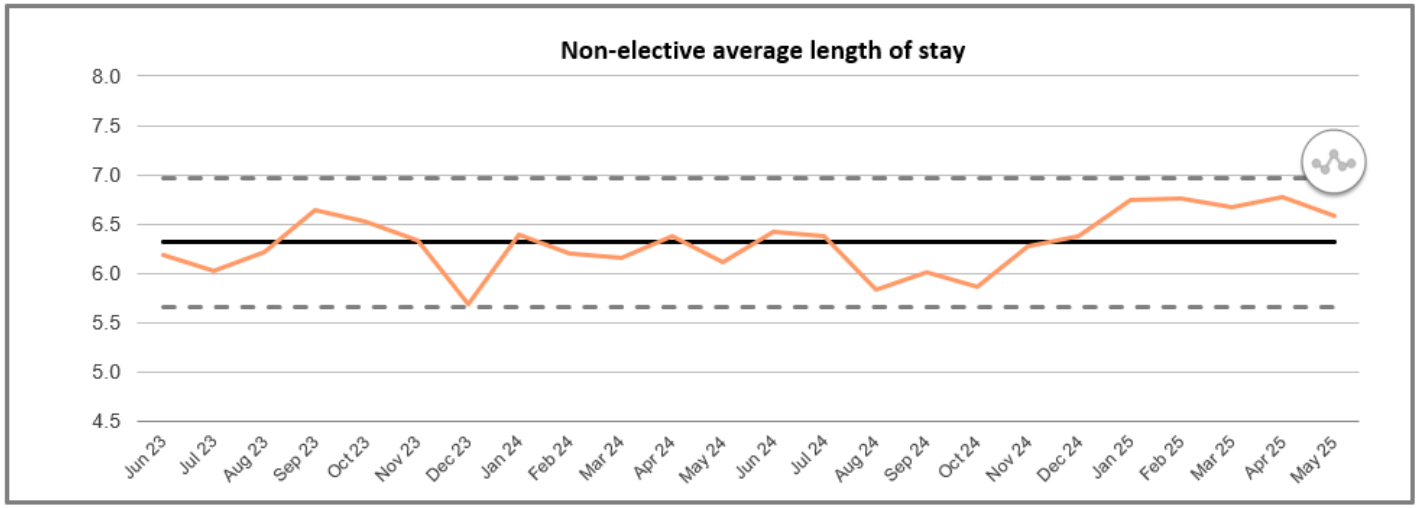
To increase training for healthcare support workers, the Enhanced care training has been increased from monthly to weekly.

2025/26 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Non-elective average length of stay

Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
6.4	6.4	5.8	6.0	5.9	6.3	6.4	6.7	6.8	6.7	6.8	6.6



Common cause - no significant change

Understanding the Data

This metric tracks the average length of stay for non-elective inpatient admissions where the length of stay is greater than zero.

It excludes same-day discharges and focuses on completed hospital spells. Data is reported monthly and helps identify variations in hospital efficiency and patient flow.

We are driving this measure because…

Higher length of stay impacts upon the quality and experience of patient care because the occupancy levels of our inpatient beds increases and resources including medical, nursing and therapy staffing become more stretched. Higher bed occupancy also means that patients are less likely to receive care in the right place at the right time, therefore extending length of stay and compounding the issue. These delays also affect access to admitted urgent care across our front door areas and in the wider community, subsequently increasing the risk of patient harm and mortality.

Performance

Non-elective length of stay was 6.6 days in May compared to the June 2024 baseline of 6.4 days (a negative variance of 0.2 days). An Urgent and Care and Flow transformation programme has been set up with the goal of reducing non-elective length of stay to levels below 2024-25 for six consecutive months. The programme of work includes the following workstreams:

1. Pre-Admission: Increasing the volume of same day emergency care (patients that are seen, treated and discharged within 24 hours). This will include improving our SDEC capability with improvement to volumes and discharge of patients on the same day in our assessment areas with primary focus within Medicine. We will also review the Frailty Pathway to improve our service provision for Frailty SDEC and we will undertake a review of our Integrated Front Door streaming pathways to support reduction in attendance to admission conversion.

2. Admission: Reducing the time between admission to becoming discharge ready. Key initiatives include Ward level quality improvement and standardisation of flow processes and Medical specialty bed base changes to improve patient access to the right medical specialty first time.

3. Transfer of Care: Reducing time between discharge ready and discharge. Key initiatives include a review of Transfer of Care hub processes and improvement in partner capacity to meet demand, especially across Pathway 1 (home first) and Pathway 2 (rehabilitation in a bedded setting/D2A). We will also improve the utilisation of the Discharge Lounge to improve flow from ED to assessment areas and specialty wards to be meeting the KPI of 33% discharges before midday.

Risks

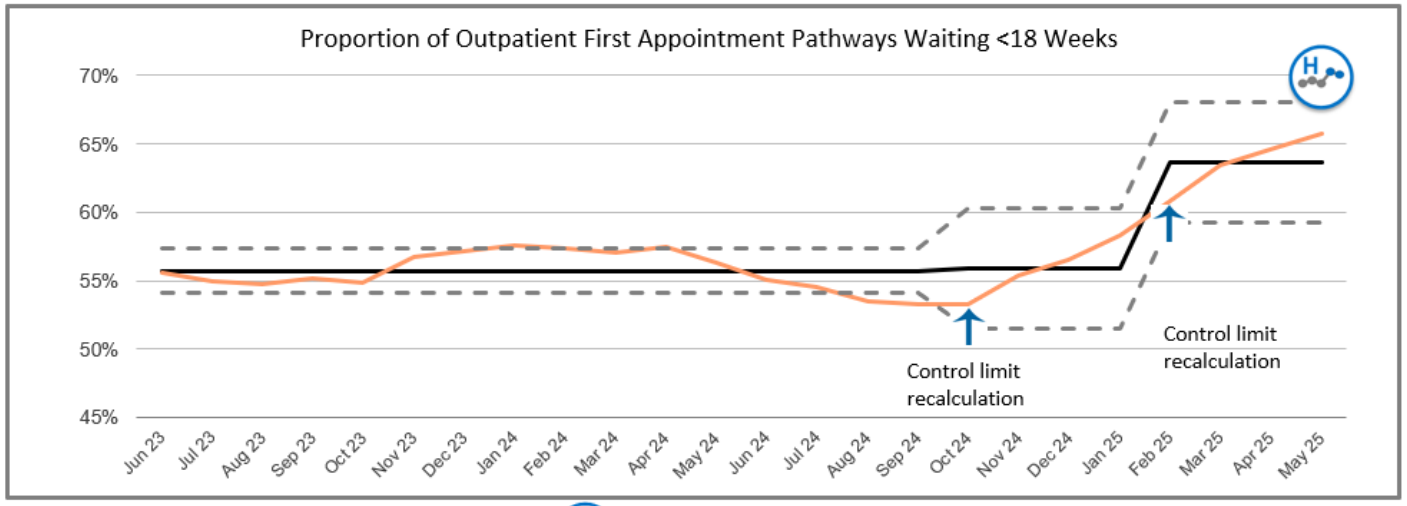
There is a risk that high hospital occupancy leads to poor patient flow through the hospital which impacts on the safe delivery of care. High occupancy resulting in delays to offloading ambulances (risk 731) , overcrowding in ED / ED majors (690) and the use of temporary esclation spaces to deliver care. This results in increased patient safety incidents / increased mortality and reduction in patient experience. The General and Acute bed occupancy operates above 98% on a regular basis.

2025/26 Breakthrough Objectives

Proportion of Outpatient First Appointment Pathways Waiting <18 Weeks

Great Western Hospitals NHS Foundation Trust

Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
55%	55%	53%	53%	53%	55%	57%	58%	61%	63%	65%	66%



Special cause - improving

Performance

The number of non-admitted (Outpatient) pathways waiting for a first appointment beyond 18 weeks continues to decrease as efforts are focused on scheduling first OPAs for patients with longer wait times sooner. This improvement has led to better performance for the reporting month, with 66% of patients now waiting less than 18 weeks for their first appointment.

The national target remains at 67%. Given the current trend, this target will likely be reviewed and increased locally at the end of quarter 1. The group continues to focus on three key elements of the patient pathway: booking in order, clinic room availability/utilisation, and straight-to-test pathways.

Several specialty pathway redesigns have been implemented, emphasising booking in order. These changes have resulted in more specialties transitioning to a Referral Assessment Service (RAS) and a simplified onward triage pathway. These new pathways are set to go live in July following the creation and signoff of clinical SOPs.

Understanding the Data

This metric measures the proportion of patients waiting less than 18 weeks for a first outpatient appointment. It includes all pathways where a first attendance has not taken place in the pathway, using a monthly snapshot.

The denominator is all such pathways; the numerator is those under 18 weeks. Data is sourced from the Waiting List Minimum Dataset (WLMDS).

We are driving this measure because...

Timely access to care is essential for better outcomes. By improving performance on this measure, we aim to reduce delays, improve patient experience, and meet the 67% target by March 2026.

Seeing a specialist sooner for their first appointment allows for earlier diagnosis and treatment, which can significantly improve health outcomes and prevent conditions from worsening. Additionally, it provides ample time to plan and execute necessary interventions within the RTT pathway, ensuring timely and effective care.

Risks

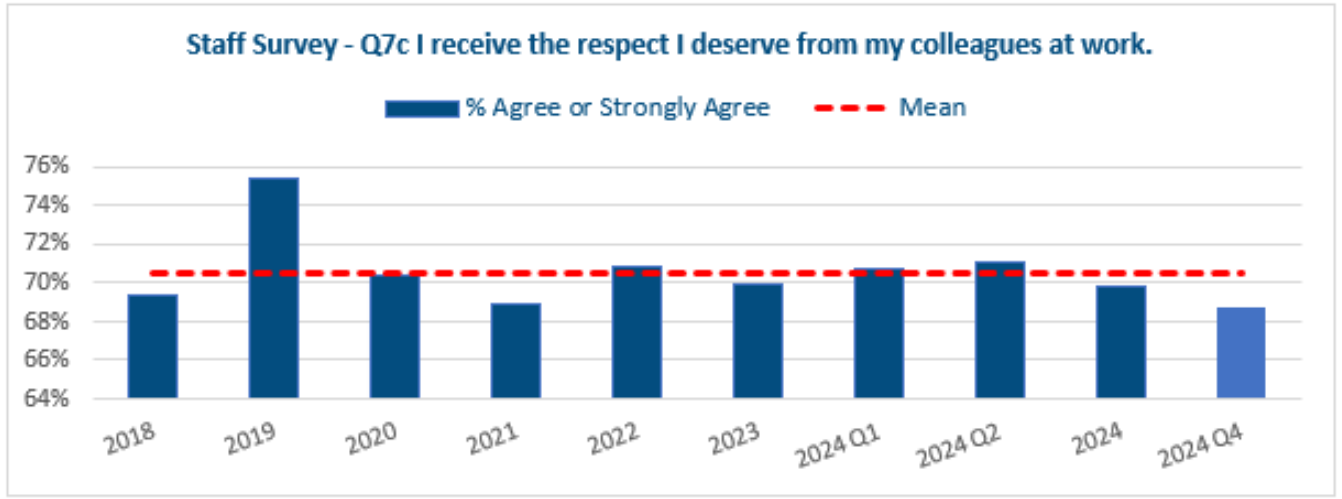
- Administrative capacity to build and support new pathways may result in delays to implementation or pausing of this sub workstream.
- Capacity Constraints: If there is insufficient capacity to handle the increased demand for early appointments, it could delay the overall process and hinder the achievement of targets (this varies by specialty).
- Resource Allocation: Ineffective allocation of resources, such as clinic rooms and staff, could lead to bottlenecks and inefficiencies in the pathway.
- Patient Compliance: Delays or non-compliance from patients in attending scheduled appointments or following prescribed pathways could negatively impact performance metrics.

2025/26 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

- To revitalise the voice of our Healthcare Support Workers and strengthen their engagement in improvement measures, the HCSW Trust forum is being relaunched with nominations to join being promoted at the Ward Manager toolkit day and Go & See events in June.
- Never Ok campaign is due for launch on 19th June to ensure wide visibility and promotion of the Trust stance that physical and verbal violence towards staff is never OK. Wiltshire Police will be present on site to advise staff around violence, and staff impact stories are being recorded for the launch.
- Analysis has identified recognition as a key component of respect. To address poor uptake of the e-card recognition platform, the Emergency Department are trialling a recognition promotion event. A joint meeting between Trust and ED recognition leads, supported by Comms, is scheduled to prepare the campaign.

Risks

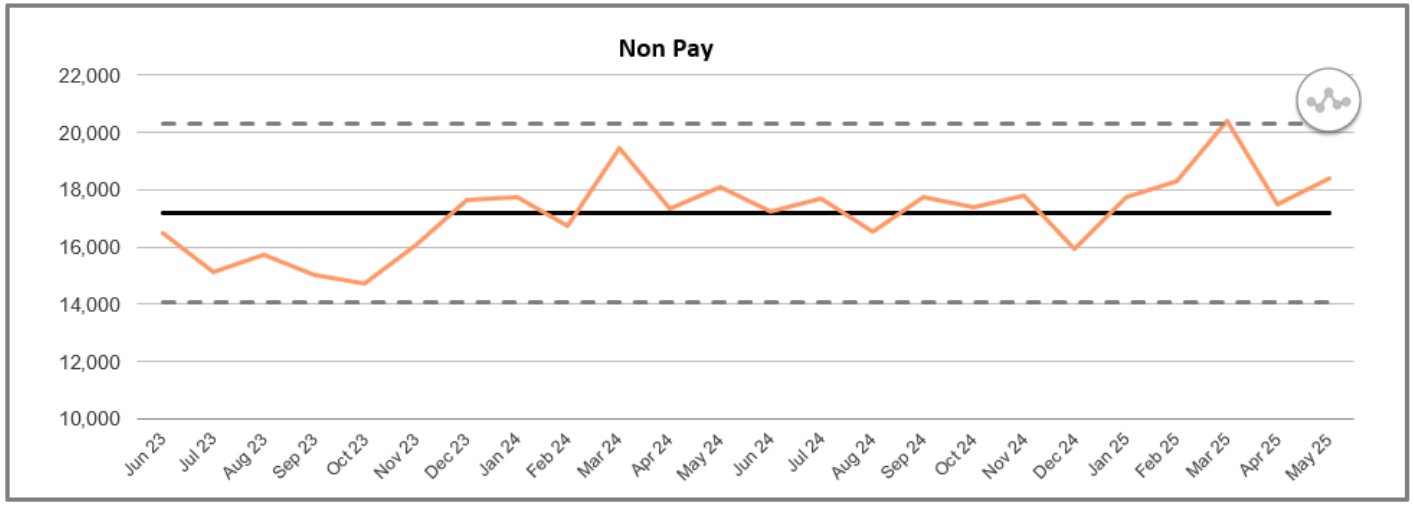
- Significant risk to staff morale and engagement due to current financial challenges, requirement to reduce our workforce, and organisational change.

2025/26 Breakthrough Objectives

Non-Pay run rate stabilisation and reduction

Great Western Hospitals NHS Foundation Trust

Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
17264	17712	16549	17727	17381	17799	15918	17764	18289	20422	17485	18390



Common cause - no significant change

Understanding the Data

The graph shows that non-pay spend has been on an upward trajectory over the previous 2 years. The sharp increase in Mar-25 reflected increase in stocks and accruals pertaining to 24/25. While some increase in costs will be driven by inflationary uplifts in supplier contracts and additional activity, the focus of the breakthrough objective will be on highlighting increases within influenceable areas such as clinical supplies, and looking for potential mitigations to current spend.

We are driving this measure because...

The Trust has a £32.4m efficiency savings target for 25/26, which is £2.7m per month. As at M02 the Trust has delivered £1.8m of actual savings, leading to an under delivery of £3.5m. Finding recurrent cash releasing savings is crucial if the Trust is to deliver on its savings programme and achieve a breakeven budget.

Non-pay is 40% of the Trust's total expenditure. Maintaining grip and control over non-pay spend, specifically in areas where clinical and operational staff have influence such as clinical supplies, is key to help deliver the efficiency savings target.

Performance

M02 costs were £1.0m higher than M01 due to additional stocking and Corporate related spend. Actual spend remains above the average trend.

The focus of the breakthrough objective will be highlighting the drivers of the non-pay increase at account and specialty level. Task & Finish groups organised between clinical/operational leads within key specialties, Procurement and Finance will undertake a detailed analysis of the data to focus on mitigations and savings. Groups are already in place for Cardiology (Medicine) and Theatres (Surgery and Planned Care) following analysis in 24/25.

Other schemes to mitigate non-pay spend and embed a cost control culture will also be undertaken. A scheme to label stock label within wards and clinical areas, showing top 10 items purchased and a traffic light system showing high cost and lower cost items, is about to commence. The Trust is also looking at removing authorisation for staff who can approve items for <£10k and freezing or adding additional approval for accounts considered to be discretionary (eg. Stationery, books and subscriptions etc).

Risks

The risks to achievement include:

a) Necessary resource commitment (time and staff) from affected departments (specialties, Procurement, Finance)
b) External factors such as inflation pushing costs further beyond the funding envelope
c) Lead times and/or group held contracts preventing quick release of costs
d) System limitations in freezing discretionary account lines

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Feb-25	Mar-25	Apr-25	May-25	Trend
IP&C	MSSA	1.92	?	4	3	2	3	
FFT	Inpatients Positive Responses	90.1% (Int)	?	88.7%	89.7%	88.8%	89.3%	
	Daycases Positive Responses	95.0% (Int)	?	94.7%	94.5%	94.9%	92.0%	

Performance & Counter Measure

There was a decrease in the Day cases positive response rate, which fell from 94.9% in April to 92.0% in May. In response we are undertaking spotlight work in this area and providing detailed comments to services to support targeted improvement efforts. In contrast, the Inpatient positive response rate showed a slight improvement, rising from 88.8% to 89.3%.

Digital response capture for Maternity remains paused with the new electronic maternity record system. As in April, no SMS data could be generated, and feedback relies solely on FFT cards and entries from the Maternity Patient Experience Co-ordinator.

There were three Methicillin-Sensitive Staphylococcus Aureus (MSSA) cases in May, currently under investigation.

Risks

Ongoing Family and Friends Test (FFT) discussions are taking place with finance teams and the wider Banes, Swindon, Wiltshire group to plan for the FFT processing changes. We continue to assess alternative options to agree on a sustainable approach for FFT delivery going forward. The risk to data quality and collection remains under active review.

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 Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Feb-25	Mar-25	Apr-25	May-25
Harm	Patient safety incident investigation	SPC		2	7	1	3
	No. of Falls in month	SPC		106	85	104	104
	No. falls with moderate harm or above	SPC		1	2	0	2
	Medication incidents with moderate harm	SPC	H	2	0	3	3
	Pressure Ulcer (Hospital Acquired)	SPC	L	20	11	6	10
Concerns and Complaints	No. of concerns received	SPC		300	324	357	317
	No. of complaints received	SPC		51	65	44	71
	Number of reopened complaints	SPC		2	2	3	5
IP&C	C.Diff	4.5	?	4	5	5	9
	MRSA	0	?	0	1	0	0
	E.coli	7.5	P	7	6	10	8
	Klebsiella	2.17	P	0	5	2	1
	Pseudomonas	1.75	?	0	0	2	0
	COVID (hospital acquired)	SPC	L	8	2	1	2

Performance & Counter Measure

There were three Patient Safety Incident Investigations (PSII) reported in the month of May. There are 21 PSII's in progress with eleven overdue against Trust internally set timelines. Work continues through Divisions to focus on the overdue investigations. In addition, the Trust Lead Investigator is supporting individual investigators to facilitate the final reports using a systems approach to identify learning.

The number of concerns received in May was 310, down slightly from 357 in April. High volumes have led to hot spot improvement meetings held weekly, supported by a standardised procedure for replication, developed by SPC through A3 work. Concerns are now reviewed in all weekly divisional meetings to improve oversight, mirroring the approach taken with complaints. The number of reopened complaints has increased to five in May. We continue to monitor closely, as this may provide early insights into the quality of responses. We received 71 complaints in month. Although this is an increase from April, volumes are in line with the previous May. Evaluation of themes has taken place with Clinical Care and Behaviours of Medical Staff as the highest contributors to steer improvement effort. ED received most complaints at 8 in month and front door teams continue to work closely with PALS.

The number of falls in month (104) has remained unchanged from April. However, there has been two falls with moderate harm or above in month.
There were 10 Hospital Acquired Pressure Ulcers in month, with a slight increase in the level of harm. Focused work on the top contributing wards continues, with the weekly panel to ensure shared learning.
There were three medication incidents with moderate harm, all are under review and the level of harm may change.
There was a rise in *C. difficile* cases in May, putting us significantly over trajectory. Nearly half of the patients (4/9) had recent chemotherapy, and this exactly matches a peak seen in this cohort of patients in May 2023. Royal United Hospital in Bath reported a similar rise, however the reasons for this are not understood yet and will be investigated. All other non-alerting infection watch metrics have fallen from last month and remain near or below trajectory and COVID remains at a long-term low.

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.

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 Care

Non-Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Feb-25	Mar-25	Apr-25	May-25
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	95.2%	98.5%	100.6%	100.3%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	99.7%	108.8%	107.6%	109.1%
FFT	Overall response rate (%)	28.5% (Int)	?	33.6%	35.1%	39.1%	25.5%
	Positive response (%)	90.0% (Int)	?	91.1%	89.0%	90.6%	82.8%
	ED & UTC Response Rate	16.9% (Int)	?	19.1%	18.8%	20.5%	21.3%
	ED & UTC Positive Responses	79.6% (Int)	?	83.6%	74.4%	79.9%	77.4%
	Inpatients Response Rate	24.6% (Int)	?	27.6%	27.9%	32.0%	26.9%
	Daycases Response Rate	24.6% (Int)	?	29.4%	27.3%	31.6%	31.2%
	Outpatients Positive Responses	97.0% (Int)	?	97.6%	98.0%	97.5%	71.4%
	Maternity Response Rate	38.4% (Int)	?	26%	100%	100%	100%
	Maternity Positive Responses	91.5% (Int)	?	88%	85%	96%	94%

Performance & Counter Measures

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

Around 1,700 FFT submissions from May remain unprocessed due to a supplier delay, which may affect reported scores. The Maternity SMS function also remains paused while data feed issues are resolved.

Positive response rates in ED/UTC fell slightly to 77.4%, and Trust-wide scores dropped to 82.8%, likely due to the processing delays. Outpatients saw a notable dip to 71.4%, while Daycase fell marginally to 31.2%. Maternity remains at 94%, though still limited to paper responses. Gynaecology OPD, Audiology, and Maternity Day Assessment are among the areas most affected by delayed data.

Improvement Actions:

- ED/UTC: Focused communication work, reinforcing real-time updates and staff visibility.
- Daycase: Targeted review planned to explore experience themes and support service leads.
- Outpatients: Local teams supported with detailed comments to guide improvements.

Putting the Hospital to Bed campaign, is being re-launching in June to drive further improvements and ensure patients receive the same excellent standard of care at night as they do during the day.

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

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Feb-25	Mar-25	Apr-25	May-25	Trend
RTT	No. of >=18 weeks waiters		H	21989	22161	21678	22320	
	No. of >=52 weeks waiters		H	1195	950	816	764	
DM01	No. of patients on DM01 waitlist			6345	6591	8092	One month behind	
	DM01 performance %	99% (Nat)	F	87.7%	90.9%	84.8%	One month behind	
	DM01 6 week wait breaches		H	779	597	1230	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	72.7%	82.1%	70.9%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	93.5%	95.2%	93.2%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	67.5%	53.5%	47.3%	One month behind	

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

Performance & Counter Measure

Diagnostics

May's validated DM01 performance showed a slight increase in performance from 84.8% in April to 85.0%. This is due to the stabilising of the waiting lists after the issues of additional waiting lists in the audiology department and Easter falling in April. The number of patients on the waiting list has increased by 5 to 8,087. There are now 1,214 patients waiting over 6 weeks vs 1230 in April 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 2,704 on the waiting list and 509 over 6 weeks. Increased support from Medicare over the next few months are expected to bring this back in line. WLIs continue to be in place to support Endoscopy.

Cancer

64.6% of the 62-day breaches were with the Plastics, Colorectal & Urology pathways.

31D performance fell short in April due to capacity in the Skin pathways, accounting for 7 of the 14 pathway breaches: Elective capacity in ENT accounted for 1 of the Plastics breaches, with Outpatient capacity being responsible for 4 breaches in Dermatology & 2 in Plastics.

Cancer waiting times for first appointment remain below standard. Skin is the largest contributors with 48.0% of all breaches. Outpatient capacity was the main reason for breaches, being responsible for 88.7% of breaches.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Feb-25	Mar-25	Apr-25	May-25	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	72.5%	70.1%	69.6%	70.3%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	9.0%	8.1%	9.0%	8.7%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	51.9%	48.3%	47.6%	47.9%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	17.5%	16.1%	17.8%	17.4%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	2572.48	2558.59	2575.72	2715.92	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1539	1752	1648	1516	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	92%	89%	87%	82%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	1207	1308	1251	1103	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	72.4%	66.8%	65.8%	59.8%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC	H	832	866	816	804	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	49.9%	44.2%	42.9%	43.6%	

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

Performance reviewed in weekly Emergency Flow meeting

4-hour performance (type 1 and 3) improved from 69.6 to 70.3%. This is 7.7% below the 25/26 national target. The reduction in performance relates to type 1 performance reducing and impacting our overall position, with some fluctuation to Type 3.

Total % over 12 hours (Type 1) was consistent at 17.8% to 17.4%. This is still over target due to delayed onward flow to admission areas, although multiple measures implemented to help mitigate this. Any prolonged length of stay in ED leads to overcrowding and subsequent delays in ambulance offload.

Ambulance handover delays over 15 minutes increased from 2575 hours to 2716 hours (phase 1 breakthrough objective = 2100 hours).

Number of ambulance handovers over 30 minutes has decreased from 1251 to 1103.

Number of ambulance handovers over 60 minutes increased from 42.9% to 43.6%.

Management of 'Timely Handover Process' with ambulance patients off-loaded into ED temporary escalation spaces, predominantly maintained as four trolley spaces: THP continues to be used consistently to support THP protocols with the ambulance services – 560 patients in April & 346 in May

Counter measures remain in place within the Breakthrough objective slides and are now being refreshed as part of the Trust UEC and Flow programme reset around reducing non-elective length of stay.

Our Performance

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Feb-25	Mar-25	Apr-25	May-25
RTT	No. of >=78 weeks waiters	SPC	L	2	2	3	5
Cancer	% 28 day faster diagnosis	75% (Nat)		86%	84%	80%	One month behind
	No. of referrals received	SPC	H	1812	1976	1957	One month behind
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.1%	0.1%	0.0%	0.1%
	Total ED Type 1 Attendances (all arrival methods)	SPC		4961	5662	5552	5509
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	83.0%	81.7%	83.1%	87.4%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		57.3%	54.9%	54.7%	59.2%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		59.3%	54.8%	51.5%	58.3%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	197	206	203	201
	Emergency Care - UTC - Median Stay	240 (Int)	P	139	159	155	150
	Total Number of Ambulance Handovers	SPC		1668	1959	1902	1845
	Average hours lost to ambulance handover delays per day	SPC		92	83	86	88

Performance & Counter Measure

ED & UTC

Number of ambulance conveyances has remained consistent during April and May at 1485. Average daily hours lost in April 2025 was 88.

Patient attendances continue to be higher than those seen in Jan/Feb around 5500.

Triage performance for ED has improved at 59%. Triage within 30 minutes is 80.4% (meantime 18 minutes) - improved.

For Type 3 (UTC only) triage performance within 15 minutes has increased from 54.7% to 59.2%. Triage within 30 minutes is 82.96% (meantime 18 minutes) - improved.

Risks

Prolonged time in ED department and associated harm from exit delay, especially post 12 hours.

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Feb-25	Mar-25	Apr-25	May-25
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		734	660	685	678
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		292	299	307	309
	Elective Patients Average Length of Stay (Days)	SPC		3.4	3.1	3.6	3.4
	Non-Elective Patients Average Length of Stay (Days)	SPC	H	6.8	6.7	6.8	6.6
	GWH Discharges by Noon (%)	SPC		16.5%	15.8%	16.5%	13.0%
	Number of Stranded Patients (over 14 days)	SPC		129	132	131	151
	Number of Super Stranded Patients (over 21 days)	SPC		73	73	72	92
	Adult general and acute type 1 bed occupancy	SPC		97.0%	97.6%	97.6%	97.3%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC		18.2%	19.0%	18.3%	19.0%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.4%	95.5%	95.9%	95.9%
	The Number of Patients in Temporary Escalation Spaces within ED	SPC		0	3	4	Waiting for data
	Total adult general and acute Temporary Escalation Space beds occupied	SPC		29	28	23	19
	Total paediatric general and acute Temporary Escalation Space beds occupied	SPC		3	0	0	0
	Total Temporary Escalation Space beds occupied	SPC		32	28	23	22

Performance & Counter Measure

Patient Flow

- ED 4 hour performance remedial action plan across Type 1 admitted, Type 1 non-admitted and Type 3 UTC.
- Trust wide UEC Flow and Transformation programme phase 2 is now in progress to support reduction in bed occupancy.
- Rapid Ambulance Handover Standard Operating procedure enacted – Trust actions to progress towards a 33 minute average handover delay underway with objective to deliver from end of June. Partner support in place to reduce no criteria to reside but currently over 18% of bed base occupied in month with target to reach 10% by end of June.
- Review of Better Care Fund commitments to support reduction in discharge ready delays. Swindon and Wiltshire local authority support for improvement in P1 length of stay and P2.
- Discharge planning events in May to expedite discharge as part of seasonal planning work.

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.

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.

Use of Resources

Great Western Hospitals NHS Foundation Trust

Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Feb-25	Mar-25	Apr-25	May-25
Use of Resources	Capital Expenditure (£'000)	SPC		5127	Waiting for data	1170	934
	Pay (£'000)	SPC		27959	47806	27255	27304
	Non Pay (£'000)	SPC		18289	20422	17485	18390

Performance & Counter Measure

Capital spend at M102 is £2.1m against a plan of £3.8m, giving an underspend against plan of £1.7m. The underspend drivers are equipment replacement (£0.7m) and EPR (£0.9m).

M02 pay costs are broadly in line with M01. Reduced nursing bank spend was offset with higher medical locum costs.

Non-Pay is £1.0m higher than M01 driven by additional stocking and higher Corporate related costs.

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

Risks

The £3.5m shortfall on the Trust's efficiency savings programme in M02 is the key driver behind the £5.6m adverse variance to budget. Delivering on the overall efficiency savings target of £32.4m through recurrent cash out schemes, particularly on pay with associated WTE reduction, is vital if the Trust if to achieve its breakeven plan in 25/26.

Our People

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Feb-25	Mar-25	Apr-25	May-25
Workforce	% of leavers within 1st year of employment	14.8% (Int)		10.4%	10.9%	10.3%	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 reduced in April to 10.3% and remains below the Trust KPI of 14.8%.
- The response rate for the Q1 Pulse Survey was 19.2%, a small decline compared to the Q4 Pulse survey (20.2%).

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.

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

Our People

Workforce Scorecard

Great Western Hospitals NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Trend Vs Last Month	Trend Vs May-24
		Vacancy																	
	W	Vacancy Rate	%	7.00%	4.04%	3.98%	3.44%	3.82%	3.53%	3.31%	3.53%	3.44%	3.34%	3.06%	2.98%	4.28%	4.26%	↓	↑
	W	Vacancy Rate	WTE	-	219.66	216.12	186.71	207.11	191.29	179.89	192.27	187.54	182.32	167.40	162.89	215.93	215.09		
	W	All Nursing Vacancy	%	7.00%	1.73%	1.73%	0.96%	1.30%	0.64%	0.72%	1.49%	1.99%	1.78%	1.24%	1.01%	0.15%	0.06%	↓	↓
	W	All Nursing Vacancy (Reg & Unreg)	WTE	-	46.13	46.07	25.61	34.47	17.00	19.26	39.90	53.22	47.73	33.37	27.15	3.52	1.47		
	W	All Registered Nursing Vacancy	WTE	-	4.75	14.57	5.24	0.02	-27.25	-36.48	-28.09	-24.47	-24.01	-10.00	-8.16	-10.86	-7.52		
	W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	-12.95	-3.59	-11.35	-23.55	-47.80	-49.08	-41.52	-42.81	-41.32	-37.51	-33.85	-41.18	-38.96		
	W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	41.38	31.50	20.37	34.45	44.25	55.74	67.99	77.69	71.74	43.37	35.31	14.38	8.99		
	W	Medical Vacancy	%	7.00%	6.78%	6.67%	7.82%	10.39%	8.99%	7.84%	6.37%	7.36%	8.01%	8.92%	8.25%	8.31%	8.05%	↓	↑
	W	Medical Vacancy	WTE	-	50.71	49.94	58.44	77.65	67.20	58.64	47.53	54.93	60.01	66.79	61.77	61.95	59.95		
	W	STT/AHP Vacancy	%	7.00%	3.67%	3.63%	3.00%	2.30%	3.92%	4.31%	3.71%	2.28%	2.21%	1.67%	1.91%	8.27%	7.73%	↓	↑
	W	STT/AHP Vacancy	WTE	-	31.27	30.91	25.62	19.64	33.48	37.01	31.82	19.62	19.03	14.42	16.50	66.18	61.87		
	W	SMA Vacancy	%	7.00%	7.77%	7.58%	6.57%	6.44%	6.30%	5.55%	6.24%	5.10%	4.74%	4.51%	4.91%	7.55%	8.22%	↑	↑
	W	SMA Vacancy	WTE	-	91.55	89.20	77.04	75.35	73.61	64.98	73.02	59.76	55.55	52.82	57.47	84.28	91.80		
	W	Recruitment Time to Hire - AFC	Days	46.00	39.40	43.20	40.40	43.80	44.10	42.80	41.40	39.50	42.19	44.30	33.60	34.80	36.40	↑	↓
	W	Recruitment Time to Hire - Bank	Days	46.00	33.30	44.00	22.90	-	30.30	26.70	42.90	37.50	42.90	42.70	38.30	40.00	18.00	↓	↓
	W	Recruitment Time to Hire - Medical	Days	46.00	39.44	35.30	44.20	57.40	37.25	38.40	44.50	36.80	45.02	41.00	36.50	38.00	37.40	↓	↓
		Workforce Utilisation																	
	W	Establishment WTE	WTE	-	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	5,043.74	5,043.74		
	W	Substantive WTE	WTE	-	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	4,827.81	4,828.65		
	W	Additional Substantive WTE	WTE	-	5.53	8.24	9.23	6.30	7.64	9.62	13.99	11.26	12.96	13.66	16.45	11.97	11.84		
	W	Bank WTE	WTE	-	235.28	254.92	264.51	269.93	268.71	270.61	289.89	270.37	325.49	305.77	413.99	311.69	306.31		
	W	Agency WTE	WTE	-	15.01	15.91	25.00	25.62	13.89	23.84	25.72	38.68	39.05	31.77	64.42	48.54	54.27		
	W	Budgeted vs Worked WTE Variance	WTE	-	36.15	62.95	112.04	94.74	98.95	124.18	137.33	132.77	195.18	183.80	331.97	156.27	157.33		
	W	Actual Worked vs Budgeted %	%	-	100.66%	101.16%	102.06%	101.75%	101.82%	102.28%	102.52%	102.43%	103.58%	103.36%	106.07%	103.10%	103.12%		
	W	Total Workforce Cost £	£	-	£25.50M	£25.21M	£25.57M	£25.87M	£25.27M	£36.50M	£26.75M	£28.12M	£27.24M	£27.93M	£28.58M	£26.55M	£26.60M		
	W	Agency Spend as % of Total Spend	%	4.50%	1.30%	2.01%	1.94%	1.58%	1.01%	1.23%	1.64%	1.60%	2.52%	1.97%	2.14%	2.26%	2.40%	↑	↑
	W	Agency Spend £	£	-	£0.33M	£0.51M	£0.50M	£0.41M	£0.26M	£0.45M	£0.44M	£0.45M	£0.69M	£0.55M	£0.61M	£0.60M	£0.64M		
	W	Agency Target £	£		£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	-£0.19M	£0.00M	£0.01M	-£0.06M	-£0.20M	£0.01M	£0.01M	£0.04M	£0.30M	£0.18M	£0.25M	-	-		
	W	Bank Spend £	£	-	£2.02M	£2.23M	£2.32M	£2.04M	£1.88M	£2.29M	£2.15M	£2.21M	£1.71M	£2.66M	£2.70M	£2.21M	£2.18M		
	W	Bank Target £	£		£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	-£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%	94.13%	90.81%	85.23%	82.25%	85.50%	83.28%	84.19%	77.28%	83.99%	84.92%	85.52%	84.22%	90.84%	↑	↓
	W	Unregistered Nursing Bank Fill	%	70.00%	87.18%	86.23%	79.50%	77.63%	78.67%	71.95%	71.89%	65.05%	70.73%	74.37%	76.95%	76.35%	87.65%	↑	↑

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Trend Vs	
																		Last Month	May-24
		Retention																	
	W	All Turnover %	%	13.00%	10.57%	10.24%	10.47%	10.91%	10.70%	11.08%	11.14%	11.24%	11.08%	11.01%	11.26%	11.31%	-	↑	↑
	W	Voluntary Turnover %	%	11.00%	8.53%	8.02%	7.90%	8.66%	8.50%	8.80%	8.75%	8.78%	8.62%	8.48%	8.55%	8.41%	-	↓	↓
	W	Number of Leavers	Headcount	-	42	56	46	63	55	54	41	45	35	30	69	37	-		
	W	Number of RN Leavers	Headcount	-	15	19	14	14	8	13	13	14	9	8	11	8	-		
	W	Registered Nursing Vol Turnover	%	-	7.52%	7.17%	7.36%	7.70%	7.30%	7.39%	7.32%	7.47%	7.25%	7.28%	6.96%	6.51%	-		
	W	Number of Unreg Nursing Leavers	Headcount	-	9	13	6	10	13	12	8	12	1	5	9	5	-		
	W	Unregistered Nursing Vol Turnover	%	-	11.00%	10.91%	10.69%	11.10%	10.34%	10.87%	10.98%	10.97%	10.27%	9.77%	10.06%	9.45%	-		
	W	Leavers within 1st Year - Rolling 12 Month	%	-	9.74%	10.98%	9.57%	11.00%	10.62%	11.04%	9.68%	9.90%	9.02%	10.37%	10.94%	10.30%	-		
	W	Number of starters	Headcount	-	43	55	55	63	94	70	131	48	68	60	61	42	-		
		Absence																	
	D	Sickness Absence % Rolling 12 Month	%	3.50%	4.45%	4.48%	4.57%	4.57%	4.53%	4.57%	4.59%	4.59%	4.61%	4.65%	4.68%	4.68%	-	↓	↑
	D	Sickness Absence %	%	3.50%	4.16%	4.61%	5.19%	4.55%	4.26%	4.87%	4.88%	4.94%	5.14%	4.92%	4.49%	4.13%	-	↓	↓
	W	Long Term Sickness %	%	2.00%	1.92%	2.12%	2.50%	2.57%	2.12%	2.29%	2.26%	2.33%	2.12%	2.49%	2.22%	2.12%	-	↓	↑
	W	Short Term Sickness %	%	1.50%	2.24%	2.49%	2.69%	1.98%	2.14%	2.58%	2.62%	2.60%	3.02%	2.42%	2.26%	2.01%	-	↓	↓
	W	Sickness Absence Cost £	£	-	£708.3k	£748.9k	£850.4k	£755.3k	£727.5k	£873.5k	£860.3k	£866.9k	£897.5k	£773.1k	£815.5k	£681.0k	-		
	W	WTE Days Lost	WTE	-	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	7,397.7	5,979.0	-		
		Learning & Development																	
	W	Mandatory Training Compliance %	%	85.00%	91.37%	91.59%	92.42%	89.84%	89.85%	90.58%	89.79%	90.06%	90.27%	90.03%	90.03%	90.46%	90.94%	↑	↓
	W	Role Essential MT %	%	85.00%	91.84%	92.30%	94.14%	89.00%	89.52%	90.57%	88.86%	89.37%	89.79%	89.70%	89.86%	90.57%	90.95%	↑	↓
	W	CQC Safe MT %	%	85.00%	90.86%	90.84%	90.71%	90.88%	90.25%	90.58%	90.97%	90.95%	90.89%	90.45%	90.24%	90.33%	90.92%	↑	↑
	W	Bank-Only Mandatory Training Compliance %	%	85.00%	83.54%	82.60%	84.77%	86.96%	82.88%	82.42%	84.73%	85.86%	83.96%	81.72%	80.81%	65.69%	64.67%	↓	↓
	W	Appraisal Compliance %	%	85.00%	84.39%	84.74%	84.88%	84.67%	84.09%	84.90%	84.29%	83.46%	84.51%	84.35%	84.40%	83.88%	81.56%	↓	↓
	W	Non Medical Appraisal Compliance %	%	85.00%	83.99%	84.87%	84.95%	84.71%	84.37%	84.94%	84.60%	83.81%	84.63%	84.44%	84.24%	84.15%	82.14%	↓	↓
	W	Medical Appraisal Compliance %	%	85.00%	87.32%	83.81%	84.40%	84.38%	82.07%	84.58%	82.09%	80.94%	83.68%	83.68%	85.48%	82.08%	77.82%	↓	↓

Our People

Workforce Scorecard

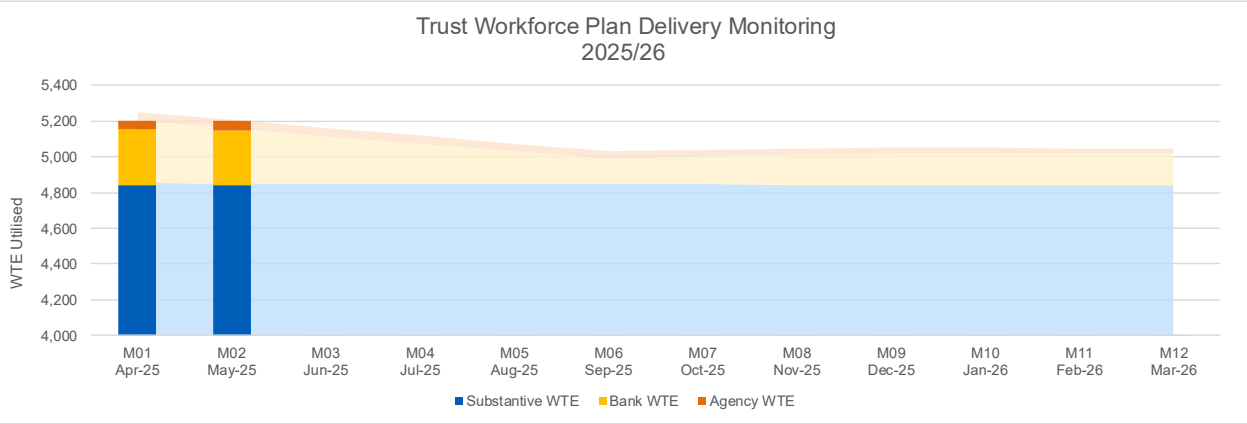
Great Western Hospitals NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Trend Vs	
																		Last Month	May-24
		Demographics																	
	W	Staff in Leadership Roles % (B8a+)	%	-	4.23%	4.26%	4.29%	4.25%	4.21%	4.28%	4.30%	4.26%	4.29%	4.25%	4.27%	4.30%	4.36%		
	W	Staff in Leadership Roles WTE (B8a+)	WTE	-	269.00	271.00	273.00	273.00	271.00	276.00	277.00	275.00	278.00	276.00	277.00	255.00	259.00		
	W	% of Leadership Roles who are Female (B8a+)	%	-	69.89%	70.11%	70.33%	70.70%	70.11%	70.29%	70.40%	70.18%	70.50%	69.93%	69.68%	68.24%	68.34%		
	W	% of Leadership Roles who from BME (B8a+)	%	-	6.32%	6.64%	6.59%	6.23%	6.27%	6.16%	6.50%	6.55%	6.47%	6.52%	6.50%	5.88%	6.18%		
	W	Staff in Leadership Roles % (B8c+)	%	-	0.94%	0.94%	0.96%	0.93%	0.93%	0.90%	0.93%	0.93%	0.94%	0.94%	0.92%	1.01%	1.03%		
	W	Staff in Leadership Roles WTE (B8c+)	WTE	-	60.00	60.00	61.00	60.00	60.00	58.00	60.00	60.00	61.00	61.00	60.00	60.00	61.00		
	W	% of Leadership Roles who are Female (B8c+)	%	-	56.67%	56.67%	57.38%	58.33%	56.67%	56.90%	55.00%	55.00%	55.74%	54.10%	53.33%	53.33%	52.46%		
	W	% of Leadership Roles who from BME (B8c+)	%	-	3.33%	3.33%	3.28%	3.33%	3.33%	3.45%	5.00%	5.00%	4.92%	4.92%	6.67%	5.00%	4.92%		
	W	% of Leadership Roles who are disabled (B8c+)	%	-	1.67%	1.67%	1.64%	1.67%	1.67%	3.45%	3.33%	3.33%	3.28%	3.28%	3.33%	3.33%	3.28%		
	W	Male % of Workforce	%	-	18.52%	18.51%	18.56%	18.48%	18.32%	18.40%	18.46%	18.51%	18.58%	18.61%	18.67%	19.33%	19.44%		
	W	Female % of Workforce	%	-	81.48%	81.49%	81.44%	81.52%	81.68%	81.60%	81.54%	81.49%	81.42%	81.39%	81.33%	80.67%	80.56%		
	W	BME % of Workforce	%	-	26.76%	27.05%	27.31%	27.53%	27.99%	28.30%	28.40%	28.46%	28.67%	29.29%	29.43%	30.08%	30.30%		
	W	White % of Workforce	%	-	65.09%	64.99%	64.84%	65.00%	64.54%	64.41%	64.30%	64.17%	63.94%	63.48%	63.22%	62.05%	61.76%		
	W	ER Cases Closed	Number	-	60	46	59	48	43	55	47	54	49	31	37	51	36		

Our People

Great Western Hospitals NHS Foundation Trust

Workforce Delivery Plan



		M01 Apr-25	M02 May-25	M03 Jun-25	M04 Jul-25	M05 Aug-25	M06 Sep-25	M07 Oct-25	M08 Nov-25	M09 Dec-25	M10 Jan-26	M11 Feb-26	M12 Mar-26
Total Workforce (OPP)	Plan	5,253	5,208	5,164	*5,120*	*5,075*	*5,031*	5,042	5,046	5,051	5,050	5,048	5,047
	Actual	**5,200**	**5,201**	0	0	0	0	0	0	0	0	0	0
	Variance	-53	-7	-	-	-	-	-	-	-	-	-	-
Substantive	Plan	4,853	4,852	4,851	*4,850*	*4,848*	*4,847*	4,846	4,844	4,843	4,842	4,840	4,839
	Actual	**4,840**	**4,840**	0	0	0	0	0	0	0	0	0	0
	of which Overtime	**12**	**12**	0	0	0	0	0	0	0	0	0	0
	Variance	-13	-11	-	-	-	-	-	-	-	-	-	-
Bank	Plan	347	306	265	*224*	*183*	*142*	157	165	174	176	178	180
	Actual	**312**	**306**	0	0	0	0	0	0	0	0	0	0
	Variance	-36	0	-	-	-	-	-	-	-	-	-	-
Agency	Plan	52	50	48	*46*	*43*	*41*	39	37	35	33	30	28
	Actual	**49**	54	0	0	0	0	0	0	0	0	0	0
	Variance	-4	4	-	-	-	-	-	-	-	-	-	-

Performance & Counter Measure

- In May we used 5,201WTE to deliver our services against a planned figure of 5,208WTE. This was a marginal increase in usage compared to April, but remained favourable to plan at -7WTE.
- The pace of reductions in the first half of this year is rapid and whilst below plan currently the Trust is required to reduce 37WTE from usage in June to remain on plan. The majority of this reduction needs to be met with temporary staffing reductions; currently Nursing and Admin are under plan for bank and agency usage, however Medical and AHPs remain above plan and presenting a risk to overall temporary staffing reductions.
- Month 3 will see a further reduction and a required reduction from current usage of:
  - **41WTE for Bank**
  - **6WTE for Agency**

Impact on Workforce

- EVRP continues throughout 2025/26 with heightened scrutiny on approvals / recruitment freeze. From WC 9th June, non-clinical vacancies will be presented to the Group CEO and MDs for approval, with oversight from the Region at the Recovery Board.
- A Mutually Agreed Resignation Scheme for the Group launched on 2nd June, and will run until 20th June with the ambition of creating some organisational flexibility with transformation and redesign. Currently there are 11 applications in progress.

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

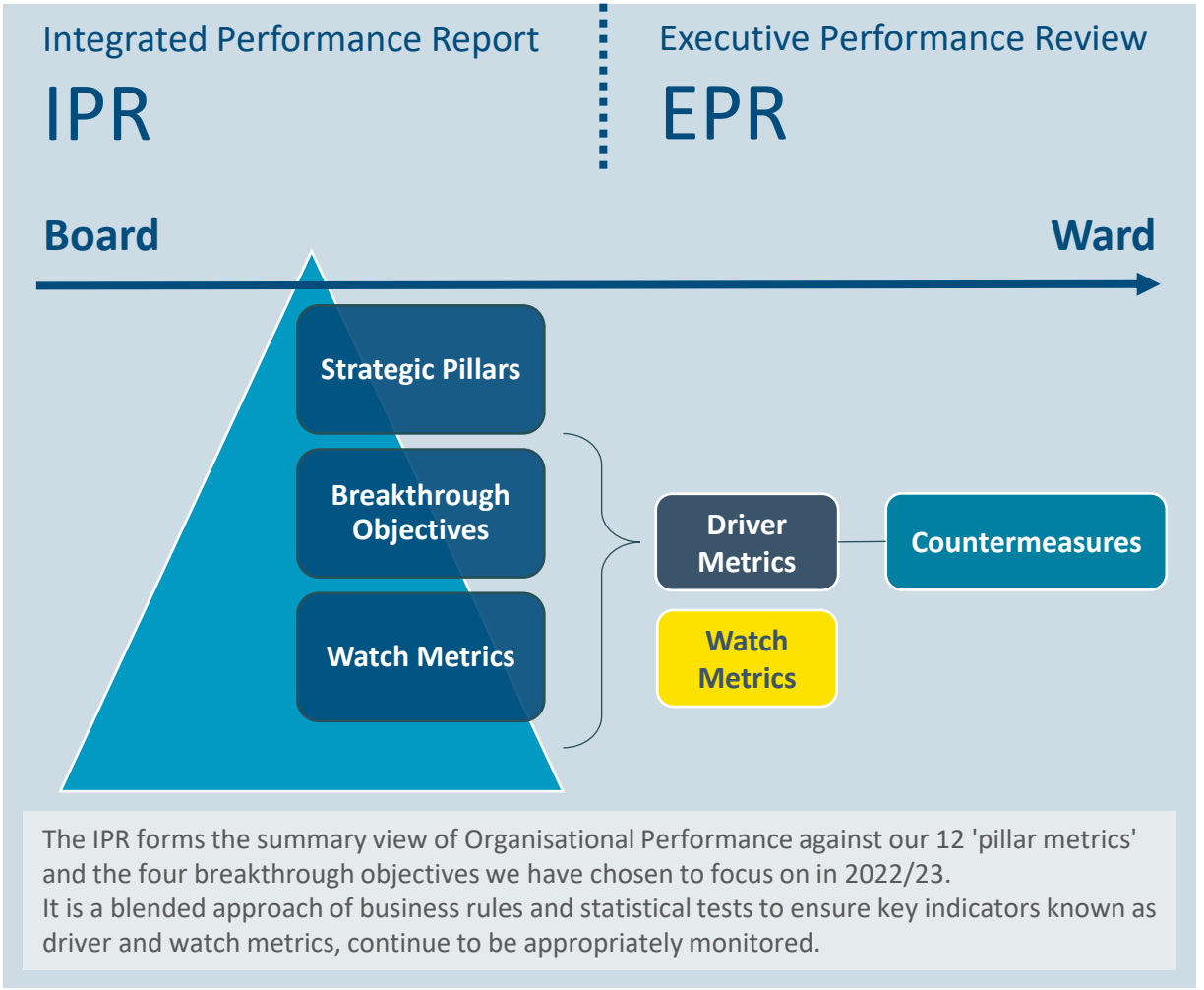
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

- 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

Great Western Hospitals NHS Foundation Trust

Vision

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

Our four strategic pillars

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 well-being, 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 our local communities.

Sustainable future

Maximise research, innovation and digital opportunities, spend wisely, and deliver on carbon net zero.

25/26 Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust

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

1 Our four strategic pillars

- Outstanding Care
- Valued Teams
- Better Together
- Sustainable Future

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

Our pillar metrics

1	Reducing Harm
2	Patient experience
3	Waiting list – over 52 week waiters
4	Cancer waiting times
5	Time in ED (Emergency Department)
6	Sickness rates
7	Staff Survey - % Recommend
8	Staff survey – addressing discrimination disparity
9	Elective waits – reducing inequality
10	Emergency department demand by area
11	Sustainability / Carbon footprint
12	Financial run rate

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.	Integrated Front Door

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

BTO	Non-elective length of stay
BTO	Wait to first outpatient appointment
BTO	Falls harm prevention
BTO	Staff Survey = respect from colleagues
BTO	Financial non-pay run rate

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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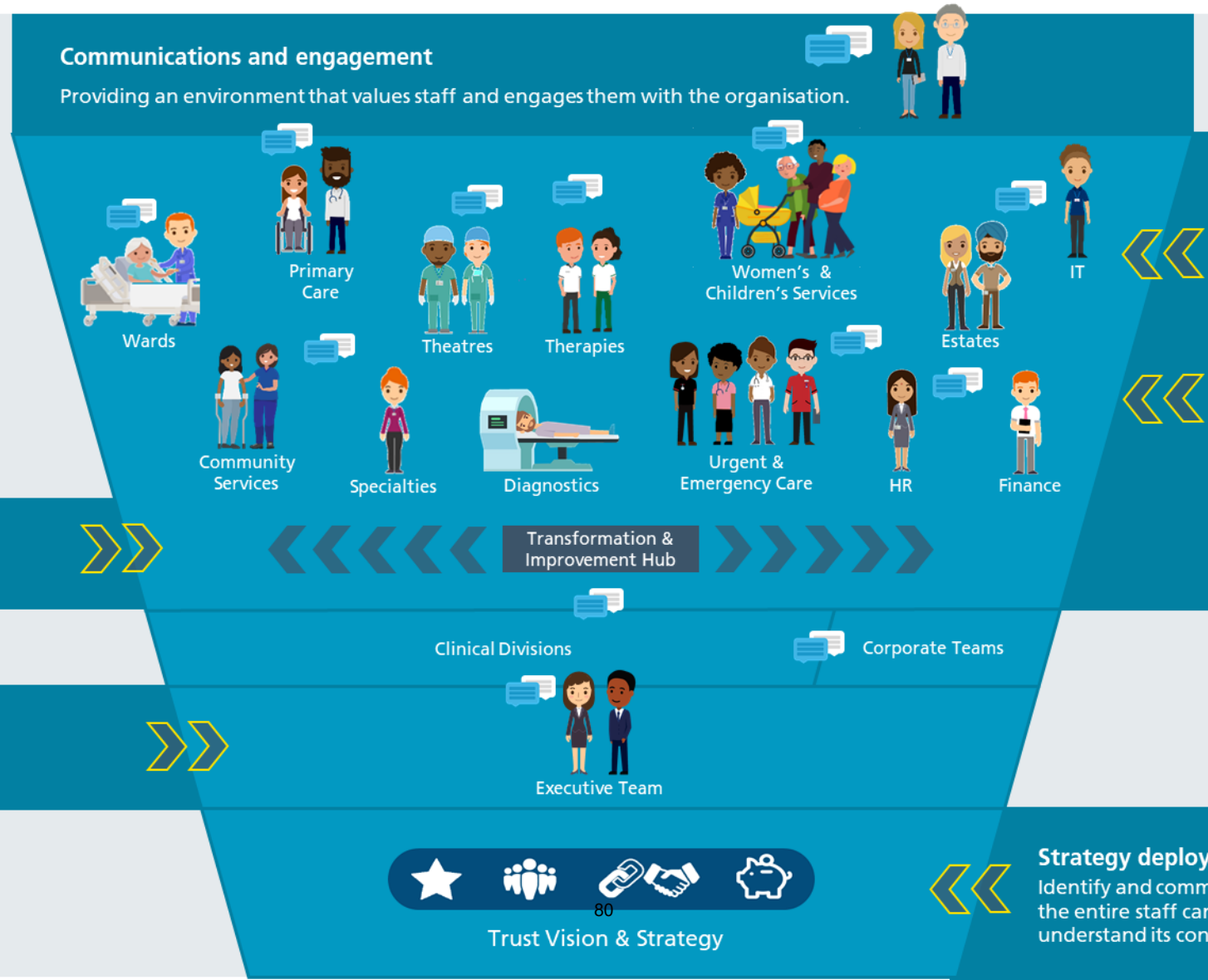


Transformational projects
Using improvement methodology to create step-change improvement.

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.

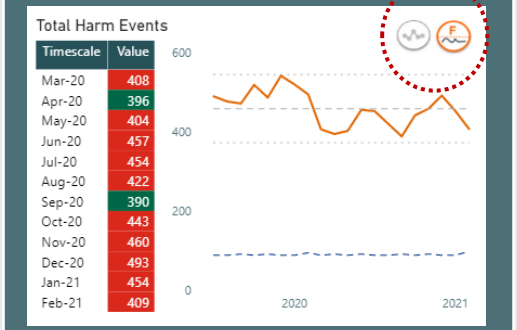
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

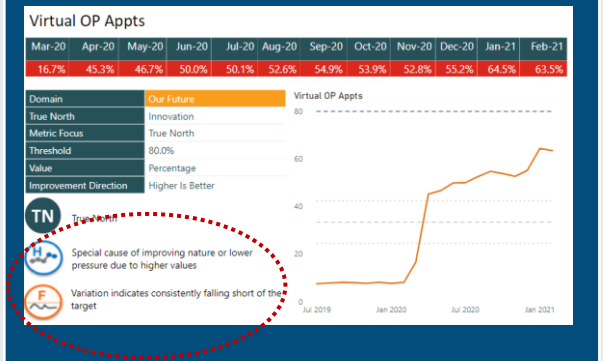
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short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

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

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

Agreed Terms

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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
Great Western Hospitals
NHS Foundation Trust

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

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	28th May 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	Time in Emergency Department	Waiting List – over 52-week waiters
	Elective waits – reducing inequality	Cancer Waiting Times
	Emergency department – demand by area	
Improving Together Breakthrough Objective	Non elective length of stay Proportion of outpatient first appointment RTT pathways waiting < 18 weeks	

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	Partial	
3. IPR – Cancer	Good	
4. IPR – ED / 4 hours	Limited	
5. IPR – Ambulance Handover	Limited	
6. Board Assurance Framework	Substantial	
7. UEC Plan / Progress Monthly Update (Verbal)	Noted	
8. Cancer Services Assurance	Good	
9. Partnership Report: Networks Update	Noted	

POINTS OF ESCALATION	The Board is asked to consider 1. How the BSW Hospitals Group might interface with clinical networks going forward, given, for example, the hospitals sit within three different Pathology networks? There is an opportunity for the Joint Committee / Board workshop to consider a stocktake of partnership arrangements with a view t which are most amenable to shared representation / leadership. 2. To note. The new terms of reference for the West of England Diagnostics Board were received.
KEY AREAS TO NOTE	**RTT** Improvement continues on RTT and ahead of operating plan in the month Patients waiting over 52 weeks down to 816 from 950 in March Patients waiting over 65 weeks up from 21 to 25 18 week RTT at 57.8%, a reduction of 0.2 percentage points from previous month 3 x 78 Week breaches – all patients have next steps booked in May **ED** ED attendances in month at 10,131 which was 97% of planned levels ED mean wait time 433 mins up from 420 last month 4 hour performance 69.6% against operating plan of 73.7%. Drop below 70% has initiated remedial action planning. 12-hour trolley waits up to 342 from 323 More patients attend ED from the most deprived quintile

	Ambulance handovers 86 hours lost on average per week, an increase from 83. Average handover time of 96 mins and operating plan trajectory for 33 minutes by June. In June there will be a leadership exchange between SWAST and the GWH hospital clinical and operational leads to review areas for improvement and share best practice. **Non-Elective Length of Stay Breakthrough Objective** April's performance was 6.8 days compared to April 24 baseline of 6.4 days. UEC programme of work is now in place focusing on pre-admission, admission and transfer of care length of stay. **Wait to 1st Outpatient Appointment Breakthrough Objective** 65% against March 2026 target of 67%. Consistent improvement of 2% per month. 3 key areas of improvement focus: - Straight to test pathway waiting list management - Booking in date order to give simplified triaging - Clinic room utilisation **No Criteria to Reside** 97 patients on average in the bed base up from 91. Current position is 43 higher than plan. Slight decrease in 21 day length of stay to 12 patients on average. Average discharge delays for Pathways 1-3 once discharge ready are being monitored and improving. **Diagnostics 6 week wait performance** Performance has dropped to 85% but remains on plan and follows changes to methodology (Audiology paediatric wait lists now included). **Partnerships Report – Networks** An update was taken from the West of England Diagnostic Board which has brought together all the clinical networks in that geography (pathology, imaging, endoscopy & physiological sciences) under one Board. GWH is in this Network for all diagnostics except pathology. South 4 Pathology network works well for GWH. Committee discussed importance of looking at individual functions when considering how the BSW Hospitals Group interfaces with the regional clinical networks. **Partnerships Report – System Recovery** BSW Delivery Groups will transition to being provider led by June. This includes for example HCRG leading on community care and the Learning Difficulties, Autism and Neurodiversity (LDAN) programmes. How this works going forward is under discussion.
BOARD ASSURANCE FRAMEWORK & RISKS	Board assurance framework presented and substantial assurance with no changes.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**Cancer** 28 day FDS at 84% down from 86.2%. Best in South West for March (22 out of 119 nationally). 62 day performance improved from 73.1% to 82.1%. 2nd in South West and 19 / 119 nationally. 4.7% of PTL > 62 days against benchmark of 6.7%. 35 breaches for 62 day against 50 in previous month. 31 day performance at 95.2% up from 93.5%. Outsourcing, tumour site pathway review and waiting list initiatives continue to sustain recovery. Plastics service provision remains an issue and third party provider and support from Salisbury NHS FT is being considered. **RTT Validation** 12 week validation sprint funded by NHSE underway. 75% validation for patients on PTL over 12 weeks, up from 8% in August last year. This compares to 60% nationally. Trust continues to work on plan to achieve 90%.
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.

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	25th June 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	Time in Emergency Department	Waiting List – over 52-week waiters
	Elective waits – reducing inequality Emergency department – demand by area	Cancer Waiting Times
Improving Together Breakthrough Objective	Non elective length of stay Proportion of outpatient first appointment RTT pathways waiting < 18 weeks	

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	Partial	
3. IPR – Cancer	Good	
4. IPR – ED / 4 hours	Limited	
5. IPR – Ambulance Handover	Limited	
6. Lessons learned 2025/26 planning process	Noted	
7. UEC Plan progress monthly update	Noted	
8. Strategic planning framework watch metrics	Approved	
9. Committee effectiveness self assessment	Receive	
10. GIRFT update	Noted	
11. EPRR update	Noted	
12. Time to first appointment	Noted	
13. Health inequalities report	Noted	
14. Partnership Report	Noted	

POINTS OF ESCALATION	1. Proposal to streamline the number of watch metrics overseen by the committee and to propose similar review by other committees 2. Proposal to reduce the frequency of meetings to bi-monthly
KEY AREAS TO NOTE	**RTT** Improvement continues on RTT and ahead of operating plan in the month Patients waiting over 52 weeks down to 764 from 816 in April Patients waiting over 65 weeks up to 31 from 25 18 week RTT at 59.6%, an increase of 1.8 percentage points from April. 5 x 78 Week breaches – all patients have next steps booked in June **ED** ED attendances have risen slightly to 10,997 in May ED mean wait time 433 mins on a par with April 4 hour performance 70.3%, an increase from 69.6%. Type 1 performance was particularly low UTC mean wait time was 162 mins, on a par with April. 12-hour trolley waits increased to 355 from 342

Ambulance handovers
Number of conveyances was consistent with April at 1485
88 hours lost on average per week, an increase from 86. Early indications noted of a material improvement expected to be seen in June data.

Leadership exchange between SWAST and the GWH hospital clinical and operational leads to review areas for improvement and share best practice postponed until July

UEC report
Some improvement in length of stay through Q1, but increase versus prior year of 0.5 days.

3 groups working on pre-admission, admission to discharge and transfer of care. Scoping of project areas is nearly complete. Further report to be received in August in line with the Winter plan.

Wait to 1st Outpatient Appointment Breakthrough Objective
66% against March 2026 target of 67%. Consistent improvement month on month.

3 key areas of improvement focus:
- Straight to test pathway waiting list management, addressing multiple pathways that remain open after patients have been seen.
- Booking in order, simplifying pathways.
- Clinic room utilisation to ensure optimum utilisation

No Criteria to Reside
104 patients on average in the bed base up from 97. Current position is 45 higher than plan.

Average discharge delays for Pathways 1-3 once discharge ready are being monitored and improving.

Diagnostics 6 week-wait performance
Performance has remained at 85% but remains on plan and follows changes to methodology (Audiology paediatric wait lists now included). Ultrasound remains the most significant contributor.

Partnerships Report – ICB
ICB undergoing significant changes and there was a first look at cluster arrangement with Dorset and Somerset, to be implemented by April 2027.

Noted from Wiltshire pharmaceutical needs assessment that this region has 1.2 pharmacies per 10000 population versus the 2.13 national average.

Planning reflections
Move towards year round planning and preparing data ahead of external requirements will be key to success. For 2026/27 planning the approach will continue to move towards increased join up across the Group with sign-off via the Joint Committee.

GIRFT
Positive visit from GIRFT team, now looking at system wide approach, for example an expansion of community dermatology to reduce pressure on the acutes.

	EPRR Business Impact Analysis remains an issue, although some progress has been made since the last meeting. **Health Inequalities** Quarterly report received and request for a proposal of key areas of focus which BSW could meaningfully impact. A Trust Management Committee workshop is planned in the Autumn to agree priorities and approach for our health inequalities delivery plan. There was a commitment to meet national reporting expectations and to focus on delivery of Core20plus5 priorities for adults and children. **Strategic Planning Framework watch metrics** Recommendations to streamline reporting to the committee were supported; the changes will result in only the relevant metrics from the national performance oversight framework being reported within the PPPC section of the IPR. There will be a reduction in duplication between oversight framework and watch metrics. A equivalent review would be relevant to other committees.
BOARD ASSURANCE FRAMEWORK & RISKS	Board assurance framework presented and substantial assurance with no changes.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**Cancer** 28 day FDS at 80.4% down from 84% but remains ahead of plan. 62 day performance improved from 70.9%, slightly below plan with plastics still a major issue - outsourcing being developed to substitute for OUH capacity undelivered. 48 breaches for 62 day against 38 in previous month. 31 day performance at 93.2% down from 95.2%. **RTT Validation** Further improvement month on month in RTT, Wait to first appointment and 52 week waiting patient numbers
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.
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Board Committee Assurance Report

Committee	**Quality & Safety Committee**
Meeting Date	22.5.25
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
	Complaints Response Rate
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. Complaint Response Rate (Breakthrough Objective)	Limited	
4. IPR concerns and complaints (Non-Alerting Metric)	Limited	
5. IPR Maternity	Good	
6. Perinatal Mortality Review Tool Report Q4	Substantial	
7. Quality Oversight of the Integrated Front Door (ED,UTC,MAU) Q4 2024/25	Partial	
8. Ward Accreditation Framework at GWH update	note	
9. Clinical Audit and Effectiveness and Nice Guidelines Update Q4 2024/25	Good	
10. EDS Update	note	
11. Safe Staffing 6 month review for `nursing, Midwifery and AHP	Good	
12. Safe Staffing Monthly Report	Note	
13. Board Assurance Report BAF1 Outstanding Patient Care-Q4 2024/25	Receive	

POINTS OF ESCALATION	
	IPR: Reduction Total Harms: • There has been no change in the overall harms in month, **IPR: continued monitoring Pressure Harms:** • The number of hospital acquired pressure harms has seen a further decline to its lowest ever level of 6 which gave the committee assurance that whilst no longer a break-through objective, the good practice has been embedded well and continues to be followed. . **IPR: Infection Control:** • The number of Healthcare associated infections remains stable, with a decrease in MSSA and *Klebsiella* but a rise in *E.Coli* (10 cases) of which 2 were related to cannula care and focussed work around cannulas continues. **IPR: Breakthrough Objective: Falls** • This has seen a significant increase in inpatient falls to 104 from 85 but there were no falls with moderate or severe harm. • However, falls sustained in patients who have fallen more than once has increased to 9 in month 9 (3 in March). • A Falls Hot topic of the month has been launched and a weekly falls panel set up to identify cases, themes and discuss causational factors. • The committee discussed the possibility of measuring the rate of falls in patients relative to hospital attendance, as data supports the fact that if rate of attendance was taken into consideration, the percentage of patients experiencing falls with harm is less in 2024/2025 compared to 2023/24.

	Complaints and Concerns Response Rate • The complaint response rate has deteriorated to 67%, reflecting a 4% decrease compared to March. A3 improvement meetings and work continue to focus on reviewing the process at divisional level. Further constructive actions from A3 work have been identified to mitigate and improve the response rate, including reviewing attendance to Complaints Writing Training, reviewing the process for allocating investigating managers, a practical top tips for effective complaints management has been devised and undertaking 'Go See' to areas of best practice.
	Maternity Integrated Performance Report • Significant progress against the CQC Action plan including 24 hr triage provision following the CQC inspection of sept 2023. • Compliance in MSD1 and PROMPT training / safeguarding remains a challenge due to fluctuations in staffing. Additional training is being offered to rotating doctors to try to get their compliance to 100%. • The committee received and were assured by the self-assessment update against the Immediate and Essential Actions from the Ockendon report and trust position on CNST year 6, having declared a position of compliance CNST year 7 guidance was released to all Trusts on 2nd April. • 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 significant reduction to rates of post-partum haemorrhage greater than 1500ml, due to focused MDT's and very active clinical teams. • Actions put in place so far: cell salvage training to all theatre teams, Grab bags of treatment support available in all birthing areas, specialist MDT sessions.
	Perinatal Mortality Review Tool ReportQ4 2024/25 • The committee was assured that the mandatory requirements for perinatal mortality reporting have been achieved by the Trust for Q4 and action plans are being developed to ensure fulfil year 7 CNST safety action 1 around perinatal mortality tool.
	Quality Oversight Integrated Front Door (Emergency Department, Urgent Treatment Centre and Medical Assessment Unit Q4 2024/25 • Delays in ambulance offloading, overcrowding and inpatient admissions continue to impact patient experience and outcomes. • April 2025 saw an unannounced CQC visit to these areas. • The initial high level verbal report identified staff as approachable, engaged, they commented on evidence of good practice and good navigation of patients through the different streams of admission. There were some concerns around some oversight in Ambulatory Majors, patient mix and timeliness of observations but overall good first feedback. • Since that visit, taking into account the verbal area of concern, a band 7 has now been put in place for better oversight and a medical register has been allocated for more direct involvement for quicker decision making. • Q4 has seen the lowest triage times for ED adults and work is ongoing to understand the reasons. • Children's Emergency Unit has demonstrated good triage times and the new environment has enabled some difficult cases to be managed well, with a much more robust model of care now possible. • There have been 2 ED Never Events and a new Patient Safety Consultant has now been put in place to mitigate against such events. • ED and UTC feedback has shown a negative deterioration, most common themes around handover delays and wait times, matron is undertaking A3 review and action plan.
	Clinical Audit and Effectiveness and Nice Guidelines Update Q4 2024/25 • Trust participated in 240/243 national audits. • No missed data submissions in Q4. • The few delayed audits are having focus work through with leads to complete. • Nice Guidelines: 82% Compliant, 16% in progress for compliance, 2% legacy records to be reassessed, less than 1% (6 guidelines) non-compliant. • Good compliance throughout Divisions over 90%.

	Electronic Discharge Summary update • New Care-flow EPR based electronic discharge summary system went live 26/3/25. • 24hr performance compares less favourably with overall performance on the previous system but direct comparison may not be possible at this early stage of use. • There have been teething issues with data quality and completeness of either the EDS or the complete process such that some. EDS have not reached target e.g. GP or patient. • There are a large number of historic EDS awaiting completion. • EDS status has been broken down by Division such that focussed support can be given. • Anticipating 2-3 months to work through the teething. Issues of a new electronic system. • Quality & Safety Committee will continue to monitor progress. • Monthly reporting of departmental/divisional compliance will be undertaken at Patient Quality Sub-Committee.
	Safe staffing 6 month Review, Nursing, Midwifery and AHP • Trust is making good progress in delivering safe staffing across Midwifery, Acute and AHP safe staffing. • Acute Nursing demonstrates compliance against the National Quality Board Safe, Sustainable and Productive staffing recommendations of Right Staff, right Skills, Right Place and Time. • High pressure periods over the winter, however, still required additional numbers of staff and shifts to cover escalation areas. • All wards are now funded and compliant with 1:8 nursing ratios but work is being undertaken to determine with which the frequency of areas working above that occur due to short term sickness absence. • Patient acuity and dependency audit March 2025 identified a picture of increasing dependency and acuity across the wards. • On a background of national maternity staff shortages, Great Western Hospital maternity unit staffing has continued to improve over the last 6 months due to recruitment and different staffing models. • Work continues towards achieving compliance with key metrics of Supernumerary status of Delivery Suite Co-ordinator, 1:1 care in labour and midwife to birth ratios. • Allied Health Practitioner workforce is in its strongest recruitment position in 18 months, employing to 9 of the 14 potential disciplines and with a plan to develop AHP apprenticeships in sonography. • AHP workforce remains predominantly female and under represented from global majority backgrounds. • New plans to rotate staff through community to enhance retention of staff. • AHP retention remains a problem as there are many competing organisations with competitive packages and career opportunities. • Good governance and oversight and escalation processes are in place. • Future recommendations include exploring different staffing model to address enhanced care and mental health requirements. • Emergency Department has the highest vacancy rate. • High number student applications on a national background of a decline in student intake. • Band 5 band has a 6 wte/month turnover, but there are not many vacancies. • Introduction of the Midwifery Degree Apprenticeship Program.
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	19.6.25
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
	Complaints Response Rate
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. Complaint Response Rate (Breakthrough Objective)	Limited	
4. IPR concerns and complaints (Non-Alerting Metric)	Limited	
5. IPR Maternity	Good	
6. Urgent and Emergency Care CQC Inspection Update – Draft Factual Accuracy Report	Note	
7. Children and Young People Survey	Note	
8. Research and Innovation Annual Report	Good	
9. Quality Accounts Draft Final	Note	
10. Quality and Safety Committee Effectiveness report	Approved	
11. Safe Staffing	Note	
12. Safe Staffing Monthly Report	Note	

POINTS OF ESCALATION	
	IPR: Reduction Total Harms: • There has been a slight increase in the overall harms in month, with 2 being related to falls with harm. • There have been 3 consecutive months of no medicines management harms and the committee assessed this with cautious optimism of an established improvement. **IPR: continued monitoring Pressure Harms:** • There has been an unexpected pressure harm increase in incidents (13) which relate to 10 individual patients. The majority being category 2, however there were four category three and one category four pressure ulcers reported. It has been recognised that 2 wards are the top contributors and there is ongoing work on retraining around pressure harm. The committee challenged around concerns of slippage in effectiveness of pressure harm care but were assured that the harms team have good oversight and action plans in place. **IPR: Infection Control:** • The focus on infection control was highlighted noting an increase in *C.diff* cases, particularly among chemotherapy patients. Efforts are being made to address this trend and improve overall infection control measures. Cannula care practices in preventing MSSA infections remains a focus to reduce the risk of introducing infections into the bloodstream. **IPR: Breakthrough Objective: Falls** • 2 falls with harm, one relating to a fractured wrist. Falls work now has resulted in a better understanding of the issues that need additional support. Top contributing factors relate to assessment areas, middle of the night moves and self-toileting on the care of the elderly wards. • However, the committee noted that there has been a slight deterioration in the overall trend in the falls rate, the committee were assured that this has been recognised and that work is now on going in assessing which of the measures determined through the previous A3 work are effective

	in falls reduction and which have no benefit. Also, where differing areas show success in falls management, trying to identify the mitigating factor having the most impact. • It is also noted the number of admissions with out of hospital falls prior to admission has also increased, which will result in increased risk of subsequent falls. • A Falls Hot topic of the month has been launched and a weekly falls panel set up to identify cases, themes and discuss causational factors.
	Complaints and Concerns Response Rate. • The complaint response rate has further deteriorated from 67% to 53%. The committee received a breakdown of divisional performance but there was no specific area with worst performance suggesting this to be a generic issue to address. • The presence of a backlog of overdue cases will take time to resolve. • There is additional focus on new complaints, to ensure response completion within required time frames. • The committee sought assurance that additional work around accountability is being undertaken. • Of additional concern is that there has been a notable increase in complaints with Emergency Department being a top contributor. Whilst this is accepted to be a true reflection of experience, most of which relate to waiting times and communication, there is also evidence to suggest that there are many formal complaints being recorded which would be better addressed through other channels.
	Maternity Integrated Performance Report • Chantal Woog will be the newly appointed Head of Midwifery, who will be commencing her new role in mid-July. CW is currently the Patient Safety Lead, and her new role is expected to bring positive changes to the Maternity Department. • Positive workforce metrics in May was reported including 100% compliance with one-to-one care in labour and an increase in shifts staffed to British Association of Perinatal Medicine (BAPM) standards. The upcoming qualification of nurses in July is expected to further improve workforce metrics. • Contributory Factors were identified relating to incidents of moderate harm training. • Positive feedback was shared from the Triage Walkabout. The staff appreciated the rationale behind the changes and were committed to improving care for families. • Ongoing improvement action plans and data reporting in place for all remaining amber actions relating to Ockenden Report and ensuring that we are aligning the IPR slides with RUH and SFT to the three-year plan. To ensure we are not duplicating work, they are aligning to a different system whereby they have undertaken a gap analysis of their outstanding amber actions. • Confidence now that BadgerNet data is true and reflective of current position. • The committee noted that there were a few incidents related to information transfer between teams, which has been identified and addressed. • Safeguarding training remains static and just below target, but a detailed plan is in place to address training for current staff and in the orientation period to ensure that with the new starters due in September there will not be a deterioration. • There were no complaints in May and the 4 concerns received were dealt with immediately.
	Update on Urgent and Emergency Care CQC Inspection-draft Factual Accuracy report • The initial report was disappointing, with specific focus points reported around ambulatory majors relating to pressure care, senior decision making and diabetes management. Almost all points raised have already been identified and are in process for address. • This area remains qualified as Requiring Improvement • The Senior Leadership, however, have submitted an extensive counter factual accuracy report as there were clear inaccuracies in the report provided. • Actions have already been identified and are in progress following points from the initial report.
	National Children's and Young Peoples Survey 2024-Full CQC • It was difficult for the committee to interpret this report as this is usually a biannual report, but due to Covid this data relates to data from over 4 years history, with huge methodology change utilised for this report. • The response rate was very low. • GWH was rated the same as most other Trusts in most areas but worse in 7 (previously only in 2 areas).

	• Whilst the methodology had changed kit was acknowledged that the bottom scoring areas related to activities for children, food provision and waiting times and Accompanied Play provision. • Measures have already been actioned to address these areas with a newly employed Play. Specialist, baby action plan, waiting times and available activity sets. • Children's services has moved to a new Division with a refreshed approach • Challenges remain around Mental Health support needs and wrap around support
	Electronic Discharge Summary update • New Care-flow EPR based electronic discharge summary system went live 26/3/25. • 24 hour performance figures compare less favourably with overall performance on the previous system but some of this is related to embedding the new system. • It has been identified there are areas not yet transitioned and still using paper which has also been a cause of some of the historic issues, this is being addressed now that it has been identified. • The committee is allowing an embedding period of 2 more months of the new system before challenging its effectiveness.
	Research and Innovation Annual Report • There has been a successful year of commercial research activity with a good increase in income revenue through this allowing for strategic reinvestment. • GWH, has not fully met its recruitment target for national research projects but there has not been any funding loss through this. • The Trust was awarded its first Research grant in 2024-25, demonstrating potential to support investigator led research which has a reputational benefit for the Trust and may impact medical recruitment positively. • The committee was assured by the report which demonstrated good progress but did demonstrate curiosity around the net cost impact of the research programme and requested an overall financial summary report, which will be provided.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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BOARD COMMITTEE ASSURANCE REPORT

Committee	**People & Culture Committee**	
Date of Meeting	24th June 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	Sickness rates	Staff Recommendation as a place to work (Respect)
	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. Committee Effectiveness Review Report	Approved	No
2. Annual Flu Report	Substantial	No
3. Annual Employee Relations Cases – Inc. 4-Step Model	Good	Yes, see below
4. Resourcing Plan Update	Noted	No
5. Employment Rights Bill – impact assessment for GWH	Received	No
6. National Education and Training Survey (NETS) 2024	Partial	No
7. Leadership and Management Training Needs Analysis	Approved	No
8. Trust Workforce Plan 2025/26	Noted	No
9. People Strategy 2019 – 2024 Closure Report	Received	No
10. Guardian of Safe Working Hours Annual Report 2024/25	Good	No
11. Postgraduate Medicine Educational Strategy	Noted	No

POINTS OF ESCALATION	The Committee's discussion of the annual employee relations case report led to a realisation that the Board should ensure that its EDI Board leadership and initiatives were sufficiently clear and robust The Committee's discussion of the annual employee relations case report highlighted the need to ensure that the Board's commitment to reducing bullying, harassment, and advancing equality, diversity, and inclusion (EDI) is clearly demonstrated and effectively actioned. It is proposed that the Board review its leadership and initiatives in these areas to ensure there are sufficient and robust actions at Board level, reinforcing its accountability and strategic oversight.
KEY AREAS TO NOTE	The committee's effectiveness review was discussed and no actions or substantive changes to the terms of reference were required. The programme to deliver annual flu immunisation for 2024/25 to frontline health and social care workers was delivered well. The Trust led the Southwest for Flu uptake and was 7th Nationally for flu vaccines for front

line staff. COVID vaccines were unfunded a decision was made to offer the COVID vaccine via Vaccination Track. The 2025/26 campaign will start in October with a national direction to improve uptake by 5%

A comprehensive summary of the employee relations cases over the last year showed that: the just and learning culture approach is working well; cases are being better recorded; long term absence issues are being addressed more effectively and formal sanctions in conduct cases are being applied more regularly.

The resourcing update demonstrated good progress against this plan and outlined significant actions in progress and being planned to collaborate with RUH and SFT on both permanent and temporary staffing.

The committee received an update on the progress of the Employment Rights Bill, legislation with contains a comprehensive overhaul of employment protections and obligations for employers across all sectors, including the NHS. The Committee noted that the forthcoming reforms may impact the capacity of the HR team. There was discussion around the possibility that, depending on the maturity of the Group, resources could be brought together and shared across the organisation to enable a "do it once" approach, improving efficiency and consistency.

For the first time the committee received the Trust's National Education and Training Survey (NETS) results for AHP, midwifery and nursing staff - although this annual survey has been conducted since 2019. The results demonstrated some good progress, improved governance and some robust plans for further improvement.

The committee approved the work being progressed on the leadership and management frameworks. It is intended that this work, which will provide a much clearer articulation of the Trust's values, behaviours and competencies, is finalised over the summer and launched in September. This will be supported by a clearer training and development framework which will be developed in collaboration with SFT and RUH.

The People Strategy 2019 – 2024 Closure Report was received; the committee acknowledged the work done by the HR function across a wide range of issues to deliver on the development, strengthening and retention of our workforce. The intention to approve the revised strategy, focussed on: collaboration; innovation, and culture - at the meeting in August was noted.

The Guardian of Safe Working Hours Annual Report 2024/25 demonstrated that although exceptions had reduced these were still at a relatively high level. The focus will remain on fully understanding and implementing exception reporting reforms, it is anticipated that the reforms will increase the number of exception reporting, however the Trust is still awaiting national guidance.

	The new Postgraduate Medicine Educational Strategy was noted. This should enable a more coherent and better co-ordinated approach to be taken across the Trust.
BOARD ASSURANCE FRAMEWORK & RISKS	The risk connected with the Trust being unable to deliver the workforce reduction programme for 2024/25 will be replaced with specific risk associated with the 2025/26 reductions. The committee noted the Trust's 2025/26 Workforce Plan, although many proposed reductions remain at the concept stage, with no detailed implementation timelines or assigned ownership.

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

Committee	Finance, Infrastructure & Digital Committee	
Meeting Date	27 May 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. Board Assurance Framework	Substantial	x
2. Finance Risk Register, including the Way Forward Program	Good	x
3. BSW Financial & Recovery Workstreams Update	Limited	✓
4. Month 1 Finance Position	Partial	x
5. Improvement & Efficiency Program	Limited	x
6. Debtors Report	Good	x
7. Overseas Visitors Report	Good	x
8. PFI Expiry re-provision options appraisal	Good	x
9. Quarterly Coding & Mortality Status Report	Partial	x
10. BAF Strategic Risks – review of emerging risks	Note	x

POINTS OF ESCALATION	**BSW Financial Update:** The Q1 forecast position for BSW Hospitals Group and ICB is materially off-plan and subject to intervention from the NHS England regional team. The Regional Team raised concerns around BSW's Month 1 finance position and confirmed the following actions: • The system is required to put in place an immediate freeze on all non-clinical recruitment, with any exceptions requiring regional approval. • Further consideration will be given at the regional level as to whether this should extend to Clinical recruitment as well. • Any planned or unplanned investments, plus any other discretionary spending, need to be stopped with immediate effect until there is more confidence that the financial plan will be delivered. • To mitigate the potential impact on the cash position, the system needs to stop all capital spending which is not yet contracted, again until there is more confidence in the delivery of the revenue plan • Deficit support funding not paid for M1 and will not be paid until sufficient assurance is in place for a return to balance. Furthermore, the Committee's assurance rating of 'Limited' is based on the scale of the risk, lack of independent challenge at the system level and immature governance processes or the lack thereof.
POINTS TO NOTE	**Month 1 Financial Position:** The Trust has commenced the 2025/26 financial year with an M01 adjusted deficit position of £2.2m, which represents a £2.2m adverse variance to plan. This is broadly in line with the under-delivery of the efficiency plan. The income is £0.7m behind the plan, partly due to the equal distribution of the plan compared to the working days available in the month. Notably, the ERF income associated with scenario 2a's planned activity is £0.4m behind the plan, partly offset by a £0.2m favourable variance against non-pay for this activity in the clinical divisions. The pay position is £1.3m, adverse to plan. Undelivered CIP accounts for £1.0m, with ongoing use of temporary staffing, particularly in front door areas, driving the remainder. Non-pay is £0.3m adverse to plan. Net drug costs are £0.2m over plan; £0.1m is driven by PbR drugs, which are within the Trust's control, and a further £0.1m is due to high-cost medications, for which we receive block income from the ICB. 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 began 2025/26 with a £27.0m cash-releasing efficiency target, which includes a £2.8m carry-forward of undelivered and non-recurrently delivered efficiency from 2024/25. As of Month 1, the programme has delivered £356,000 to date, which is £1.73m under the plan and represents a 17% achievement against the £2.08m target for the month. Of the efficiencies delivered, 69% are recurrent, an improvement on last year's M01 (55%). The under-delivery of efficiencies is a significant driver of the Trust's £2.2m overspend against the plan in M01. All divisions must continue to identify and implement savings schemes and ensure the I&E tracker is fully populated for M02 reporting. Currently there is a high risk of delivering the efficiency programme for 2025/26, hence the Committee has assured this as 'Limited'. While the recurrent delivery proportion in M1 is improved, the low delivery volume and high risk of schemes undermine confidence. There is, however, a good assurance for the process of identifying and tracking of savings.
	Clinical Coding Report: Clinical Coding capacity and backlog volumes are still not at an acceptable level with only short-term risk mitigations in place. Until sustainable improvement is seen this report will remain partial assurance.
BOARD ASSURANCE FRAMEWORK & RISKS	**Board Assurance Framework:** The significant level of assurance is around the process to support the completion of the BAF to enable effective scrutiny and challenge by the Committees, and ultimately, by the Board of Directors.
	Finance Incl. Way Forward Program 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.
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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	23 June 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	✓
2. Month 2 Finance Position	Good	x
3. Improvement & Efficiency Program	Limited	x
4. Capital Prioritisation	Good	x
5. Estates & Facilities Risk Report	Good	x
6. PFI Quarterly Report	Good	x
7. ERIC Annual Submission	Good/Approve	x
8. Green Plan Renewal	Good/Approve	✓
9. Climate Change Risk Assessment	Good/ Approve	x
10. Letter of Indemnity for Aseptic	Approve	
11. Procurement Recommendation Reports	Good/Approve	✓
12. CDC Business Case	Approve	x
13. Committee Effectiveness & Review of FIDC Terms of Reference	Good/Approve	x
14. BAF Strategic Risks – review of emerging risks	Note	x

POINTS OF ESCALATION	**BSW Financial Update:** The BSW financial position is adverse to the plan at Month 2 by **£13.5m**. The individual organisation positions are as follows: GWH, **£5.7m** off plan; RUH, **£7.2m** off plan; SFT, **£3.8m** off plan; and ICB, £3.2m ahead of plan. The current positions illustrate deteriorating positions at all Provider Trusts, which are partially offset by the ICB improving its favourable position compared to the plan. For all providers, issues persist with the delivery of efficiency and improvement programs, resulting in run rates exceeding required levels. Mitigating plans are in place to address this to some degree. The current "expected" position at Q1 is **£15.2m** adverse to plan. This has led NHSE to withdraw deficit support funding, further deteriorating the position and highlighting the urgent need for corrective actions. The financial position of both the Trust and the wider BSW system is extremely challenged in 2025/26. Currently there needs to be a greater degree of confidence in the deliverability of efficiency and workforce plans in all BSW organisations before the assurance rating can be improved. This is being monitored on a fortnightly basis by the BSW Strategic Recovery Board. Furthermore, the Committee's assurance rating of 'Limited' is based on the scale of the risk, lack of independent challenge at the Group level and immature, albeit evolving, governance processes.
POINTS TO NOTE	**Month 2 Financial Position:** For M02 2025/26, the Trust has an adjusted deficit position of **£5.6m**, representing a **£5.6m** adverse variance to the plan. The income is **£1.5**m behind the plan, with the key driver being the removal of the Trust's deficit funding of **£1.6m**, which was off plan. It should be noted that if the Trust were receiving the deficit funding, the variance to plan would reduce to £4.1m, reflecting the tangible gap the Trust needs to bridge. ERF income associated with scenario 2a is **£0.2m** favourable to the plan, partially offset by a **£0.1m** underperformance against private patients. The pay position is **£2.7m**, adverse to plan. Undelivered CIP accounts for **£1.9m**, with ongoing use of temporary staffing, particularly in front door areas, driving the remainder. Work continues with unwavering focus on reducing temporary staffing spend, particularly in areas where substantive staffing is near or at complete establishment levels, to reassure stakeholders about the cost-saving measures being implemented. Notably, enhanced care and escalation costs remain high, up 41% from M02 2024/25. Non-pay is **£1.5m** adverse to plan. While passthrough drug costs are offset by income, there is an underlying **£0.2m** pressure due to overperformance on ICB-related drugs, resulting in lower transitional funding. The non-pay undelivered CIP target is £1.3m, with the remaining £0.1m spread across other non-pay lines. Non-pay savings are focussing on areas where the run rate is trending upwards, along with broader grip and control measures such as stock control on the wards and reducing discretionary spending. 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: As of Month 2, the programme has delivered **£1.83m** year to date, which is **£2.57m** below the planned **£4.41m** year-to-date (YTD) target, representing 42% achievement. While the Month 2 position demonstrates a significant improvement in delivery and increased recurrent performance, substantial risks remain. Delivery is still below plan, and a high proportion of schemes remain redrafted (45%). The increase in momentum and delivery confidence, along with strengthened divisional ownership, is encouraging. However, the high levels of high-risk schemes, particularly within Corporate, continue to present a material risk to full-year delivery. The assurance level remains 'Limited' to achieve Partial assurance by the end of Q1 through focused implementation and governance improvements. Several financial controls have been implemented, including tightened expenditure controls, enhanced scrutiny of recruitment and agency use, stricter sign-off procedures for non-essential spending, and robust divisional accountability frameworks. These measures are in place to reassure stakeholders about the cost-saving measures being implemented. Delivery progress is essential to regain access to deficit funding.
	Green Plan 20025-2028: A comprehensive Green Plan, along with detailed actions, was submitted to FIDC for review and approval. The Committee, as a key part of this process, was assured that adequate measures are in place to monitor and control environmental risks and are regularly reviewed. However, we did raise concerns regarding the delivery of the plan, given the challenges around funding, to ensure that these actions are adequately and effectively addressed.
	Estates & Facilities Risk Report: 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?	
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Board Committee Assurance Report

Committee	**Charitable Funds Committee**
Meeting Date	14 May 2025
Committee Chair	Julian Duxfield, Non-Executive Director

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Financial Reporting	Good	
2. Cases of Need	Good	
3. Fundraising	Partial	
4. External review action plan	Partial	
5. Divisional Charitable Funds Spending Plans	Good	
6. Fund Rationalisation – Direction of Travel	N/A	
7. Charitable Funds Partnership Agreement with HCRG	N/A	
8. Arts – Direction of Travel	N/A	

POINTS OF ESCALATION	The Funds Rationalisation proposal will be brought to Trust Board for approval in due course.
BOARD ASSURANCE FRAMEWORK & RISKS	The Committee received the financial reports for the last financial year. The Fund balance at 31 March 2025 was £955k, of which £723k is Restricted and £232k is Unrestricted. The total income which was reported (£554k) did not, however, include all legacy income but this figure will be available for the next meeting, at which point the accurate fundraising return on investment data will be available. The total expenditure for the year was £861k. We reviewed the 'Cases of Need' and it was agreed to transfer all available funds into funding the Clix prescription collection lockers, and it is expected that final funding will be released at the August meeting. It was agreed not to approve the Penicillin De-Labelling project because there is no Trust budget confirmed as available to fund this into the longer-term and it is not appropriate to add further future cost pressures onto the Trust. As a consequence of the recent relocation of the systemic anti-cancer treatment services within the Trust, we have the opportunity to renovate an unused area (hydrotherapy pool) to expand our health & wellbeing offer and estate to patients and their families. This will involve co-designing the space with patients, relatives and staff. It was agreed that a proposal, to be reviewed at the next meeting, will be developed and have a significant fundraising campaign associated with this. The Committee agreed a proposal to accrue a portion of funds quarterly to projects which the Committee have approved, but which cannot currently be funded in their entirety with the available fund balance. This allocation method will enable the sustainable funding of larger projects without disrupting ongoing charitable spending and ensure financial flexibility while safeguarding strategic initiatives. This was done for the Clix prescription collection lockers case as outlined above. The Committee received an outline plan on the project to rationalise the 98 charitable funds across GWH. The consultant we have engaged will produce a full paper for circulation to the Committee in mid-July for feedback. A final paper will be presented at the August CFC meeting and this will also be presented for approval at the Trust's August Board meeting. The Committee received the Charitable Funds Partnership Agreement with HCRG to enable continuation of the arrangements in place for charitable funds donated for

	Community Services in the Swindon & Wiltshire area. This is a departure for the Charity in holding funds for an independent organisation. As a result, formal arrangements have been drawn up which mirror the processes of funds draw down (through Cases of Need to the Committee), management of donations and annual spending plans. In common with the previous arrangements there will be overheads charged to HCRG to support the running of the Charity and ensure that costs are fairly attributed. We await HCRG's response to this agreement. Divisions were asked, as is usual each May, to present their plans for the forthcoming financial year. Each plan has a RAG rated target that encourages Divisions to commit as much of the funds as possible. All three Divisions had identified commitments equivalent to around $^{2}/_{3}$ of their current funds, a satisfactory situation. Each Division provided the Committee with a good level of assurance about their divisional focus on spending these funds and dialogue with each Division will continue for the remainder of the year to monitor the situation. The Committee received a presentation outlining a proposed GWH Arts Programme which aims to integrate art into healthcare settings to enhance the environment for patients, visitors, and staff. The Committee was supportive of the direction of travel and a full proposal will be presented at the August meeting.
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	**Audit, Risk & Assurance Committee**
Meeting Date	24 June 2025
Committee Chair	Helen Spice, Non-Executive Director

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Board Assurance Framework	Substantial Assurance	
2. Risk Register Report	Good Assurance	
3. Annual Report and Accounts 2024/25	Approved	
4. ISA 260 Report 2024/25	Good Assurance	
5. Internal Audit Annual Report and Head of Internal Audit Opinion 2024/25	Good Assurance	
6. Internal Audit Progress Report and Action Tracking	Good Assurance	
7. Internal Audit – EPR Implementation Final Report	Limited Assurance	
8. Internal Audit – Medical Rostering Final Report	Limited Assurance	
9. Internal Audit – 2025/26 Plan	Approved	
10. Local Counter Fraud Annual Report 2024/25	Approved	
11. Local Counter Fraud Progress Report	Good Assurance	
12. National Cost Collection 2024/25 pre-submission assurance	Good Assurance	
13. Clinical Negligence Litigation Report	Noted	
14. Losses and Compensation Report Q4 2024/25	Noted	
15. Annual Committee Effectiveness Review	Approved	

POINTS OF ESCALATION	The Committee approved and recommended approval to the Board of the amended Terms of Reference for the Audit Risk and Assurance Committee.
KEY AREAS TO NOTE	The Committee received the ISA 260 Report from Deloitte for 2024/25 following the completion of their annual audit work and their Value for Money Review. The Committee approved the Annual Report and Accounts for 2024/25 on behalf of the Board. The Committee received the KPMG Internal Audit Annual Report for 2024/25 which rated The Head of Internal Audit Opinion as one of: 'Significant assurance with minor improvement opportunities'. At the time of the meeting the internal audit review of the Data Security and Protection Toolkit had not been finalised. The Committee was assured by management and the internal audit team that this would be completed and submitted by the deadline of 30 June 2025. This did not impact the final audit opinion. It was noted by the Committee that the 4 out of 7 reviews completed in the year were rated as 'Partial Assurance with improvements required'. KPMG noted that in addition to the ratings given they also take into account, the actions identified and completed, management approach and the Trust's performance against other organisations in considering their rating and confirmed their overall opinion as Significant assurance with minor improvement opportunities. KPMG provided two final internal audit reports for 2024/25. The internal audit review on Medical Rostering was rated as 'Partial Assurance with improvements required'. KPMG recognised that this review had been chosen by management as there were areas that they knew could be improved upon. The actions are now underway to improve these processes. The Committee requested that a follow up review is conducted early in 2026/27 to ensure that the actions are embedded and performing as they were intended. KPMG also provided the final review on EPR Implementation that was conducted across all three Trusts in BSW. This review was rated as 'Partial Assurance with improvements required'. This review was conducted in February/March but has only just reached the Committee. The Committee raised concerns about this review as the actions that were identified as part of the review are significant. The Committee are also aware that these actions, with deadlines of 30 June have still not yet been implemented and could have a significant impact on the project. The Committee therefore rated this review Limited and required immediate action by management, who were not in attendance, to provide assurance that the actions will be addressed swiftly. The Committee received a report on Clinical Negligence Claims activity for 2024/25. The Committee welcomed the report. As it is the first time this report had been received by the Committee there were a number of questions to develop understanding of our claims activity so the Committee agreed not to rate the report at this stage until this understanding is more embedded.

BOARD ASSURANCE FRAMEWORK & RISKS	The Committee reviewed the systems and processes around the Board Assurance Framework and the work undertaken by the Board Committees to review the BAF on a regular basis and confirmed their assurance that the BAF and its processes remain effective. The Committee received an update on the actions and processes being undertaken by management to review risk across the organisation and were assured that the processes are in place and effective although continue to raise concerns about risks with no actions. The Committee also noted that there has not yet been appropriate consideration of the impact of the newly established Group on our risk management processes and reporting. The Committee requested that at the next update there is a plan in place to consider the impact of the Group on our risk management processes and reporting but recognising this will evolve over time.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The Committee recognised the extensive work that has gone into the preparation of the Annual Report. The Committee also recognised the progress that had been made by the Finance Team in the clearance of a number of the outstanding process issues from the prior year audit and the significant work done by the team to get the audit completed.
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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Report Title	**Safe Staffing 6 month review for Nursing, Midwifery and AHP**				
Meeting	**Trust Board**				
Date	**10/07/2025**	**Part 1 - Public**	✓	**Part 2 - Private**	☐
Accountable Lead	Luisa Goddard, Chief Nurse				
Report Author	Ana Gardete Deputy Chief Nurse, Kat Simpson Director of Midwifery and Neonatal Services; Juliette Sherrington Associate Director of Allied Health Professionals				
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:

The report gives the committee assurance of safe staffing processes for Nursing, Midwifery and AHP within the Trust and highlights areas of concern.

Report

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

This report aims to provide the Trust Board with assurance that staffing has been managed over the past 6 months in line with the National Quality Board guidance and Developing Workforce standards.

It makes recommendations for maintaining a safe sustainable nursing, midwifery and allied health professional (AHP) workforce through the triangulation of professional judgment and professional evidenced based acuity tools.

The Trust Board last received a Safe Staffing Paper in November 2024.
This report covers:

- Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations,
- Safe staffing related to AHP
- Nurse staffing compliance with national guidance

The **Acute Nursing** report highlights the compliance against the National Quality Board Safe, Sustainable and Productive staffing recommendations of Right Staff, Right Skills and Right Place and Time. The Trust has moved from Quartile 3 to Quartile 4. The Trust has a value of 9.2 (peer median is 8.6) for total nursing staff and Quartile 3 5.3 (peer median 5.1) for registered nursing staff. Health care support workers is 3.7 with a provider median of 3.4.

Although this is a positive picture, the Model Hospital does not take into account temporary escalation areas. Over the winter months, to staff these areas safely, additional shifts have been required which impacts the increase in the numbers of staff. The report also highlights that all wards are now funded to be compliant with the 1 nurse to 8 patient ratios. However, further work in under way to determine the frequency of areas working above that due to short term absence.

Maternity and Neonatal Safe Staffing
The report covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report. It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing has continued to improve over the last six months by identifying different staffing models, and recruitment. The key metrics of Supernumerary status of the Delivery Suite Coordinator, one-to-one care in Labour and midwife to birth ratio are all presented and discussed. Although there is ongoing work to ensure compliance, there are no specific areas of immediate concern.

The neonatal unit at Great Western Hospital (GWH) is classed as a local neonatal unit (LNU). Babies cared for, are those who require short term intensive care (ITU) up to 48 hours, high dependency (HDU) care and low dependency care. The report describes the position against the British Association of Perinatal Medicine (BAPM) standards (2010). To meet the standards there is a focus on increasing the number of band 5 registered nurses that hold the qualified in Speciality (QIS) course. External funding has enabled the further development of Advanced Neonatal Nurse Practitioner (ANNP) roles.

Allied Health Professionals
The AHP workforce is in its strongest recruitment position in 18 months. A long-term workforce plan (1-3 years) is in place, focusing on training, retention, and workforce reform. Capacity and demand modelling will be integral to ensuring a sustainable AHP workforce at GWH.

Conclusion
The Trust continues to make good progress in delivering safe staffing across Acute, Midwifery and AHP safe staffing. The work on recruitment and retention is demonstrated in improvements in the workforce metrics and is supporting the drive to improve patient care.

There is good governance and oversight of staffing and escalation processes in place for any concerns.

The report will make recommendations to the committee regarding actions required to achieve a sustainable and effective nursing, midwifery and AHP workforce.

- Ensure robust recruitment and retention plans for registered nursing.
- Ensure the next Birth Rate + report recommendations inform future workforce planning to achieve safe staffing.
- To complete dedicated SNCT for ED
- To explore a different staffing model to address enhanced care and mental health requirements

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 500 There is a risk of poor-quality metrics and reduced staff morale/high turnover due to inpatient wards working at a ratio of 1:10 for registered and unregistered staff. This is against the national guidance of 1:8 or below.	9
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Nursing, Midwifery and AHP workforce group, Trust Management Committee, 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:			
The paper describes the governance of safe staffing across the Trust.			

Recommendation / Action Required	
The Board/Committee/Group is requested to:	
The Board is asked to note the recommendations of the report.	
Accountable Lead Signature	Luisa Goddard.
Date	**28/04/2025**

1. Introduction

Following publication of the Francis Report (2013) and the subsequent “Hard Truths” (2014) document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels.

These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward. This is published on the NHS Choices website.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift

- Provide a six-monthly report on nurse and midwifery staffing to the Board of Directors.

The Royal College of Nursing (RCN) Workforce Standards (2021) report has also been fully reviewed and compliance continues to improve with actions in place to support best practice.

The Board of Directors is expected to confirm their staffing governance processes are safe and sustainable. This report aims to provide the committee with assurance that staffing has been managed over the past 6 months in line with national recommendations and to highlight areas that are not compliant or need further work to improve compliance. The report will make recommendations to the committee regarding actions required to achieve a sustainable and effective nursing and midwifery workforce.

The Board last received a Safe Staffing Paper in November 2024.

The report covers:

- Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations,
- Safe staffing related to AHP
- Acute Wards compliance with national guidance and the Emergency Department Safer Nursing care Tool review.

1.1 Background

The NHS Improvement 'Developing Workforce Safeguards' (October 2018) supports Trusts to use best practice in effective staff deployment and workforce planning utilising evidence-based tools and professional judgement to ensure the right staff, with the right skills are in the right place at the right time. Using this approach will ensure that safe staffing levels are determined on patient needs, acuity and risks and can be monitored from 'ward to board'. This triangulated approach to staffing decisions is also supported by the CQC.

Table 1- NQB: Safe, Sustainable and Productive Staffing

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

For the acute inpatient wards, this report will focus the updates in the structure of Right Staff, Right skills and Right place and time

2.0 Right Staff

To support professional judgement, evidence-based workforce planning includes Care Hours per Patient Day, Safer Nursing Care Tool, Fill rates (planned vs actual staffing) and Model Hospital benchmarking.

2.1 Fill Rates – Nursing staff planned vs Actual (in-patient beds)

The Trust submits monthly returns to the Department of Health via the NHS National return. This return details the overall Trust position with actual hours worked versus hours expected for all inpatient areas. The percentage fill rate for registered nurses and health care support workers for day and night shifts together with the overall Trust percentage fill rate. This return also includes CHPPD.

The fill rates report is presented monthly to Quality and Safety Committee, highlighting areas for improvement.

The fill rates have remained above the expected benchmark of 85% for the months reported. It should be noted that there remains a level of fluctuation in the fill rates related to recruitment, the need for enhanced care and additional patients on wards due to operational pressure.

Table 2 Trust wide Fill Rates

	Safer Staffing – average fill rate RN (%)	Safer Staffing – average fill rate HCA (%)
Oct-24	95.6%	101.6%
Nov-24	97.2%	103.1%
Dec-24	98.0%	101.7%
Jan-25	97.3%	99.4%
Feb-25	95.2%	99.7%
Mar-25	98.5%	108.8%

2.2 Care Hours Per Patient Day (CHPPD)

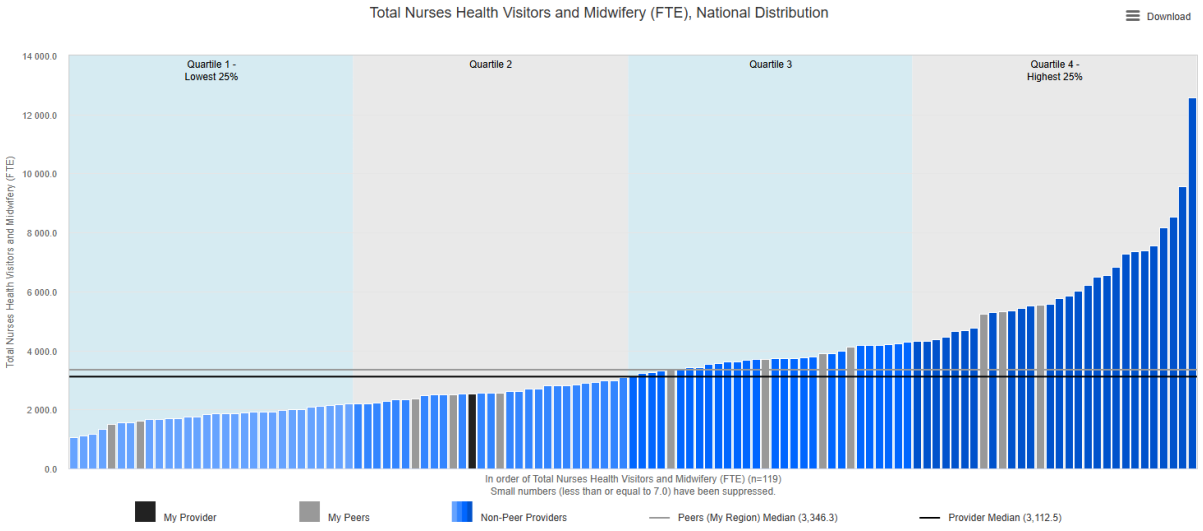
The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone.

Every month the hours worked during day shifts and night shifts by registered nurses and by health care assistants are added together. Each day the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate the average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day.

The Model Health System is a digital tool provided by NHSE which provides national benchmarking on productivity and quality. CHPPD is available as a benchmark against other Trusts, it is produced from actual wholetime equivalents worked i.e. not funded establishments.

The latest data is January 2025 and shows that for registered and unregistered staff, the Trust has moved from Quartile 3 to Quartile 4. The Trust has a value of 9.2 (peer median is 8.6) for total nursing staff and Quartile 3 5.3 (peer median 5.1) for registered nursing staff. Health care support workers is 3.7 with a provider median of 3.4. Although this is a positive picture, the Model Hospital does not take into account temporary escalation areas. Over the winter months, to staff these areas safely, additional shifts have been required which impacts the increase in the numbers of staff.

Recent data from April 2025 also describes that for total full time equivalent Nursing and Midwifery staff, the Trust is on Quartile 2.



This demonstrates how the Trust is comparing within a safe benchmark to peers and national benchmarking.

2.3 Safer Nursing Care Tool

The Safer Nursing Care Tool (SNCT) is a nationally recommended, evidence-based tool that enables nurses to assess patient acuity and dependency and by incorporating a staffing multiplier ensures that nursing establishments reflect patient needs in acuity / dependency terms.

It is recommended that it is used at least once a year to inform establishments and facilitate consistent nurse-to-patient ratios in line with agreed standards.

The acute wards completed a 2-week data collection in March 2025. This will allow a comparison against the 3 data point recommendations and current funded establishment in more detail.

However the results are shown below, which demonstrates the increasing number of patients that are dependent on nursing care to meet most or all of their nursing needs. One of the most significant changes compared to the previous data collection in September 2024, is the introduction of new descriptors, level 1c (for patients who require one-to-one care or continuous supervision to maintain safety) and level 1d (for patients who require the exclusive care of twi healthcare professionals at all times).The number of Level 2 acute patients is also increasing and seen across a variety of wards with a concentration on Dove, Meldon and Acute Cardiac Unit.

Results of patient acuity and dependency audit March 2025

Level Descriptors
Level 0 – needs met by normal ward care
Level 1a – acutely ill patients requiring intervention
Level 1b – dependent on nursing care to meet most of all their needs
Level 1c – require one-to-one care or continuous supervision to maintain safety
Level 1d - require the exclusive care of two health professionals at all times
Level 2 – acutely ill requiring intervention, normally in Level 2 designated beds.

Unit	Lvl. 0	Lvl. 1a	Lvl. 1b	Lvl. 1c	Lvl. 1d	Lvl. 2	Lvl. 3
Dove Inpatient Roster - J65027	1	2.7	4.8			2.5	
Aldbourne - J65313	4.6	1.7	5.6				
Beech & EPU - J65917	4.7	1.6	10.9				
Children's Unit & PAU - J65923	11.2	3.5	2			2.1	
Critical Care Unit - J65355	1	1.9	1.8			3.2	2.9
Daisy/DSU - J65351	10.6		1				
Meldon Ward - J65337	16.4	2	18	1		2	
SAU - Surgical Admissions Unit - J65380	11.8	1	1.8				
Trauma Unit - J65387	2	1.3	34.7	1.5			
Acute Cardiac Unit - J65621	1.4	8.8	1.7			2	
Acute Stroke Unit - J65624	7.1	1.5	7.9	1		1.6	
Ampney Ward - J65331	4	1.5	14.6	1		1	
Jupiter Ward - J65625	2.4	4.1	25.5				
Kingfisher Medicine - J67273	8.7	7.3	15.2	2.4	1		
LAMU Nursing - J65634	8.1	11.1	8.4	1.6	1	1.7	
MAU Nursing - J67565	8.2	3.6	5.3			1	
Mercury Ward - J65638	16.5	3	12.5	4		1	
Neptune Phase 2 - J65637	5.5	7.6	21.4			1.5	
Saturn Phase 2 - J65647	6.8	14.5	10.7	4		1	
Teal Ward - J65639	5.6	1.1	27.7				
Woodpecker Ward - J65314	5.5	2.4	25.5			1	

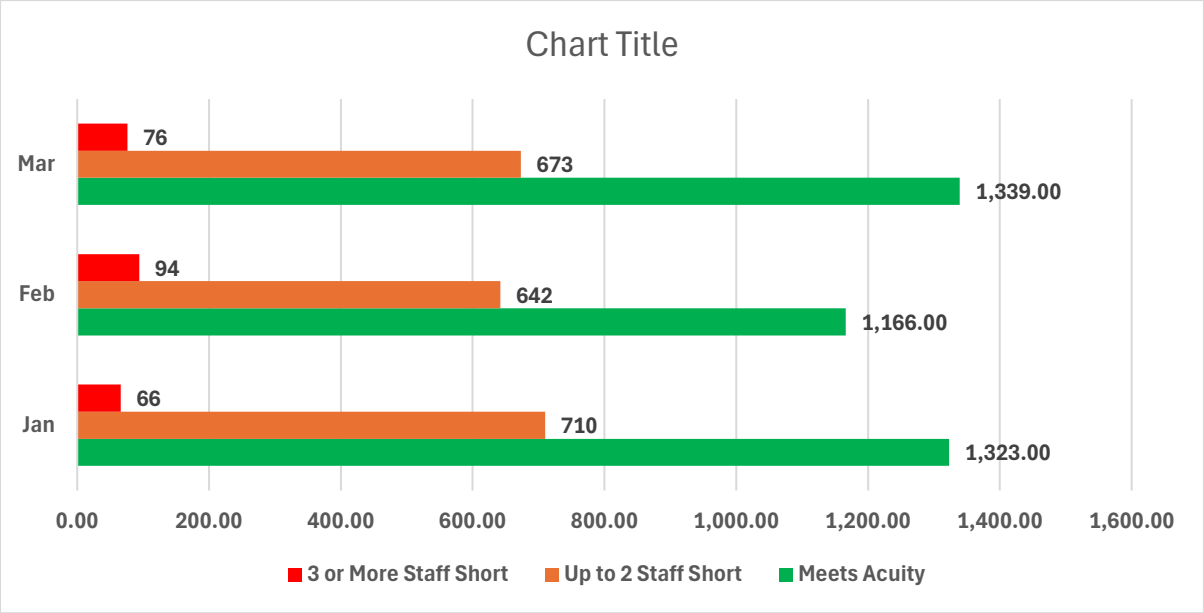
A review of the data collected demonstrates that the wards can meet patient need based on current funded establishments, in keeping with the previous investment in safer staffing.

The audit for March 2025 shows an increasing picture of dependency and acuity across the inpatient areas, which likely reflects seasonal pressures. During the establishment reviews, the ward managers reflected on the increase in the numbers of patients requiring enhanced care, and although this is not significantly recognised in the data collection, in terms usage of the new descriptor level 1c, this is probably because it is the first time the teams have used the new descriptors and as such we will need to compare the data with future monitoring periods.

2.4 Nurse to Patient Ratios

National guidance since the Francis Report (2015), including NICE guidance, states that nurse to patient ratios should not be greater than 1:8. There is an increasing body of evidence that links ratios greater than 1:8 to higher mortality as well as poor nurse sensitive indicators and poorer patient experience.

Following the agreed 3 year safer staffing investment, all wards are now in line with guidance. The establishment reviews with the Chief Nurse have provided assurance that the wards are working at a funded establishment of 1:8 ratio. However, it should be noted that the wards are still working at higher ratios when covering last minute absence. A snapshot review of the past three months demonstrates that out of 6089 shifts (day and night), 2261 shifts (37%) were on amber and red staffing numbers, meaning that the wards weren't fully staff by either registered nurses or healthcare support workers. This continues to be monitored and escalated through the 3 times a day staffing meetings to ensure mitigations can be put in place so that patient safety is maintained.



Emergency Department

ED was not part of the March data collection and this will be done separately. Since November 2024, with the introduction of the timely handover process, with the aim to improve handover standards and reduce delays, there have been significant pressures added to the ED team. In

recognition of this, the ED establishment has increased to reflect the required skill mix in triage and to allow safe staffing of an ambulance handover space ensuring patient safety.

3.0 Right Skills

3.1 Recruitment and Retention

3.1.1 Vacancies and turnover for nurses

The reduction in Registered Nursing and Health Care support worker vacancies has been maintained and although there was an increase in the number of vacancies for healthcare support workers, this has reduced significantly with 48.56wte joining the Trust in January and February 2025.

The average leaver rate for Band 5 registered nurses stands at 6.09 WTE per month, reflecting an improvement from the previous year's 7.76 WTE per month. Benchmarking on Model Hospital for January 2025 has the 12-month rolling turnover at 8.1% with the national average as 9.2%, this places the Trust in Quartile 2. Within the BSW system, we have the highest 12-month rolling turnover rate, with RUH at 7.8% and Salisbury at 8%.

The table below describes the Trust turnover rates for registered and unregistered staff.

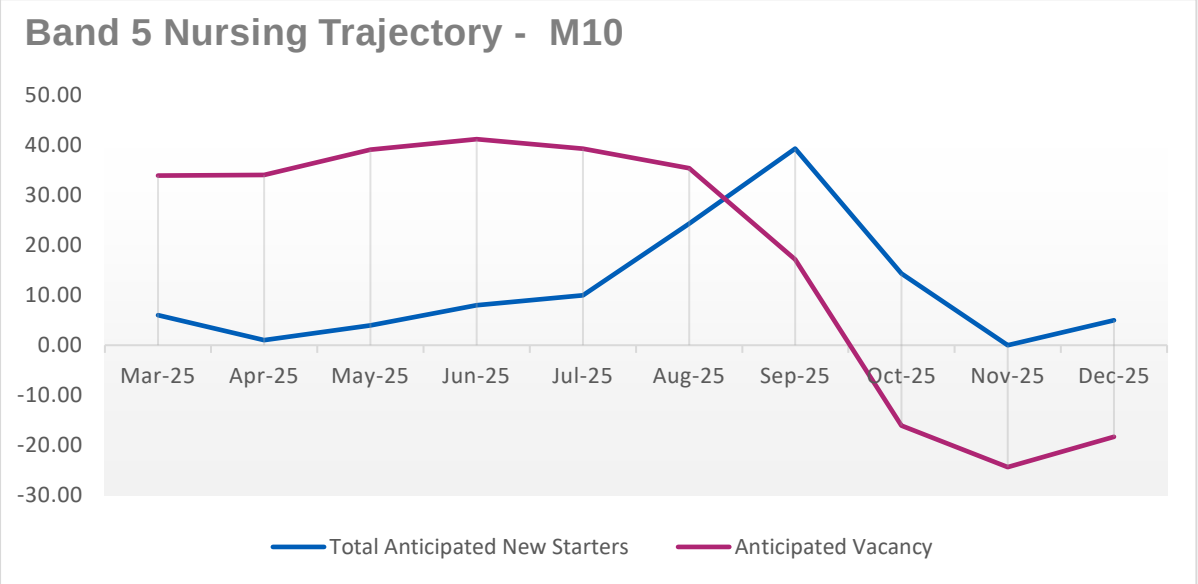
Staff Group	Average HC	All Leavers HC	All Turnover	Vol Leavers HC	Vol Turnover
Registered Nursing and Midwifery	1,978	170	8.59%	142	7.18%
Unregistered Nursing and Midwifery	1,013	122	12.04%	99	9.77%
Trust Total	5,612	618	11.01%	476	8.48%

Recruitment of Healthcare Support Workers continues to be successful and in order to improve retention in this group we have strengthen the career pathways available, with further education and development to band 4 and band 5 roles. In addition, the Trust continues to support developmental off site "Away days" which reiterates our organisational commitment to staff.

The recruitment trajectory remains in a positive position as detailed below. This year, we had an unexpectedly high number of student applications and the equivalent of 72.28wte newly qualified nurses have been recruited and will join the Trust from July 2025. Although we had a high number of applications, the national trends indicate a decline in student intake, necessitating the development of alternative pathways .

Band 5 Registered Nurse trajectory to December 2025

Trust	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Average Leaver	6.09	6.09	6.09	6.09	6.09	6.09	6.09	6.09	6.09	6.09
Budgeted WTE (Estimated)	813.71	842.28	842.28	845.28	831.84	831.84	831.84	831.84	830.84	842.18
Contracted WTE(Estimated)	785.81	797.34	788.81	785.44	789.26	808.64	828.24	823.4	834.63	836.89
Recruitment Pipeline (Anticipated Start date)										
The Nursing Associate Higher Apprenticeship (SNA)	0.00	0.00	0.00	0.00	0.00	0.00	15.00	0.00	0.00	0.00
SIFE Progression Scheme	0.00	0.00	0.00	5.00	0.00	0.00	0.00	0.00	0.00	5.00
Registered Nurse Degree Apprenticeship (RNDA)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
NQ Nursing Intake	0.00	0.00	0.00	0.00	10.00	24.37	24.37	14.37	0.00	0.00
Standard Nursing Pipeline (Trac)	6.00	1.00	4.00	3.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Anticipated New Starters	6.00	1.00	4.00	8.00	10.00	24.37	39.37	14.37	0.00	5.00
Anticipated Vacancy	**27.99**	**33.08**	**35.17**	**33.26**	**29.35**	**11.07**	**-22.21**	**-30.49**	**-24.40**	**-23.31**
Trust ex. Corporate Services & Midwives										



Current Recruitment initiatives include; supporting local students to have a positive placement experience at the Trust and student recruitment events to support them into the Trust, continuing the 'SIFE' process which supports HCSW who have an overseas registration to gain NMC registration and complete a 'return to acute' course; continuing the Nursing Associate Higher Apprenticeship with subsequent support to the Registered Nurse degree apprenticeship for those who want to progress and regular bespoke open days / recruitment events for clinical areas.

3.1.2 Areas with highest vacancies

Vacancies and turnover are discussed by division at the Nursing, Midwifery and AHP workforce group. Areas with high vacancies or turnover are discussed in detail and the recruitment and retention plans are presented. To support areas with high turnover, particularly in relation to registered nurses, a review took place with the deputy recruitment manager to clearly identify how many newly qualified nurses areas can adequately support.

4.0 Right Place and Time

4.1 Safe staffing process

The Trust continues to have 3 times a day safe staffing meetings chaired by a divisional director of nursing or deputy. This ensures that no ward is left on a 'red shift' and there is effective deployment of staff.

There is a monthly Nursing, Midwifery and AHP workforce group that reviews the workforce metrics including compliance with roster metrics and any recruitment and retention plans.
A monthly report to the Quality and Safety Committee details areas of concern as well as reporting the fill rates.

A yearly establishment review takes place with the Chief Nurse and Ward Managers to ensure that there is 'ward to board' reporting and understanding of how safe staffing feels in the clinical area. The key recommendations from the yearly establishment reviews were as follow:

- Convert Enhanced Care usage to substantive staff/Explore alternative staffing model.
- Review acuity trends on Saturn and Meldon to increase Registered Nursing establishments.
- Increase Band 6 presence on night shifts by converting Band 5 posts.
- Address gaps in core clinical skills through targeted training.
- Review portering provision to release nursing time.
- Increase Headroom to 24%.
- Invest in ED, CEU, and MAU staffing to meet rising demand and ensure patient safety.
- Review Ward Clerk cover across inpatient areas.

6.0 Maternity staffing

6.1 National / regional context

This paper covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report that covers staffing/safety issues to the Board on a six-monthly basis, (MIS-Year-7-guidance.pdf).

Maternity staffing is reviewed using Birthrate Plus (BR+) which is a nationally recognised tool to calculate Midwifery staffing levels. The methodology underpinning the tool is the total midwifery time required to care for women on a 1:1 basis, throughout established labour. The principles underpinning BR+ methodology is consistent with the recommendations in the NICE Safe staffing guidelines for Maternity settings and have been endorsed by the Royal College of Midwives and the Royal College of Obstetrics and Gynaecologists. Following the full Ockenden report, an immediate and essential action mandated that 'The feasibility and accuracy of the BirthRate Plus tool (BR+) and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.' The Trust will continue to utilise the BR+ methodology pending the findings of the national review.

Trusts are expected to commission a BR+ report every 2-3 years, and a revised report was received by GWH's in May 2022, which identified a registered midwife gap of 3.33wte. The most recent BR+ review has been received in March 2025, which on initial review has not identified staffing gaps.

The 2022 BR+ report is reflective of a 24% uplift in maternity services. Following the Ockenden report there is a requirement to reflect a workforce that can accommodate increased levels of training. This requires a 28% uplift (including maternity leave) to achieve this training requirement. Further analysis of the workforce across the LMNS is in progress to develop a system wide approach to a sustainable headroom uplift.

6.2 Current midwifery staffing position / vacancies / maternity leave / sickness absence

It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing continues to improve through identification of different staffing models, recruitment locally and through engagement with the NHS England international recruitment program. The Trust do not plan to actively recruit via the international recruitment program for maternity services at present as workforce modelling does not support the need for the additional resources required for the program to be successful. The local pipeline further mitigates this approach.

The embedded recruitment plan continues to ensure a rolling planned model of recruitment to ensure that there is a constant pipeline of new starters.

A recruitment and retention lead is in place utilising NHS England funding to provide a robust orientation and preceptorship program with an aim to improve retention in the first year after qualification and reduce the time taken to consolidate the enhanced skills to support them working in all areas of the service.

The inpatient services have been successful with recruitment with the ongoing vacancy sitting within the maternity care centre and community midwifery workforce. A rolling recruitment program is in place which supports new staff to join the Trust via a comprehensive preceptorship program. This program is being further developed to introduce rotations through all areas of the service following 9-12 months working in the inpatient setting to consolidate skills. The hub-based nature of community midwifery provides the opportunity to experience this model of care without the isolation that may have been associated with working out of GP practices. The recruitment strategy for experienced midwives has been reviewed to allocate staff to their area of service on appointment, which enables the areas of the greatest service need to be prioritised.

The below table illustrates the level of staff turnover across departments, monthly between March 2024 and February 2025. The turnover within the Specialist Midwives team has stabilised following a period of time in the previous 12 months where career progression opportunities and secondments were notable. There have been successful appointments into vacant posts which indicates that the succession planning achieved through the appraisal process is providing staff with the skills and abilities to progress within the wider team. The increased turnover in the Hazel and Delivery Midwife group reflects some geographical relocation and a noted increase of newly qualified midwives not being retained in the first 12 months. This is expected to be mitigated with the preceptorship strategy outlined above. The turnover within the community teams has stabilised. The next steps will focus on the opportunities for a shift-based model which may influence the retention of staff who would prefer not to work in an on-call model.

Department	Avg HC	All Leavers	All Turnover	Vol Leavers	Vol Turnover
Ante-Natal Screening - J65919	3	0	0.00%	0	0.00%
Birthing Centre - J65921	14	1	7.41%	1	7.41%
Community Midwifery - J65918	41	4	9.76%	3	7.32%
Continuity of Carer - Midwives - J65922	5	0	0.00%	0	0.00%
Day Assessment Unit - J65910	20	2	10.00%	2	10.00%
Hazel & Delivery Staff - J65914	98	12	12.31%	11	11.28%
Specialist Midwives - J65920	21	1	4.76%	1	4.76%

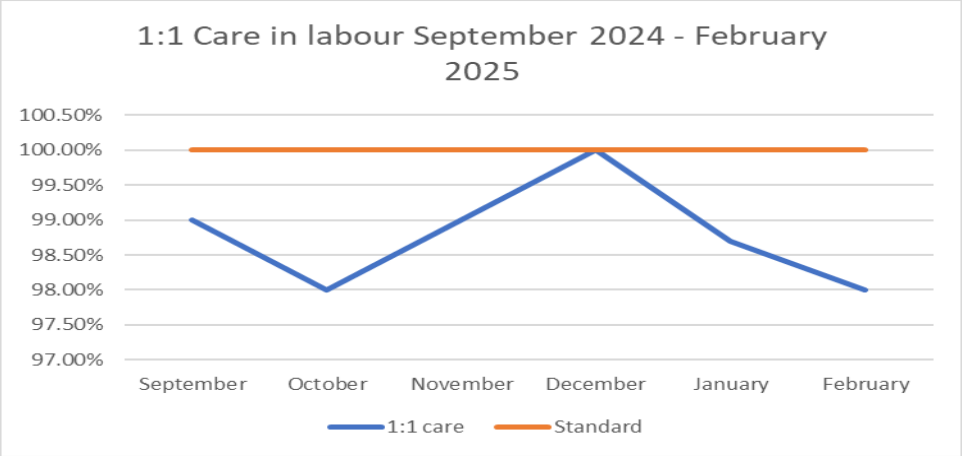
There is an increased sickness rate within both Antenatal Screening and Birth Centre teams which are both small teams so the absence appears higher as percentage. These both relate to long term or planned sick leave. The ward manager teams are working with the Trust wide

working group to ensure that supportive steps are in place for staff both to receive calls to notify sickness and in welcoming colleagues back to work following absence. The increased sickness within the community staff relates to long term sickness with mitigations in place including staff support to return to work.

Sickness Rates as of February 2025			
Department	ST	LT	% Sick
Ante-Natal Screening - J65919	2.47%	21.98%	24.45%
Birthing Centre - J65921	5.00%	10.25%	15.25%
Community Midwifery - J65918	2.07%	6.10%	8.17%
Continuity of Carer - Midwives - J6592	0.85%	0.00%	0.85%
Day Assessment Unit - J65910	0.13%	7.49%	7.62%
Hazel & Delivery Staff - J65914	3.53%	3.35%	6.88%
Specialist Midwives - J65920	0.09%	0.00%	0.09%

6.3 One-to-one care in Labour and Midwife to birth ratio

The NICE clinical standard (QS105 updated 2017) indicates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee Midwife under direct supervision. This is audited monthly, and the data demonstrates that there is fluctuation between 98% and 100% compliance over the 6-month period. Each case where 1:1 care is not fully achieved is reviewed to ensure that escalation processes have been utilised to minimise the impact on the family, and to provide opportunities to develop escalation pathways to prioritise labour care in line with the Maternity Incentive Scheme (CNST) safety action 5, with a detailed action plan in place to support achieving 100% compliance. There have been no patient safety concerns associated with occasions where the 1:1 care was not achieved.

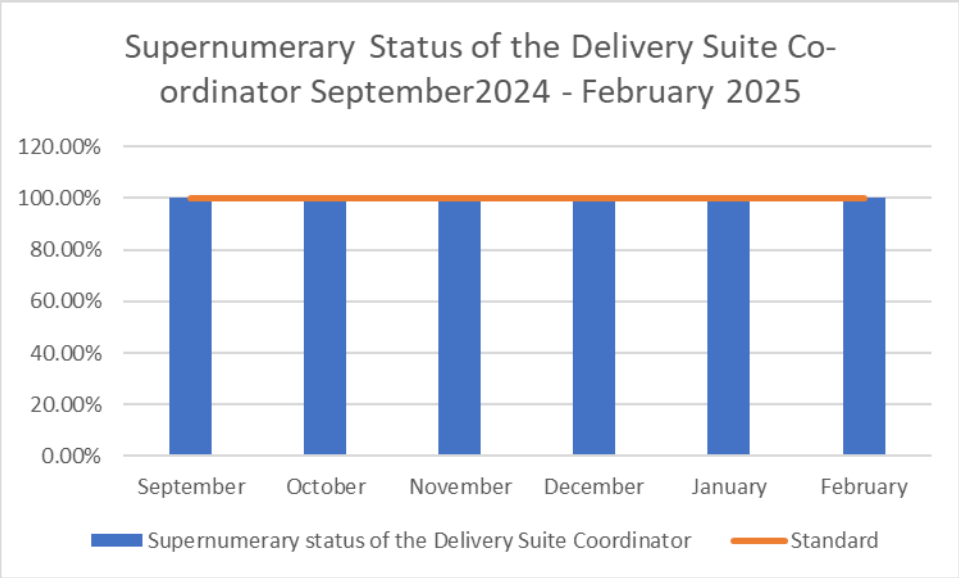


The Maternity Service monitors and reports the Midwife to Birth ratio monthly. The ratios are reviewed against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 28 births as recommended by the Royal Collage of Midwives and Safer Childbirth (2007). The midwife to birth ratio is calculated using the funded establishment rather than the actual staffing numbers in line with national guidance. The table below demonstrates a fluctuation in the midwife to birth ratio which is impacted by variable birth numbers month on month and the vacancy factor in the community midwifery team.

Trust	December 2024	January 2025	February 2025
Standard aim:	1:28	1:28	1:28
Great Western Hospital	1:25.1	Data not available for report due to BadgerNET migration	1:24.5
Royal United Hospital Bath	1:26	Data not available	Data not available
Salisbury Foundation Trust	1:22	Data not available	Data not available

6.4 Supernumerary status of the Delivery Suite Coordinator

The midwifery coordinator in charge of the Delivery Suite must have supernumerary status to ensure there is an oversight of all birth activity within the service. This is defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service, which is specified within the Maternity Incentive Scheme (MIS). Over the period September 2025 – February 2025 100% compliance was achieved. The continued focus is on maintaining 100% compliance.



6.5 Red Flags

The Maternity unit uses a 'Red Flag' indicator system, captured via BR+, to identify critically low staffed shifts. It has identified 10 red flags which trigger escalation and follows a procedure for mitigation. This takes an overview of staffing across Maternity and relocates staff to areas of need as required.

The red flags are defined as:

- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes for suturing)
- Missed medication during an admission to hospital or midwifery-led unit (for example diabetes medication)

- Delay of more than 30 minutes in providing pain relief
- Delay of more than 30 minutes between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay of 2 hours or more between admission for induction and beginning of process
- Delay recognition of and action on abnormal vital signs (for example, sepsis or urine output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour (see graph 6.3)

Other clinical and management actions are captured to represent to activity within the service including redeployment of staff to other services/sites/wards based on acuity.

The data below shows the periods of September 2024 to February 2025 when 28 red flags were recorded. Whilst there were 2 red flags reported during the reporting period time, for "The delay of more than 30 minutes between presentation and triage", from January 2025 the service no longer relocates to Delivery Suite overnight and is staffed appropriately.

The significant impact that the relocation of Triage services has had on patient safety is evident from the data.

An increase in red flags related to "Delay of 2 hours or more between admission for induction and beginning of process" has been observed which was reported on 17 occasions. This was due to acuity and flow, and no harm occurred as a result. This will feed into A3 around reducing the length of stay which will consequently improve the flow through Maternity services.

The Acute Unit Midwifery on call system is now embedded in the service to minimise the impact of red flag triggers on service delivery. During the reporting period, the Acute Midwife On call has been utilised on 3 occasions. The Acute Unit On Call system has had a further impact on reducing the need to call the community teams into the unit; this has meant that we have continued to offer a home birth service.

Number of Red Flags recorded
01/09/2024 to 28/02/2025

Red Flags	Breakdown of Red Flags	Times occurred
RF1	Delayed or cancelled time critical activity	5
RF2	Missed or delayed care (for example, delay of 60 minutes for suturing)	2
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	1
RF4	Delay of more than 30 minutes in providing pain relief	0
RF5	Delay of more than 30 minutes between presentation and triage	2
RF6	Full clinical examination not carried out when presenting in labour	0
RF7	Delay of 2 hours or more between admission for induction and beginning of process	17
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1

6.6 Recruitment and retention

There is a recruitment and retention Divisional group who meet regularly, with an improvement plan in place including:

- Introduction of the Midwifery Degree Apprenticeship Program (MDAP). Four members of the existing midwifery support worker team have initiated the MDAP with Winchester University.
- The retention funding via NHS England has been confirmed to be continuing for a further 12-month period.
- An extended supernumerary period for newly qualified midwives is in place, utilising nationally available funding
- Scheduled meet and greets with divisional staff, new starters and students
- Review and refresh of preceptorship package
- Blended learning programme with University of West England
- Working with Universities to increase student midwife places

- Return to practice programme
- Successful completion of the education program for Internationally Educated Midwives
- Health Education England funding for nurses to undertake 2-year Midwifery course
- Close working with Swindon College, supporting T level student placements
- Health and well-being programme
- Apprenticeship and Nurse Associate model to 'grow our own'.

Funding was secured to provide an enhanced Professional Midwifery/Nurse Advocate model for restorative supervision. This is being used alongside 2 funded places for newly appointed professional midwifery advocate training places to expand the offer of the advocacy service to support staff in line with the national framework.

6.7 Continuity of carer

One of the key areas of focus were identified in the Better Births report (2016) to improve outcomes of maternity services was identified as continuity of carer. Two teams were initiated at Great Western Hospital (GWH) in 2022 with an aim to deliver the model of care to the most vulnerable families. The CORE20PLUS5 approach identified these families to include women or birthing people from Black, Asian and minority ethnic communities and the most deprived groups defined by the national index of deprivation.

The commitment in terms of work/life balance required for a CoCr model has not been found to be sustainable locally and despite financial remuneration to staff GWH has not been able to continue this model of care at present and following challenges in recruitment the CoCr model at GWH was paused in December 2023 with actions in place to mitigate the impact of this change on women and birthing people. At present Continuity of Carer is not achievable within the current recruited workforce, therefore the prioritisation of antenatal and postnatal continuity in the community remains the focus.

7.0 Neonatal staffing

The neonatal unit at Great Western Hospital (GWH) is classed as a local neonatal unit (LNU). Babies cared for are those who require short term intensive care (ITU), up to 48 hours, high dependency (HDU) care and low dependency care. The unit comprises of 8 HDU/ITU cots plus 10 low dependency cots. Neonatal units have an unpredictable and fluctuating activity level, and so should aim to operate at 80% capacity to allow for times of high acuity. National standards for neonatal nursing care, and medical provision have been developed to safeguard patient safety, and we have a duty to comply with these standards. The neonatal unit at GWH works within the South West Neonatal Network to provide the right level of high-quality care to each baby as close to home as possible.

The provision of adequate neonatal nursing staffing, including neonatal transitional care services, are core requirements for the CNST (Clinical Negligence Scheme for Trusts) Maternity Incentive Scheme with Trusts required to evidence that the neonatal unit meets the BAPM neonatal nursing standards. Where this is not achieved a local action plan must be in place which should be shared with the LMNS and Neonatal ODN.

In 2010, the British Association of Perinatal Medicine (BAPM) published the third edition of BAPM Service Standards for Hospitals providing Neonatal Care.

In 2017, BAPM published Neonatal Transitional Care, a framework for Practice. These documents inform the NHS England Service Specification for Neonatal Critical Care Services

which states the minimum nurse to patient staffing ratios based on an average unit occupancy of 80% for neonatal services should be:

- 1:1 for Intensive Care (1 Qualified in Speciality (QIS) nurse to 1 patient, with no other responsibilities for that nurse)
- 1:2 for High Dependency
- 1:4 for Special Care.
- 1:4 for Transitional Care

These care levels are defined in specific detail by nationally set criteria. To meet BAPM/NHSE standards with the unit at full cot capacity staffing levels on each shift should be:

- 2 nurses for 2 Intensive Care cots
- 2 nurses for 4 High Dependency cots
- 3 nurses for 12 Special Care cots
- 1.5 nurses for 6 Transitional Care cots
- 1 Supernumerary Shift coordinator on each shift

Staffing requirements will fluctuate with acuity and therefore staffing to an average cot occupancy result in staffing being set at 7.0 wte per shift. Staffing data is reported on a monthly basis to demonstrate both the skill mix on a shift to shift basis and amongst the whole neonatal nursing workforce.

The budgeted establishment meets the BAPM neonatal nursing standard. The proportion of staff who are QIS trained is reported monthly via the Perinatal Quality Surveillance model (Integrated Performance Report) and can be seen in the table below. Whilst the trained workforce metric does not yet meet the 70% target there is a robust plan in place to acheive this by the end of Q2 2025/26. This target is not currently met due to an increase in new staff who are not QIS trained, and not due to attrition. There is a clear escalation pathway in play to ensure that this does not impact on the quality of care provided. There are 5 staff currently undertaking the QIS course, due for completion summer 2025. This will be the first time the service has run two cohorts of nurses attending due to the availability of courses and the operational impact of ensuring safe staffing whilst releasing staff due to the covering clinical shifts on LNU. Options are being explored to provide training with the SW Neonatal ODN in Autumn 25.

There is a pilot QIS programme commencing Jan 2025 which will run in Plymouth and be led by the SW Neonatal Operational Delivery Network (ODN). The expectation is that from Sep 2025, the course will be delivered by the Network in Bristol. This will follow directly on from the Foundation programme that the ODN have been running for the past 18 months and that all new registered nurses are enrolled on when they join the Trust.

	Target	Threshold		Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
Percentage of shifts staffed to BAPM QIS recommendations	90%	≥90%	<90%	98.3%	96.6%	100%	95.1%	95.1%	69.6%
Percentage of Registered Nurse or Midwifery staff who hold Qualified in Speciality (QIS)	70%	≥70%	<70%	60.6%	63.4%	62.4%	63.3%	62.7%	62.1%

The reduction of agency staff has been sustained and has not impacted the skill mix on a shift-to-shift basis.

The funded establishment meets the BAPM standards for neonatal nursing staff based on the cot capacity and activity. This has been reviewed and approved in collaboration with the Operation Delivery Network (ODN).

7.1 Recruitment and Turnover in The Neonatal Unit

Turnover Rates			
Department	Average Head Count	All leavers	All Turnover
Neonatal Unit – J65931	49	3	6.1%

Sickness Rates			
Department	Short Term Sickness	Long term Sickness	Total % Sickness
Neonatal Unit - J65931	1.98	3.42%	5.71%

The sickness has increased from 5.71% in the previous reporting period to 6.84% in the current period, and reporting at higher than this time last year. Whist short term sickness has slightly reduced, long term sickness has increased from 3.42% to 4.87%. Recruitment of nursing staff continues, with the aim of staffing the neonatal unit to BAPM safe staffing standards following the operational delivery network (ODN) review of staffing against acuity.

Recruitment into Band 5 posts for nurses who are not yet QIS has been successful, with the recruitment and retention focus on supporting those nurses through a preceptorship program and with educational support to increase the annual intake of nurses onto the QIS education pathway. This program of education was commenced in January 2024, which is being led by our Neonatal Practice Educator, has been positively evaluated by staff, which has positively impact on the turnover rate in the last 6 months.

The Lead Advanced Neonatal Nurse Practitioner (ANNP) is now embedded within the team with one further qualified ANNP in role. There has been limited applicants for the remaining post despite a focused recruitment campaign. The 4 apprenticeship ANNPs have entered the second year of the 3 year program. The qualified posts support both the development of the service provision locally, provide educational, peer support and mentorship to the trainees and nursing workforce, alongside facilitating enhanced service development work and supporting the medical workforce. These roles support career development opportunities within the workforce. With the pipeline of apprentices, a fully staffed rota will be in place from 2026 of all of the team take up full time posts. An options appraisal is underway for recruitment of a further trainee via an apprenticeship or traditional MSc pathway to qualification to ensure a staggered approach to when the trainees qualify. This will ensure that all newly qualified ANNP have access to appropriate support and opportunities during their period of consolidation post qualification.

7.2 Temporary staffing

There has been considerable focus on reducing agency use on the neonatal unit. A consistent and robust strategy was implemented in November 2023 with increased controls has demonstrated a sustained reduction in agency staff bookings.

8.0 Allied Health Professionals report

8.1 Workforce Overview

Allied Health Professionals (AHPs) are degree-level practitioners who contribute significantly across health and social care settings, encompassing assessment, diagnostics, treatment, discharge, and rehabilitation. As the third-largest clinical workforce within the sector, AHPs at Great Western Hospital (GWH) play a critical role. GWH employs professionals from nine of the fourteen recognised AHP disciplines, including:

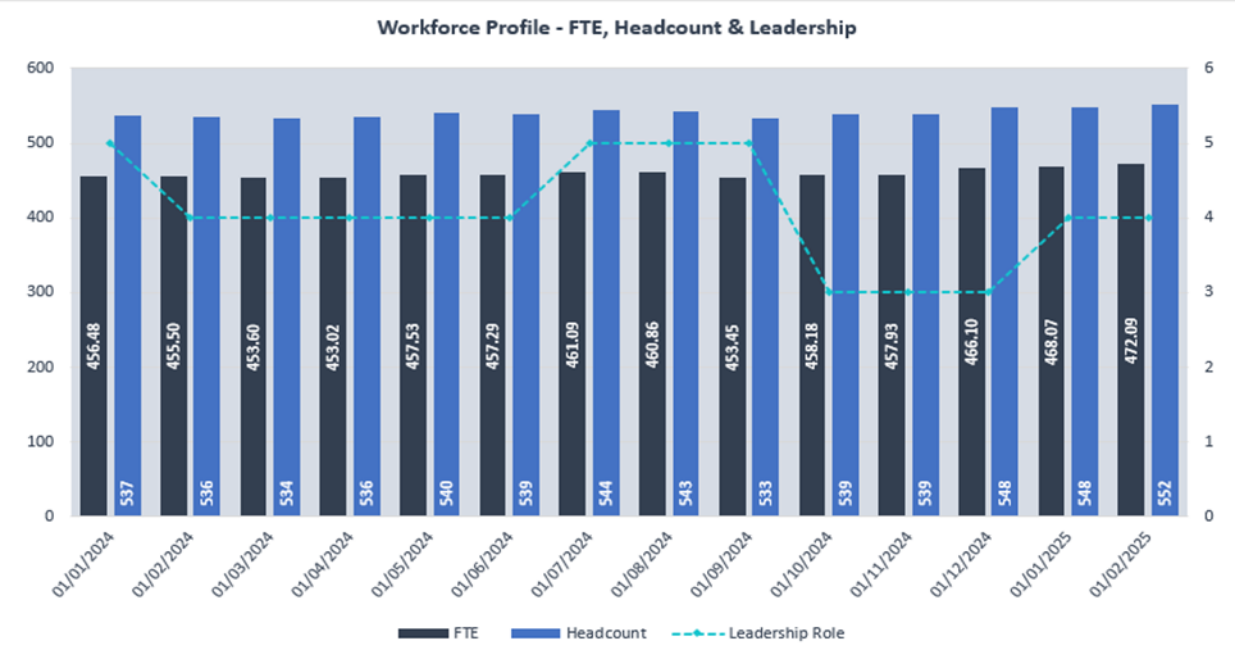
- Dietitians
- Occupational Therapists
- Operating Department Practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Podiatrists
- Radiographers
- Speech and Language Therapists

AHPs are regulated by the Health and Care Professions Council (HCPC) and supported by both registered and unregistered staff, with a workforce ratio of 3:1.

Currently, GWH employs 472.09 Whole Time Equivalent (WTE) AHPs, representing 546 individuals. While there has been a reduction in headcount over the past six months, WTE

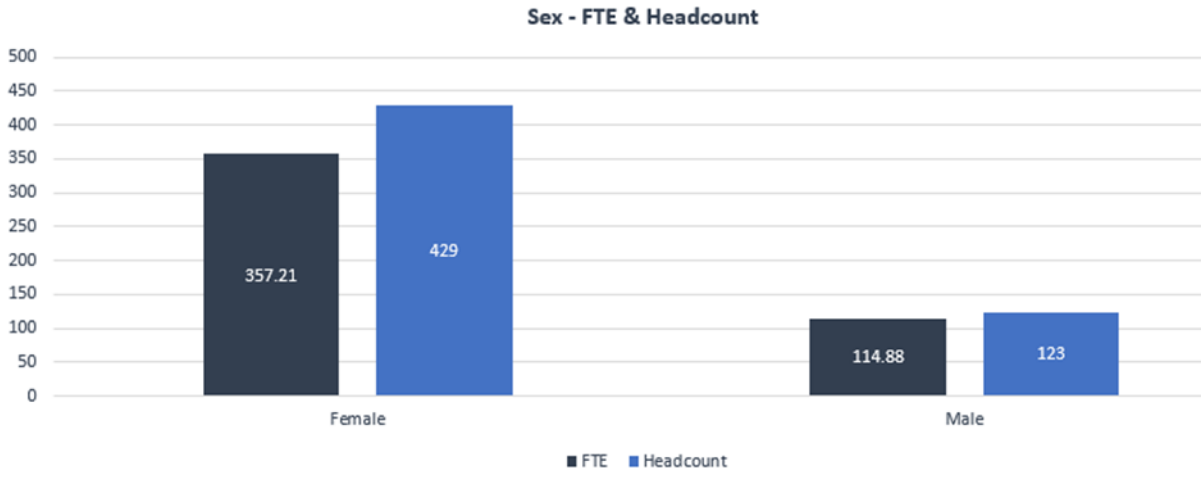
has increased. The majority of AHPs are based in the IC&C division, which is due to be renamed in alignment with the transfer of the community contract. Radiographers are positioned within the medical division, and orthoptists within SW&C which will undergo renaming in April. Given that AHP services operate across multiple divisions, governance and activity tracking remain complex and should be considered when formulating business cases.

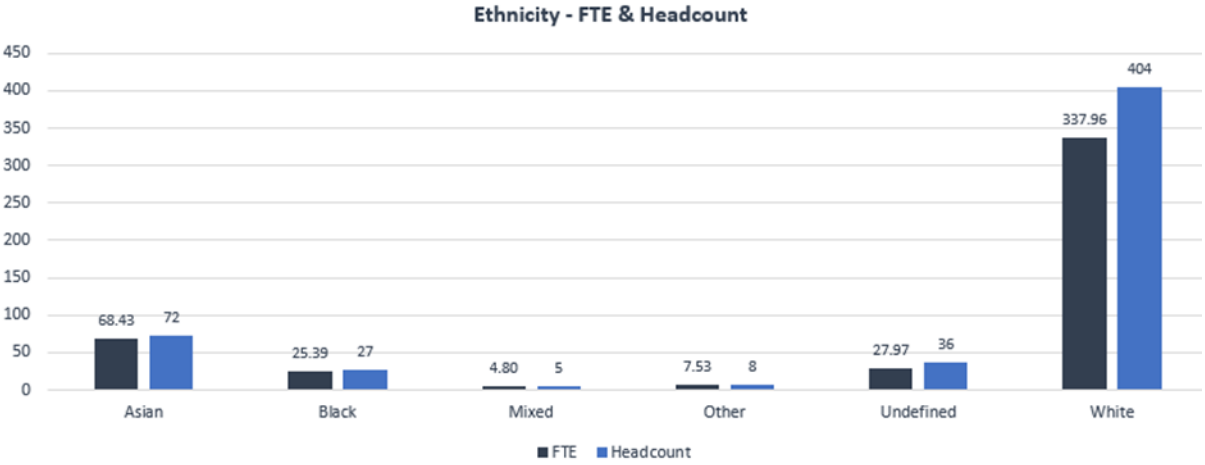
Some AHPs undertake extended roles beyond traditional clinical practice, such as leadership positions or work in urgent treatment centres (UTCs). The Associate Director of AHPs maintains regular engagement with all registered staff.



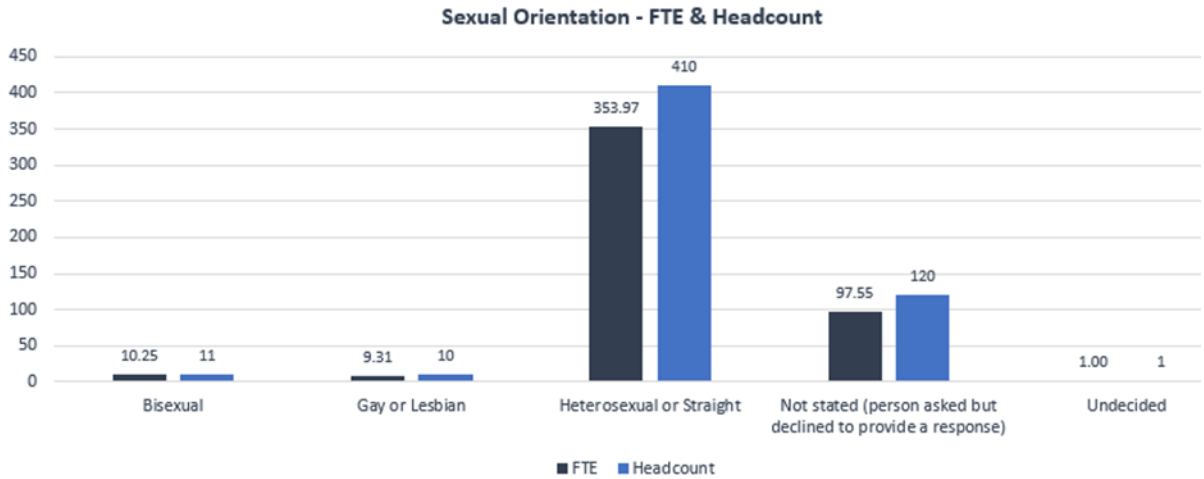
8.2 Workforce Diversity

The AHP workforce at GWH remains predominantly female, with underrepresentation of individuals from global majority backgrounds. This trend aligns with the Southwest region but does not fully reflect the local Swindon population. Efforts to address this disparity include early career pathway initiatives targeting the local population. However, limited availability of early career apprenticeship opportunities restricts conversion into employment within the Trust.





The proportion of staff reporting their sexual orientation remains consistent with the past six months, with a small percentage identifying as part of the LGBTQ+ community.



8.3 Workforce Supply

8.3.1 Vacancies

AHP vacancies have steadily declined since a peak in September and currently stand at less than 1%. Recruitment efforts in imaging and acute therapies are seeking to adopt a recruit-to-turnover model, with an aim to eliminate Band 5 vacancies by next year.

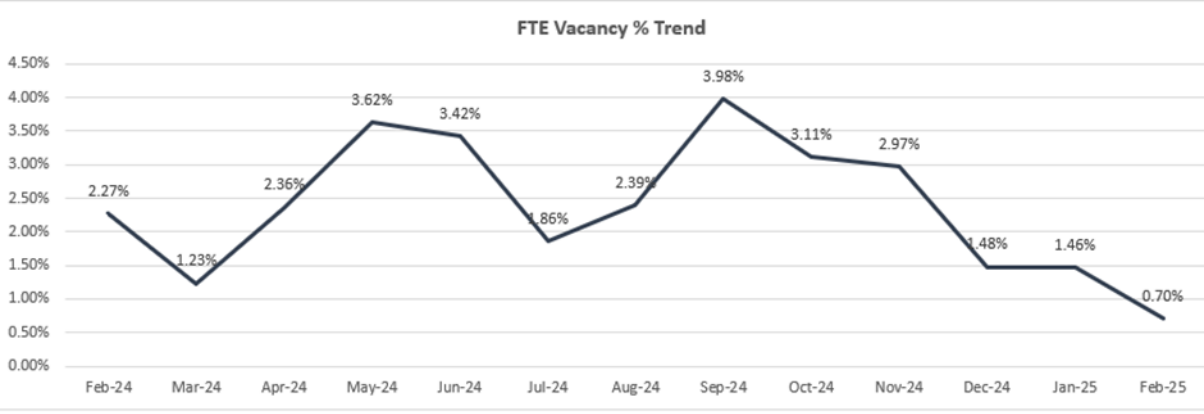
Turnover remains low in orthoptics, dietetics, and speech and language therapy. Operating Department Practitioners (ODPs) are over-recruited in line with nursing strategy. Podiatry is undergoing a service review due to the community contract, which may require further workforce planning once the new model is finalised. Band 5 podiatrists remain challenging to recruit, necessitating a long-term focus on T-Level and apprenticeship opportunities.

A long-term AHP workforce plan was submitted to People and Culture in January, detailing a 1–3-year strategy for workforce development and growth.

Recently introduced AHP career clinics provide proactive interventions to address retention concerns. Lack of career progression remains the primary reason for staff departures, prompting further development of Advanced Clinical Practitioner (ACP), early years, and degree apprenticeship opportunities.

Diagnostic radiography continues to experience challenges, particularly in breast imaging and ultrasound. The introduction of clinical practice educators is yielding positive results in retention, though apprenticeship uptake remains low.

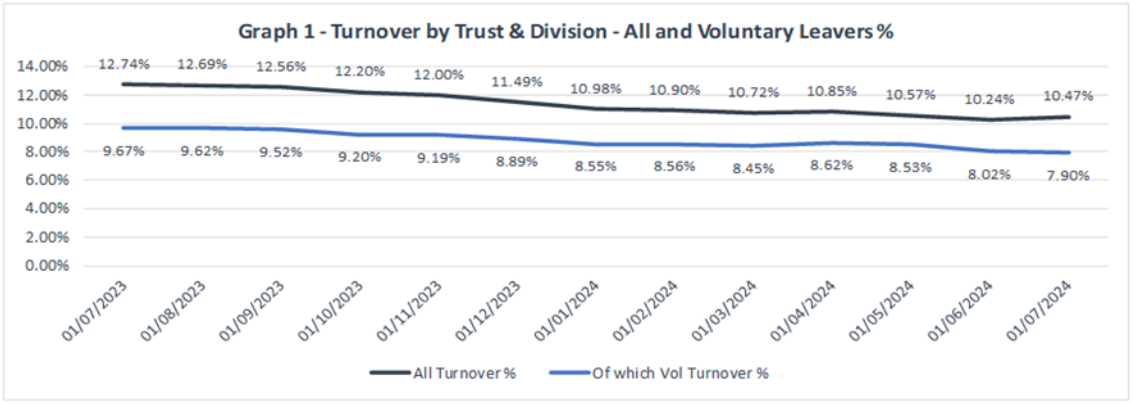
Both imaging and acute therapies report the highest vacancy levels and lowest AHP staff satisfaction in the latest staff survey. It is anticipated that the reduction in vacancies will positively impact future survey results, alongside targeted support interventions.



8.3.2 Recruitment and Retention

Recruitment and retention rates have improved, with turnover decreasing from 11.5% (total) and 9.8% (voluntary) to 10.4% (total) and 7.9% (voluntary).

Retention remains a concern; particularly as competing organisations offer greater flexibility and career progression. To address this, AHP "Stay Clinics" are being rolled out to provide staff with career development discussions. Exit interviews are also being implemented to gather feedback and improve retention strategies.

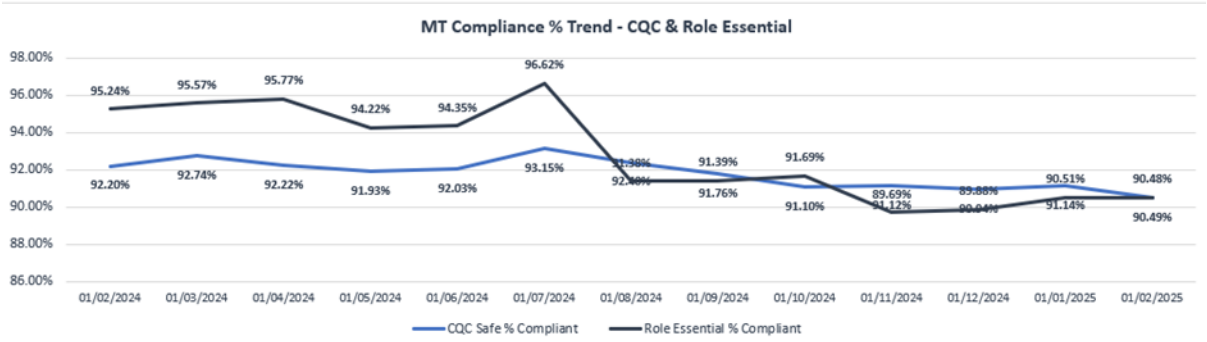


8.3.3 Sickness

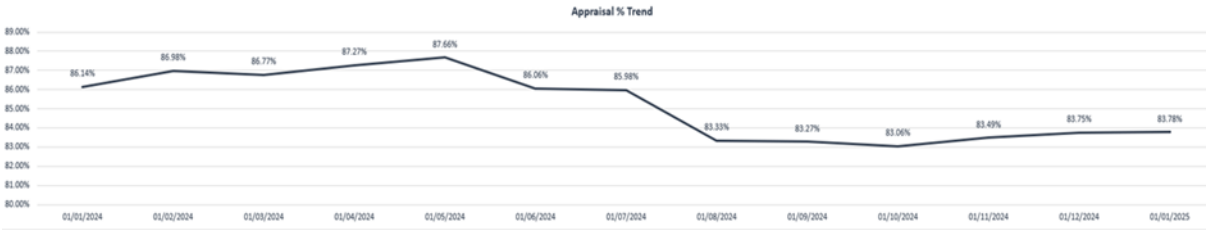
Sickness rates have increased over the winter months but remain close to the Trust target of 3.5%. Imaging and acute therapies report the highest sickness rates, correlating with workforce shortages and lower staff satisfaction. Collaborative efforts are underway to address these challenges over the next six months.

8.3.4 Appraisal and Mandatory Training

Mandatory training compliance remains within target and is CQC-compliant despite winter pressures.



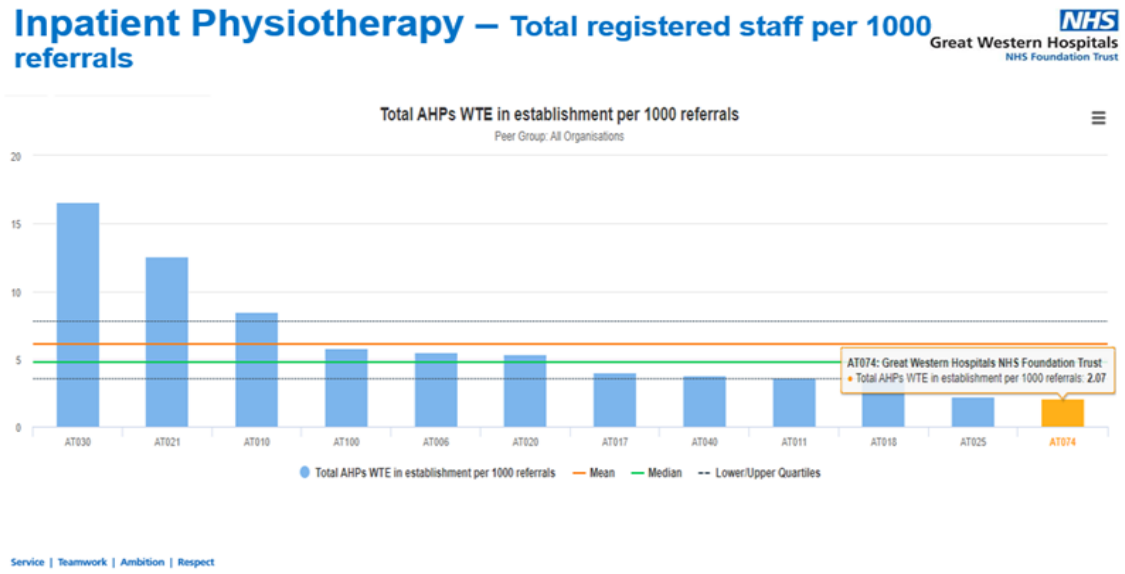
Appraisal rates have remained stable at 83%, slightly below the Trust target of 85%. Efforts are ongoing to achieve compliance within the next six months.

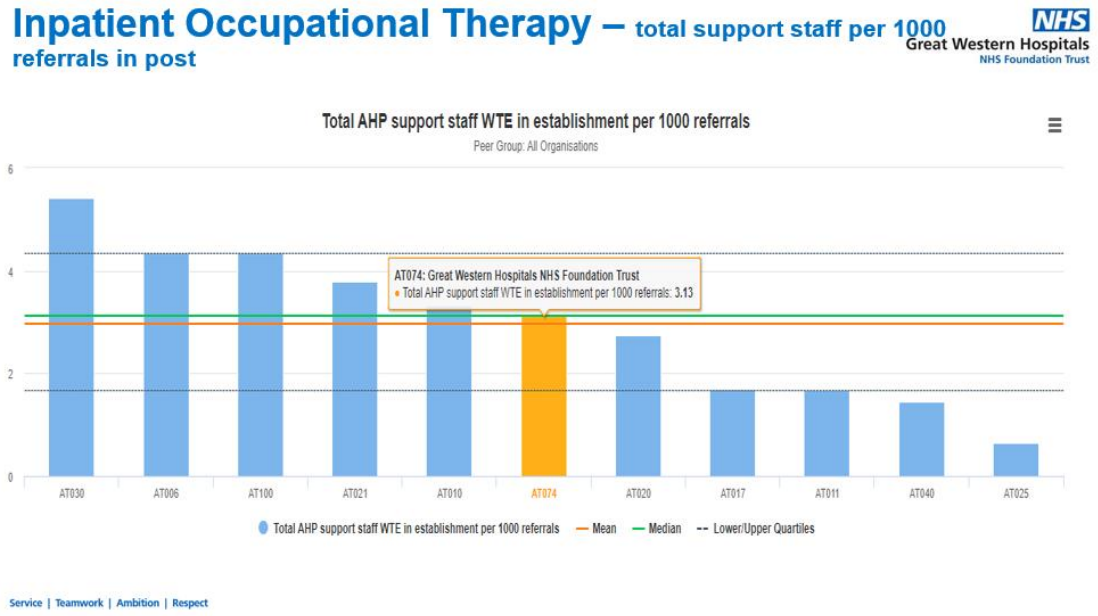


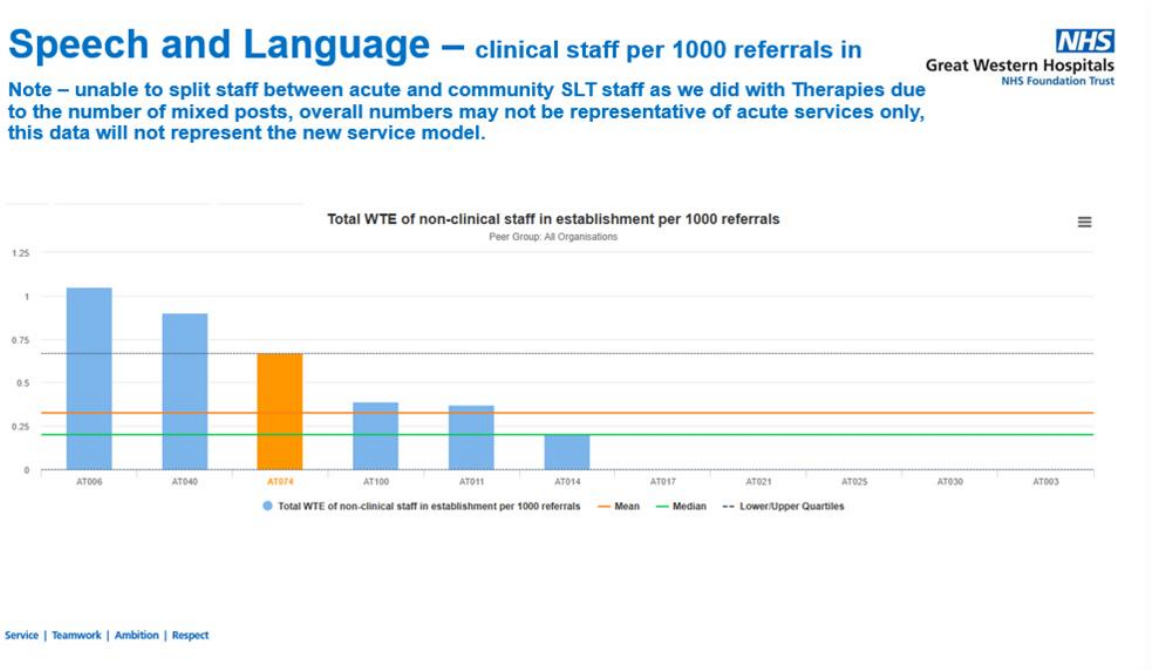
8.4 Safer Staffing

There is no mandated reporting on AHP workforce safety or effectiveness. National efforts to standardise workforce reporting since 2016 have had limited impact. To address this gap, all AHP teams have been tasked with developing capacity and demand tools to inform future workforce planning.

A voluntary National benchmarking exercise has been conducted for occupational therapy, physiotherapy, dietetics, podiatry, and speech and language therapy. Results indicate that physiotherapy staffing is below the national average, occupational therapy is at midpoint, and the remaining professions are above average. The impact on these results of hosting community services remains unclear, therefore this benchmarking will be repeated this year with the omission of community services. The results from the exercise differ to the model health system because in this instance, the benchmarking data is based on referrals into service compared to registered staff. This enables us to contextualise staffing in relation to activity. We may therefore have higher numbers of registered physiotherapist compared to another acute trust, but they may not have as much activity.







Local benchmarking of imaging across the Acute Hospital Alliance (AHA) is recommended for the coming year.

8.5 Pipeline Supply

GWH has been proactive in developing its AHP workforce through apprenticeships, with 60% of AHP areas utilising Level 6 apprenticeships to build a sustainable pipeline. The first cohort of GWH AHP apprentices is now transitioning into registered roles.
However, staff are experiencing educational fatigue due to increased demands from learners. To address this and reduce staff turnover, clinical practice educators have been introduced in key areas. However, it remains uncertain whether these roles will continue to be supported given the current reduction in headcount.

Imaging has benefited from its partnership with the University of Gloucestershire, successfully filling most of its Band 5 vacancies with recent graduates from this program. Further analysis is underway to assess recruitment trends from Band 5 feeder universities for other AHP groups. This will help prioritise student placements at universities most likely to supply GWH's future workforce.

Two substantive education and workforce roles have been recruited and will continue to drive the pipeline development agenda alongside the AD of AHPs.

8.6 Ongoing Work

- Recruit-to-turnover and headroom planning for imaging and acute therapies.
- Short-term workforce planning, particularly for winter pressures.
- Expanding early-career pathways and apprenticeships.
- Implementing capacity and demand tools for workforce alignment.
- Reviewing stay clinic and exit interview data for retention strategies.
- Continuous monitoring of sickness, mandatory training, and appraisal rates.

8.7 Conclusion

The AHP workforce is in its strongest recruitment position in 18 months. A clear long-term workforce plan (1-3 years) is in place, focusing on training, retention, and workforce reform. Capacity and demand modelling will be integral to ensuring a sustainable AHP workforce at GWH.

9. Trust Risk Register

As per NQB guidance, the Nursing and Midwifery staffing risks are on the Trust Risk Register. There are 2 of note.

Risk 500 - Nurse to patient ratios - safe nurse staffing - Score 9
There is a risk of poor quality metrics and reduced staff morale / high turnover due to the inpatient wards working at a ratio of 1:10 for registered and unregistered staff. Wards can work to 1:10 when short notice gaps occur. This is against the national guidance of 1:8 or below.

Risk 1132 Financial affordability of high quality patient care if nursing and midwifery temporary staffing costs are not reduced - Score 9

There is a risk to the financial affordability of high quality patient care if nursing and midwifery temporary staffing costs are not reduced, this would impact on ability to maintain safer staffing levels and the Trust's financial recovery plan.

10. Conclusion

This report has outlined the safe staffing processes and assurance on delivery of safe staffing across Acute nursing, Midwifery and AHPs.

11. Recommendations

The report makes the following recommendations:

- Ensure robust recruitment and retention plans for registered nursing.
- Ensure the next Birth Rate + report recommendations inform future workforce planning to achieve safe staffing.
- To complete dedicated SNCT for ED
- To explore a different staffing model to address enhanced care and mental health requirements

Report Title	**Research Annual Report 2024-25**				
Meeting	**Trust Board**				
Date	**10/07/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Donna Noonan / Badri Chandrasekaran				
Report Author	Donna Noonan				
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:

This report demonstrates the research department's performance against all indicators, and identifies strategic next steps for sustainable growth and improvement

Report

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

Recruitment of participants into research trials did not meet the 2024-25 target, but the proportion of commercial recruitment (and income) has increased. This allows for strategic reinvestment to ensure balance is maintained in the GWH research portfolio.

Studies that have closed to recruitment have finished on or near the recruitment target and we have a high response rate to the National Institute for Health and Care Research's Participant in Research Experience Survey (PRES).

The Trust was awarded its first Research Grant in 2024-25, demonstrating potential to support investigator-led research, and this is an area in which there needs to be re-investment in resource.

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)	Aspects of research income is non-recurrent and activity-based (#1134)	6
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	n/a	
Next Steps	Re-invest research income to enable sustainable growth and improvement	

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:

This report provides data on research activity against performance indicators. There are no indicators that present risk of inequalities

Recommendation / Action Required

The Board/Committee/Group is requested to:

Acknowledge the work of our research staff across the Trust and performance across all indicators.

Acknowledge our aim for sustainable growth and improvement.

Accountable Lead Signature	Donna Noonan
Date	**23/06/2026**

1. Purpose

To provide assurance for the Trust Committee on GWH research activity.

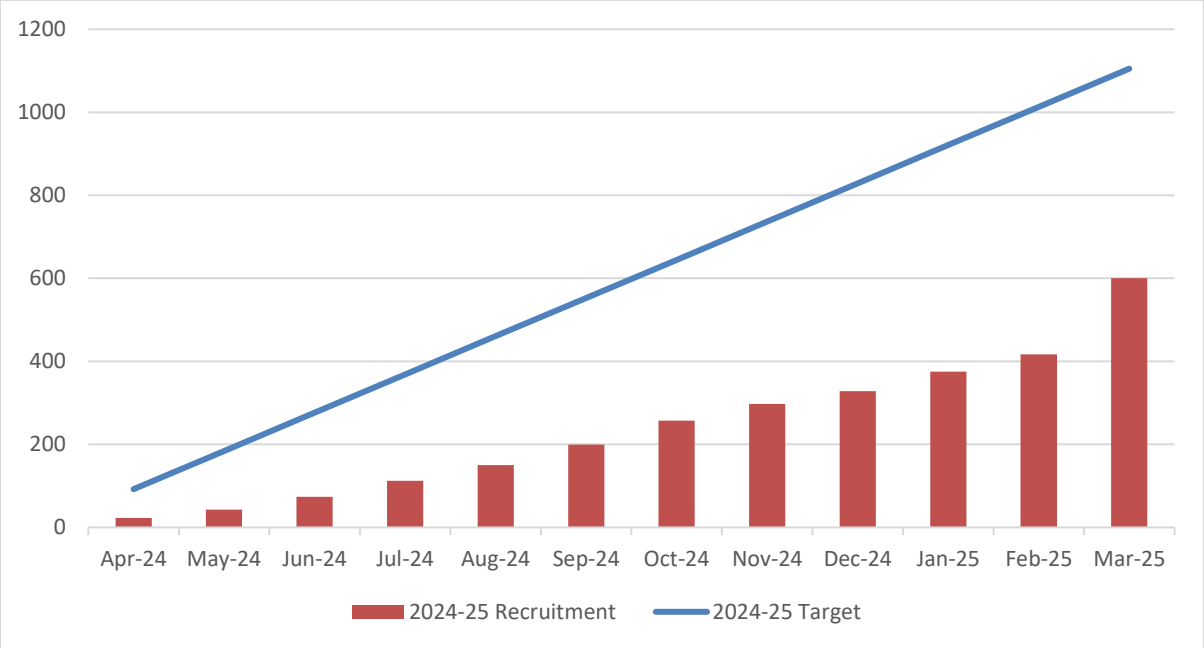
2. Background

This paper provides a summary of R&I performance and next steps.

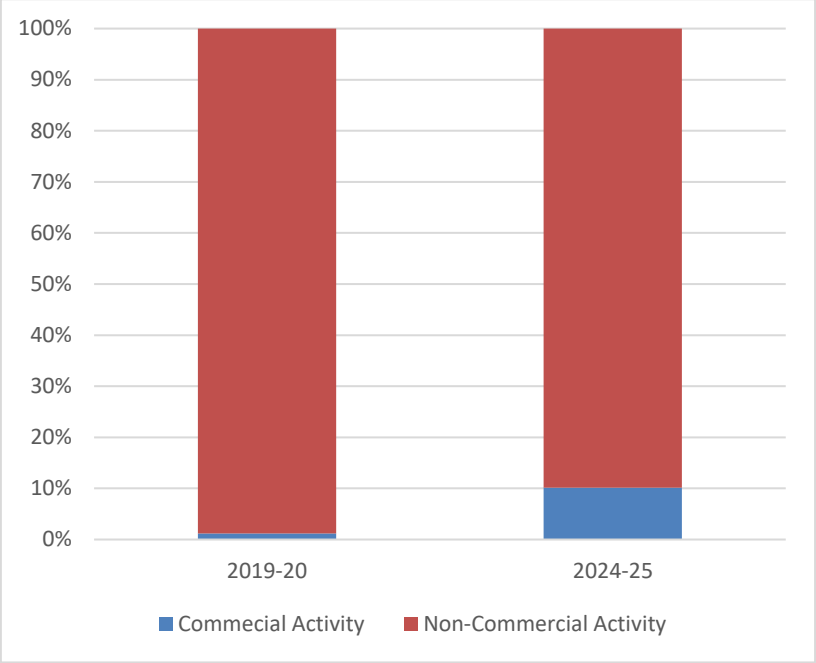
3. Research Performance

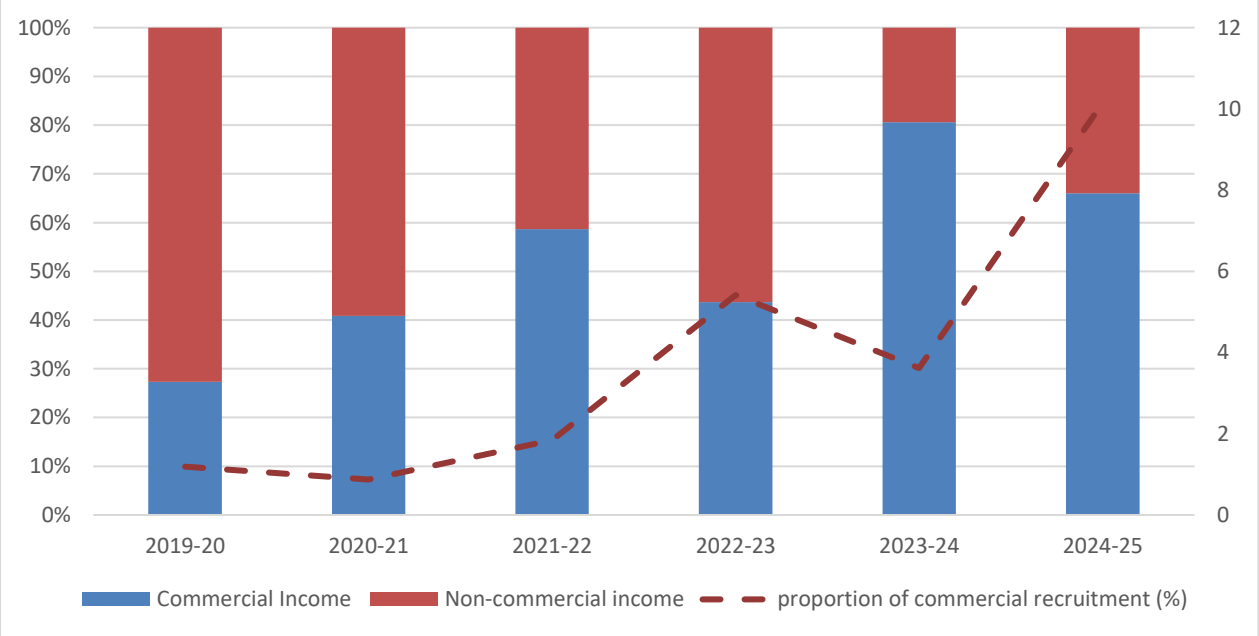
3.1. Recruitment

While NIHR no longer uses number of research participants to inform its financial allocations, it continues to monitor participant recruitment against recruitment in the 12 months before pandemic (i.e. 2019-20). At GWH, our 2019-20 baseline is 1095 research participants recruited. A stepwise approach has been taken to post-pandemic recovery of our local research portfolio, with activity reaching 56% and 89% of the pre-pandemic baseline in 2022-23 and 2023-24 respectively. Accordingly in 2024-25, a target of 1105 was set to reflect 100% of pre-pandemic activity.



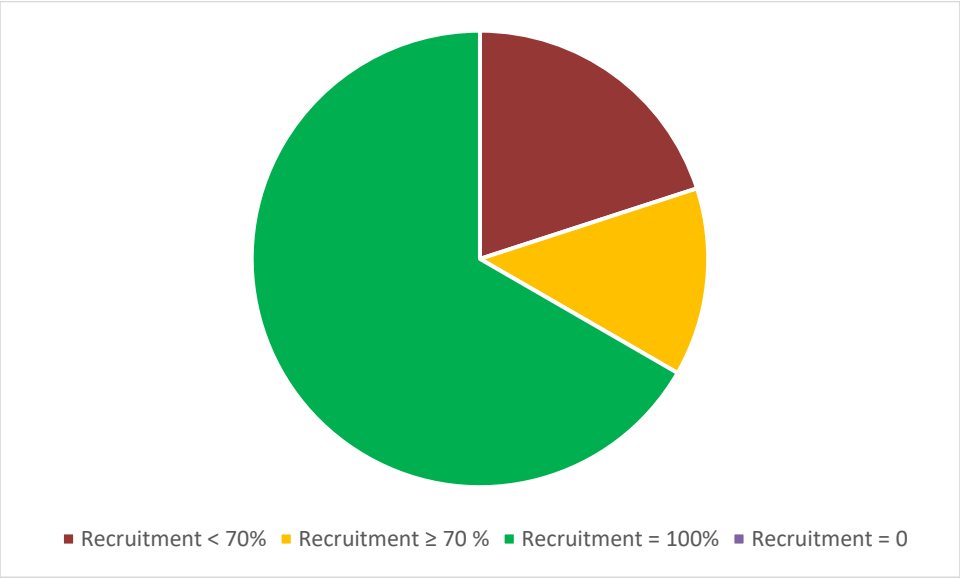
While this target was not met, 2024-25 saw 369% difference in the number of participants recruited to commercial trials compared to pre-pandemic 2019-20 activity, highlighting a shift in the balance of our research portfolio. In 2024-25, 10% of recruitment was to commercial trials, the highest proportion seen to date. Commercial research activity tends to be more resource intensive than non-commercial activity, with smaller recruitment targets, but with higher rates of income generated.





3.2. Recruitment to time and target

Recruitment to time and target is an important metric for research as it provides early indication of whether a study is going to be able to answer the question it is setting out to address. Of the 15 studies that closed at GWH in 2024-25, 80% recruited more than 70% of the study target.



3.3. Research Grants

2024-25 has seen the award of the first GWH-led research grant, providing £269,839 of funding for a 36-month project, delivered in collaboration with NHS, academic and third-sector partners. A proportion of this income is pass-through payments to the collaborating organisations, but the award reflects GWH's potential to develop a locally-led research portfolio in partnership with other key stakeholders.

3.4. Participant in Research Experience Survey

The National Institute for Health and Care Research's Participant in Research Experience Survey (PRES) is an annual nationally standardised survey used to collect research participant's views and experiences of participating in research. The NIHR monitor response rate to the survey, with survey data used to improve accessibility, recruitment and retention to research studies. In 2024-25 a weighted average of 64% of new GWH participants on PRES eligible studies completed the survey, with GWH having the highest proportional response rate of all organisations in the West of England Regional Research Delivery Network.

3.5. Performance summary

GWH is demonstrating strong potential for sustainable growth and improvement. Delivering studies to time and target is highly valued by research organisations looking for sites to conduct their research, and it is something that brings them back with their research business. By placing emphasis on commercial research, we enhance our opportunities to support the UK Life Sciences, which offers new care pathways for patients, and generates income for GWH to re-invest into further growth of the Trust's research capabilities.

We have also demonstrated that GWH has capability to support our staff to develop their own investigator-led funding applications to deliver research projects that meet the needs of our local patient population. As the 2024-25 PRES results are published by the NIHR, we will use the outcomes to further improve the way that research is delivered at GWH so that we can continue to enhance research participant's experiences.

4. Income and Expenditure

Research is externally funded, and income-generating, with certain income streams being entirely activity-based. The complex nature of research funding mechanisms means income is not always realised in the period that the research activity takes place. In 2024-25 research income across all income streams was £1,249,096, with departmental expenditure (pay and non-pay) totalling £833,967.09. The remaining income was transferred or allocated in accordance with its intended purpose/funding terms. See the Table below for a summary of income and expenditure.

Income Stream	**TOTAL (£)**
NIHR Income	-849,748.02
Research Income	-128,578.98
Pay Award Uplift	-46,733.00
Enablement Funding (carry forward)	-15,500.00
Excess Treatment Costs	-17,305.67
NIHR Capital Award	-183,786.33
Research Grants	-7,444.00
Income Total	**-1,249,096.00**
Expenditure & Funding Allocation	**TOTAL (£)**
Expenditure - R&I Pay	808,787.07
Expenditure - R&I Non-Pay	25,180.02
Allocations, Transfers*	211,695.00
Expenditure & Funding Allocation Totals	**1,045,662.09**
Variance**	**-203,433.91**
** Includes all additional costs retained or paid out in accordance with funding T&C such as strategic research capacity build, Principal Investigator allocations, grant payments, funded research SPA, development awards, and overheads.*	
*** Of which, -£183,786 is capital allocated to R&I (spend shows elsewhere in Trust budgets), -£35,140 is an overhead contribution, and -£6,453 is accruals. Variance also accounts for a £20,372 NIHR capital award underspend returned to NIHR post-award.*	

5. Next Steps

4.1. Balanced Portfolio

A focus for 2025-26 will be to ensure that we can continue to support growth of income-generating commercial activity while also sustaining our non-commercial portfolio. Non-commercial research, led by non-commercial organizations (e.g. academia, healthcare providers), is varied and wide-ranging, from clinical trials to public health population studies. Being able to balance our portfolio will maximise GWH's contribution to the spectrum of research which optimises care provision and clinical outcomes.

Following formation of the Hospital Group between GWH, RUH, and SFT, there is opportunity to explore ways to optimise the balance of the regional portfolio, maximizing recruitment targets while minimizing duplication of effort. Regional collaboration may make our sites more attractive to both commercial and non-commercial research Sponsors.

4.2. Set-up Times

While the NIHR do not currently monitor the time that research sites take to open a research study, efficient set-up of research gives us the best chance of recruiting to time and target. Opening on time is also valued by research organisations as it ensures that their projects are likely to deliver on time, while enabling patients to access research opportunities as early as possible. Therefore, in 2025-26, GWH will introduce a metric to issue confirmation of Capacity and Capability on time (i.e. by the planned start date).

4.3. Grants

In order to further develop a portfolio of locally-led research grants, we will explore opportunities to enhance capacity to support our aspiring researchers to prepare and submit high-quality funding applications. This is a potential area for regional collaboration within the Hospital Group. While plans for how research teams across the three Trusts will co-align are still in preparation, this is a mutually identified area of focus for 2025-26. For example, this may include exploring potential for jointly-funded posts aimed at providing dedicated support to expand the number of high-quality investigator-led grants submitted across the Hospital Group. In turn, this could increase the value of NIHR Research Capability Funding awarded across the Group.

4.4. Sponsorship

As we develop a portfolio of locally-led research, GWH will also need to be able to meet the principles and responsibilities of Sponsor as set out in the UK Policy Framework for Health and Social Care Research. These take account of legal requirements and other required standards throughout the research life-cycle to promote the interests of research participants. In 2025-26 we will aim to identify and begin to address the necessary resource requitements, seeking to ensure that the research we facilitate and manage is designed and

conducted safely and to a high-quality. We will also implement systems to ensure that we can meet NIHR targets set for Sponsors relating to the set-up and delivery of these projects.

6. Summary and Recommendations

We ask the Committee to acknowledge the work of our research staff across the Trust, our performance across all indicators, and our financial position.

We would like to highlight our aim for sustainable growth and improvement, and that the next steps outlined in this report provide a strategic approach to doing so.

Report Title	**Committee Effectiveness Review 2024/25**				
Meeting	**Trust Board**				
Date	**10/07/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Finance, Infrastructure & Digital Terms of Reference Appendix 2 – Quality & Safety Committee Terms of Reference Appendix 3 – Performance, Population & Place Terms of Reference Appendix 4 – People & Culture Committee Terms of Reference Appendix 5 - Audit, Risk & Assurance Committee 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:

In line with best practice annual committee effectiveness review undertaken.

Report

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

The committees of the Board have completed an annual review and self-assessment of performance using a standardised approach.

Each committee produced an Annual Report and has reviewed their Terms of Reference as appropriate as well as an annual cycle of business.

Attendance has been good during 2024/25 and all committee meetings have been quorate allowing committee business to be appropriately transacted.

Each Committee has continued to meet its Terms of Reference and has delivered a comprehensive programme of work on behalf of the Board, providing timely reporting of issues via monthly Committee Chair Assurance Reports. This year a comprehensive exercise to map reports presented during the year against duties in the terms of reference was undertaken with any gaps considered at each committee. Any adjustments will be incorporated into the meeting's annual forward plan.

This report invites the Board to note a committee effective review has been undertaken and to consider the terms of reference of the Board Committees as attached. Minor amendments have been made to reflect feedback from committee members, or where job titles have changed, these are highlighted in yellow, with the exception of Performance, Population & Place Committee changing the frequency of the meeting as reference below.

There were no issues or concerns to draw to the attention of the Board about the effectiveness of the committees, the committee structure generally or the terms of reference for each committee, although it should be recognised that moving to a group model the committee structure and governance arrangements are under review and potential changes to the existing committee structure will change.

There was some discussion within committees around the move to Group, particularly the frequency of meetings however it was considered not appropriate at this stage with the **exception of Performance, Population & Place who considered that moving to bi-monthly was appropriate and the terms of reference have been amended accordingly.**

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	Quality & Safety Committee Finance, Infrastructure & Digital Committee Performance, Population & Place Committee People & Culture Committee Audit, Risk & Assurance Committee
Next Steps	To align annual work plans to the terms of reference

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	☐	☐	✓
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 approve the terms of reference for the following Board committees:-

	Quality & Safety Committee ***Finance, Infrastructure & Digital Committee*** ***Performance, Population & Place Committee* – noting that the frequency of the meeting has changed** ***People & Culture Committee*** ***Audit, Risk & Assurance Committee.***
Accountable Lead Signature	Caroline Coles, Company Secretary
Date	**27/06/2025**

FINANCE, INFRASTRUCTURE & DIGITAL COMMITTEE TERMS OF REFERENCE 2025/26

Purpose
The purpose of Finance, Infrastructure & Digital Committee is to support the Trust in achieving all its strategic objective with particular reference to: "**Maximise research, innovation and digital opportunities, spend wisely, and deliver on carbon net zero.".**

1. AUTHORITY

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

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

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

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

2. ROLE

2.1 To support the implementation of the Board's Strategy by seeking assurance about the Trust's financial, estates and digital strategies, including, to the extent necessary and relevant considering the wider BSW system's strategies.

2.2 To ensure that any material, long term financial or business risks identified are brought to the attention of the Trust Board to ensure they are reflected within the Trust's Risk register and Risk management process and to advise the Audit, Risk and Assurance Committee on the adequacy of any mitigation plan and recommend any areas requiring Audit scrutiny.

2.3 To seek assurance on behalf of the Board that the strategic risks linked to strategic pillar (4) *"Maximise research, innovation and digital opportunities, spend wisely, and deliver on carbon net zero."*, and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

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

2.5 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the Finance, Infrastructure & Digital Committee shall consist of:

- Three Non-Executive Directors (not including the Chair) – at least one of whom will have financial background
- Three Executive Directors; the Chief Financial Officer, Chief Operating Officer and the Chief Officer for Improvement & Partnerships.

3.2 The Committee may call other officers of the Trust to attend as appropriate, however the following will be invited to attend meetings of the Committee on a regular basis:

- Chief Digital Officer
- Director of Estates & Facilities
- Director of Procurement & Commercial Services
- Deputy Chief Financial Officer
- Company Secretary

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

3.4 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

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

4.2 The Committee may call other officers of the Trust to attend as appropriate.

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

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

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 *Voting* – When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

4.6 The work of this Committee will be supported by the Executive Director Lead, the Chief Financial Officer.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 The Committee will normally meet on a monthly basis with additional meetings being called where necessary. However, meetings that are not required will be cancelled.

7. DUTIES

7.1 Financial Strategy and Business Planning

7.1.1 Review for recommendation to the Board the Trust annual and medium-term financial plans, assess the assumptions therein and the alignment with overall Trust objectives, including, to the extent necessary and relevant considering the wider BSW system's annual plans;

7.1.2 To review and make comment to the Board on the long term strategic financial plans of the Trust, and to the extent necessary the wider BSW system, including the level of capital investment and financial risk;

7.1.2 Review in-year performance against financial plan, particularly gaining an understanding of key assumptions and risks, and review the latest year end forecast outturn, and to the extent necessary the wider BSW system;

7.1.3 Review through 'Deep Dive Reviews' any areas requiring particular scrutiny;

7.1.4 Review levels of contingency within the Trust financial plans and the phasing of key developments and efficiency schemes, ensuring that the full impact of any developments (including depreciation and cost of capital) have been appropriately included;

7.1.5 Review and develop reporting arrangements;

7.1.6 To consider and advise the Board on the impact of changes to the financial regime, including, but not limited to, the introduction of financial and governance arrangements in support of the Integrated Care System (ICS), and to monitor robust plans to manage the change

7.2 Income and Contract Management

7.2.1 Review the Trust contracting approach with key commissioners

7.2.2 Monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes.

7.2.3 Consider material opportunities to grow new income streams and market share of existing services.

7.2.4 To review, approve and/or recommend to Board operational contracts in line with the financial limits within the Scheme of Delegation.

7.3 Improvement and Efficiency

7.3.1 Review the process for developing the Improvement & Efficiency Plans and for the oversight and delivery of the programme within the Trust, including the monitoring of efficiency savings;

7.3.2 Review the implementation of the Trust's strategies and plans to provide assurance on the delivery of both financial and non-financial benefits. In the case of non-financial benefits to highlight any shortfalls to the appropriate committee or to the Board;

7.3.3 Consider and recommend any major transformation programmes that the Trust should undertake;

7.3.4 Review the annual Improvement & Efficiency Plans to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable;

7.3.5 Receive assurances regarding efficient and effective resource planning, particularly with respect to staffing and the deployment of agency staff;

7.3.6 Receive benchmarking and other relevant information to assess Trust productivity and ensure targeting or efficiency programmes;

7.4 Major Capital Investment Scheme

7.4.1 The Committee has a duty to ensure that a Business Case is prepared which includes sufficient information on the business needs, benefits, risks, funding and affordability, available options, costs, clinical and quality outcome measures, project development milestones, project management and regulatory requirements for it to decide whether or not to approve the scheme or lease.

7.4.2 To review, and recommend, Outline Business Cases and Full Business Cases prior to submission to the Board in line with the financial limits within the Scheme of Delegation;

7.4.3 In respect of major capital projects of the Trust, and to the extent necessary the wider BSW system, to consider business cases in detail and where necessary advise on strengthening prior to making recommendations to the Board for its approval or

otherwise. To monitor these projects post-approval and scrutinise any cost or time variances.

7.4.3 If major capital investment schemes are approved by the Committee, and by the Board of Directors if appropriate, the Committee will be responsible for reviewing the outcomes achieved following completion.

7.5 Key Commercial Arrangements

7.5.1 The Committee will review key commercial arrangements including long-term leases, partnership arrangements and major service developments. The Committee will track the progress of such developments, as appropriate.

7.6 Procurement

7.6.1 Review the Trust Procurement Strategy, systems and arrangements for obtaining best value;

7.6.2 Monitor progress against the NHS Standards of Procurement within the Trust.

7.7 Other – Financial

7.7.1 To advise on cash management strategies and levels of cash holding;

7.7.2 Review financial systems arrangements including those used for costing, income and service level reporting where appropriate.

7.8 Infrastructure (Estates & IT/Digital)

7.8.1 To approve for recommendation to the Board the Estate and IT strategic plans to ensure that it aligns with the Trust Strategy and operational objectives, including patient care delivery, and that the necessary information governance and technology arrangements are in place to support the developing Integrated Care System (ICS);

7.8.2 To seek assurance regarding operational delivery of estates and facilities (to include equipment management, health & safety, security, Way Forward Programme operational design) and IT plans including benefits realisation, value for money and approaches to the prioritisation of resources, data quality and informatics;

7.8.3 Seek assurance about the resilience of Digital services specifically in relation to the IT operational performance, digital infrastructure, defending against, and recovery from, external threats;

7.8.4 To review key commercial partnerships as appropriate;

7.8.5 Consider the risks to the delivery of the IT programmes, Digital Services, and Estates and Facilities infrastructure in line with the review of the Board Assurance Framework and Corporate Risk Registers.

7.8.5 To work with system partners to ensure the delivery of integrated estates planning.

7.9 Other

7.9.1 To oversee Finance, Estates and Digital Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference.

7.9.2 Take responsibility for gaining appropriate levels of assurance for those items related to finance and infrastructure on the BAF for which the Committee has accepted responsibility for board assurance.

7.10 ICS

7.10.1 To receive and review financial and other relevant reports of or relating to the BSW ICS and provider collaborative.

8 Other

8.1 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

9. REPORTING RESPONSIBILITIES

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

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

10. MEETING ADMINISTRATION

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

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

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

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

11. REPORTING/PROVIDING ASSURANCE

11.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- ~~Trust Investment Group~~ Trust Resource Reallocation (& Investment Group)
- Infrastructure Sub-Committee
- Way Forward Programme Board
- Capital Management Group
- Information Governance Steering Group

11.2 The Committee will also consider key assurance reports as outlined in appendix 1.

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

12. REVIEW

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

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

Version Control

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Finance & Investment Committee to Finance, Infrastructure & Digital Committee and expanded remit
V1.1	For review	May 2022	Finance & Investment Committee	Considered revised TofR for Finance, Infrastructure & Digital Committee. Amendments include:- • New format • Revised membership • Incorporate oversight and assurance on estates and IT/digital matters • Reference to assigned strategic risk • Added deputies for Executive Directors and voting process • Link to the Strategic Framework • Summary table of meeting remit
V1.2	Clarification	Aug-22	Company Secretary	Differentiate between the focus for IT between this committee and Performance, Population & Place Committee in the summary of meeting; this Committee focusses on systems (not performance)
V2.0	Annual Review	Mar-23	Company Secretary	• Job title changes • Reference to BSW ICS • Update sub-group reporting
V2.0	Approved	May-23	Board	As above
V2.1	Revised	Jun-23	Chairs PPPC & FIDC	Agreed to add IT service performance

				as part of remit of committee so as not to split IT elements between committees.
V3.0	Annual review	May-24	FDIC	- 2.5 added '*the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make'*. - 3.3 added subject experts as regular attendees - 7.8.3 added IT operational performance - Appendix 1 undated strategic risks - Updated appendix 2
V3.1	Updated	Aug-24	Board Meeting	- Amended voting in the event of equality of votes.
V4.1	Annual Review	Jun-25	FIDC	- Amendment to strategic objectives - Change name of meeting in 11.1 - Summary – name changes

Appendix 1 - Summary

Committee	Finance, Infrastructure & Digital Committee
Chair Lead EDs	Faried Chopdat, Non-Executive Director Simon Wade, Chief Financial Officer ~~Felicity Taylor-Drew~~ Benny Goodman, Chief Operating Officer ~~Claire Thompson~~ Emily Beardshall, Interim Chief Officer for Improvement & Partnerships
Frequency	Monthly
Membership	3 x NEDs 3 x EDs
Quorum	2 x NEDs 1 x ED
Assurances	**Financial** Finance Report /IPR Financial strategy & policy management incl SFIs & SofD Business Planning – Operating Plans and Budget setting Reference Cost Submission Business case approval up to £500,000-£1m Improvement & Efficiency / Cost Improvement Programme Way Forward Programme Private Patients Performance data **Procurement** Contracting Report Review delivery of Procurement & Commercial services **Information Governance** SIRO Report (inc. Data Protection & Security Toolkit Performance) **IT Infrastructure** IT Infrastructure (systems) Cyber security update IT service performance **Estates & Facilities** Estates/infrastructure performance Health & Safety **Risks** Corporate risks - Finance, IT/Digital, Estates Board Assurance Framework
Strategic Risks	Use of Resources – Finance (S6) Use of Resources – Estates Infrastructure (S7) Use of Resources – Digital (S8) Use of Resources – Cyber / IT system failure (SR9)

QUALITY & SAFETY COMMITTEE
TERMS OF REFERENCE
2025-26

Purpose
The purpose of the Committee is to support the Trust in achieving all its strategic objective with particular reference to: **"Continuous quality improvement and co-creation of services with local communities, with a focus on prevention and early intervention."**.

1. AUTHORITY

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

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

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

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

2. ROLE

2.1 To obtain assurance on behalf of the Trust Board that the Trust has in place the necessary structures and processes for the effective direction and control of the organisation so that it can meet its objectives, in particular, the provision of safe high quality patient care and that it complies with all relevant legislation, regulations and guidance that may from time to time be in place.

2.2 To seek assurance on behalf of the Trust Board that strategic risks linked to strategic pillar (1) "Continuous quality improvement and co-creation of services with local communities, with a focus on prevention and early intervention", identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

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

2.4 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the Quality & Safety Committee shall consist of:

- Four Non-Executive Directors (not including the Trust Chair), at least one of whom will have a clinical background
- Two Executive Directors; Chief Nurse & Chief Medical Officer

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

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

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

4.2 The Committee may call other officers of the Trust to attend as appropriate, however The following will be invited to attend meetings of the Committee on a regular basis:

- Deputy of Midwifery & Neonatal Services
- The Company Secretary

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

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

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 *Voting* – When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

4.6 The work of this Committee will be supported by the Executive Director Leads, the Chief Nurse and Chief Medical Officer.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 The Committee will normally meet on a monthly basis with additional meetings being called where necessary. However, meetings that are not required will be cancelled.

7. DUTIES

7.1 Patient Safety

7.1.1 The Committee will review the aggregated analysis of adverse events (including serious incidents requiring investigation (SIRIs) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems ~~except for compliance with the Mental Health Act (MHA), Mental Capacity Act (MCA) and Human Rights Acts~~ and associated codes of practice ~~which is monitored at the Mental Health Governance Committee.~~

7.2 Patient Experience

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 ~~The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.~~

7.3 Patient Outcomes

7.3.1 The Committee will review the annual clinical audit programme and ~~recommend its approval to the Trust Board, and~~ monitor its delivery.

7.3.2 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 Quality Improvement

7.4.1 The Committee will make recommendations to the Trust Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 ~~The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Great Care Campaign~~

7.4.3 The Committee will obtain assurance that the relevant breakthrough objectives and strategic initiatives, for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

7.5 Performance Monitoring

7.5.1 The Committee will advise the Trust Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will regularly review quality performance where there is ongoing non-compliance as set out in the NHS Constitution or the NHS Oversight Framework.

7.5.4 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.5 ~~The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.~~

7.6 Other

7.6.1 To oversee quality and safety Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference.

7.6.2 Take responsibility for gaining appropriate levels of assurance for those items related to safety and quality on the BAF and the Corporate Risk Register for which the Committee has accepted responsibility for board assurance.

8. REPORTING RESPONSIBILITIES

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

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

9. MEETING ADMINISTRATION

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

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

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

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

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Patient Quality Sub-Committee

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

11. REVIEW

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

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

Version Control

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Quality & Governance Committee to Quality & Safety Committee and revised remit
V1.1	For review	May 2022	Quality & Governance Committee	Considered revised TofR for the Quality & Safety Committee. Amendments include: • New format • Reference to assigned strategic risk • Added deputies for Executive Directors and voting process • Clarify remit on safeguarding • Link to the Strategic Framework • Summary table of meeting remit
V2.0	Annual Review	March 2023	Company Secretary	• Job title change • Added oversight of Improving Together matrix for quality • Added reference to NHSE Oversight Framework • Added reference to corporate risk register
V2.0	Approved	May 2023	Board	As above
V3.0	Annual Review	Apr-23	Company Secretary	- Added 2.3 the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make. - Increased 3 NEDs to 4 NEDs in membership - Add Director of Midwifery & Neonatal services as regular attendee - CMO name and title change - Appendix 2 updated
V3.1	Updated	Aug-24	Board Meeting	- Amended voting in the event of equality of votes.
V4.1	Annual Review	May-24	Quality & Safety Committee	- Strategic pillar amended to align with new Trust Local Strategic Direction 25-28 - Added Company Secretary as regular attendee - 7.1.2 : Delete reference to Mental Health Governance Committee as longer exists - 7.2.2 : Delete as PLACE is represented to FIDC under Estates & Facilities - 7.4.2 : Delete as the Great Care Campaign no longer exists - 7.5.5 : Delete as duplicated in 7.5.3

Appendix 1 - Summary

Committee	Quality & Safety Committee - Summary
Chair Lead EDs	Claudia Paoloni, Non-Executive Director Luisa Goddard, Chief Nurse Steve Haig, Acting Chief Medical Officer
Frequency	Monthly
Membership	4 x NEDs 2 X EDs
Quorum	2 x NEDs 1 x ED
Assurances	Quality Performance - IPR/Oversight Framework Quality Strategy Patient experience including national and local surveys Complaints performance data Incident data / Never Events Clinical Risks Quality Report GIRFT oversight Clinical Audit Plan Clinical Effectiveness including NICE Learning from Deaths Infection Prevention & Control/DIPC Research and Development Approval of Resuscitation Policy End of Life Care Children & Young People Safeguarding Adults & Young Children Mortality and Morbidity Performance Maternity & Neonatal - Ockenden Medical device/equipment safety Medication safety Performance data Safer Staffing Freedom to Speak Report Clinical litigation Board Assurance Framework / Corporate Risk Register
Strategic Risk	Quality (SR1)

Great Western Hospitals
NHS Foundation Trust

PERFORMANCE, POPULATION & PLACE COMMITTEE
TERMS OF REFERENCE
2025/26

Purpose
The purpose of Performance, Population & Place Committee is to support the Trust in achieving all its strategic objective with particular reference to: "***Collaborative and integrated working to improve quality of care and address health inequalities in our local communities***."

1. AUTHORITY

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

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

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

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

2. ROLE

2.1 Consider and advise the Board on the impact of operational management arrangements and to monitor arrangements in place for performance management.

2.2 Consider and advise the Board on the healthcare needs of the population we serve and how these are being met.

2.3 Consider and advise the Board on the development of our role at place in the ICS/ICA, Acute Hospital Alliance, networks and other (eg academic) partnerships.

2.4 To seek assurance on behalf of the Board that the strategic risks linked to strategic pillars (3) "*Collaborative and integrated working to improve quality of care and address health inequalities in our local communities*.", and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

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

2.6 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the Performance, Population & Place Committee shall consist of:

- Three Non-Executive Directors
- Two Executive Directors; the Chief Operating Officer and Chief Officer for Improvement & Partnerships.

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

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

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

4.2 The Committee may call other officers of the Trust to attend as appropriate.

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

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 *Voting* – When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

4.6 The work of this Committee will be supported by the Executive Director Leads, Chief Operating Officer and Chief Officer for Improvement & Partnerships.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 The Committee will normally meet on a bi-monthly basis with additional meetings being called where necessary. However, meetings that are not required will be cancelled.

7. DUTIES

7.1 Operational Performance

7.1.1 To seek assurance that the measures incorporated in the Integrated Performance Report and the Oversight Framework to the Trust Board meet both internal requirements and those of external stakeholders. Where performance is below the standard required, the Committee will ensure that robust recovery plans are developed and implemented.

7.1.2 To monitor delivery of the operational plan on at least a quarterly basis.

7.1.3 To review the operational performance from the wider BSW Integrated Care System to ensure the management of any performance challenges.

7.2 Embedding Continuous Quality Improvement & Learning

7.2.1 To oversee the delivery and embedding of Improving Together approach to continuous quality improvement and learning.

7.2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives, for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

7.3 ICS & Partnerships

7.3.1 To obtain assurance that Trust plans will positively impact on population health to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities.

7.3.2 To oversee the development of GWH as an anchor organisation.

7.4 Model of Care

7.4.1 To horizon scan for, be aware of, influence and respond to policy changes relating to models of care.

7.4.2 To ensure that changes in services at the Trust drive the outcomes required in the BSW model of care.

7.5 Other

7.5.1 To oversee Performance, Partnerships and Improvement Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference.

7.5.2 Take responsibility for gaining appropriate levels of assurance for those items related to Performance, Partnerships and Improvement on the BAF for which Committee has accepted responsibility for board assurance.

8. REPORTING RESPONSIBILITIES

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

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

9. MEETING ADMINISTRATION

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

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

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

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

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. These include:-

- Divisional Board USC
- Divisional Board SW&C
- Divisional ICC
- Elective Care sub-committee
- Urgent care & Flow sub-committee
- Inclusion & Health Inequalities Sub-Committee

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

11. REVIEW

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

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

Version Control

Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Performance, People & Place Committee to Performance, Population & Place Committee and revised remit
V1.1	For review	June 2022	Performance, Population & Place Committee	TofR of Performance, Population & Place Committee and approved subject to the following amendments: - 2.2 add 'healthcare' before needs and change we to 'how these are being met' - 7.3.1 delete across the entire population - Add to remit; JSNA annual review, ICS work programme plan, clinical networks and EPRR
V1.2	Clarification	August 2022	Company Secretary via PPPC	Add 7.1.2 to include IT Service performance in Committee remit. To note that Finance, Infrastructure and Digital Committee to focus on Digital Strategy/Systems.
V2.0	Annual Review	March 2023	Company Secretary	• Amendment to job title • Strengthen reference to partnership working • Reference Oversight Framework • Include assurance sub committees • Transferred BSW Academy to People & Culture Committee
V2.0	Approved	May 2023	Board	As above
V2.1	Revised	Jun-23	PPPC/FISC Chairs	IT services performance to be part of FIDC
V3.0	Annual review	May-24	Company Secretary via PPPC	- 2.6 added '*the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make'*. - 10.1 amended feeder groups/forums to the committee - Appendix 1 changed name of Chair of PPPC - Appendix 1 changed strategic risks - Updated appendix 2
V3.01	Updated	Aug-24	Board Meeting	- Amended voting in the event of equality of votes.
V4.0	Annual Review	Jun-25	PPPC	- Change strategic objective - Change in frequency of meeting to bi-monthly

Appendix 1

Committee	Performance, Population & Place Committee
Chair Lead EDs	Bernie Morley, Non- Executive Director ~~Felicity Taylor-Drew~~ Benny Goodman, Chief Operating Officer ~~Claire Thompson~~ Emily Beardshall, Interim Chief Officer for Improvement & Partnerships
Frequency	Monthly
Membership	3 x NEDs 2 x Eds
Quorum	2 x NEDs 1 x ED
Remit	Improving Together & Oversight Framework performance data – IPR Winter Plan EPRR Community Services Benchmarking & Model Hospital Report - Impact of ICS plans on the Trust JSNA review Population Health Management ICA work programme Clinical Networks Integration of Services Delivery of Improving Together PMO Performance Board Assurance Framework
Strategic Risks	Patient Care Through Joined Up Services - Performance (S4) Patient Care Through Joined Up Services – Partnerships (S5)

PEOPLE & CULTURE COMMITTEE
TERMS OF REFERENCE
2025/26

Purpose
The purpose of People & Culture Committee is to support the Trust in achieving all its strategic objectives with particular reference to: ***"Investing in training, resources, and well-being, while bringing teams together with the Improving Together approach."***.

1. AUTHORITY

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

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

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

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

2. ROLE

2.1 To monitor, review and report to the Board on the cultural and organisational development of the Trust, and to receive and provide the Board with assurance with regard to:

- the organisation's understanding of strategic workforce needs (including wellbeing, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them.

- the implementation of key HR controls, including recruitment and retention, and performance management including appraisal systems.

- the commitments of the NHS Constitution and the stated values of the Trust and standards of behaviour are being practiced at all levels of the organisation, based on evidence.

- the achievement of key deliverables in relation to the equality, diversity and inclusion (EDI) plan, and to monitor key metrics in relation to EDI.

- the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements.

- ensure engagement and consultation processes with staff reflect the ambition and values of the Trust and also meet statutory requirements

2.2 To seek assurance on behalf of the Board that the strategic risks linked to the strategic pillar (2) *"Staff and volunteers feeling valued and involved in helping improve quality of care for patients",* and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

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

2.4 The Committee will demonstrably consider the equality, diversity and inclusivity implications of decisions they make.

3. MEMBERSHIP

3.1 The membership of the People and Culture Committee shall consist of:

- Three Non-Executive Directors

- One Executive Directors - the Chief People Officer

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

3.3 One of the Non-Executive members will be appointed Chair of the Committee by the Board.

4. ATTENDANCE

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

4.2 The Committee may call other officers of the Trust to attend as appropriate, in particular the Chief Nurse and Chief Medical Officer.

4.3 No other party may attend without the specific invitation of the Chair of the Committee.

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

Any Executive Director and/or Non-Voting Board Director may act as a nominated substitute / deputy in the absence of any Executive Director and/or Non-Voting Board Director and this attendance will count towards the quorum.

4.5 *Voting* – When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

4.6 The work of this Committee will be supported by the Executive Director Lead, the Chief People Officer.

5. QUORUM

5.1 The quorum shall be three members (2 Non-Executive Directors and 1 Executive Director).

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet on a bi-monthly basis with additional meetings called where necessary. However, meetings that are not required will be cancelled.

7. DUTIES

7.1 People

7.1.1. Review the development and delivery of the Trust's sustainable workforce strategy, including, to the extent necessary and relevant considering the wider BSW system's strategies, focusing on:

- Strategic workforce information and planning.
- Recruitment and retention.
- Staff experience and engagement, reward, recognition, health and wellbeing
- Education, learning and organisational and leadership development.
- Equality, diversity and inclusivity

7.1.2. Provide assurance that the Trust's People Strategy and policies effectively respond to national and regional people strategies and policies.

7.1.3 Review strategic intelligence and research evidence on people and work, and distil their relevance to the Trust's strategic priorities.

7.2 Culture and Values

7.2.1 The role of the committee would be to oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback.

7.2.2. Oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications to the Board.

7.2.3. Oversee the development and delivery of the Trust's strategy and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area.

7.3 Organisational Capacity

7.3.1 The role of the Committee would be to oversee the development and delivery of a strategy regarding a sustainable workforce (more generally), including, to the extent necessary and relevant considering the wider BSW system's strategies. That would include development of new roles, recruitment and retention etc.

7.3.2. Review plans for ensuring the development of leadership and management capability, including the Trust's approach to succession planning and talent management.

7.4 Education and Training

7.4.1 Review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system.

7.4.2. Secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff.

7.5 Staff Health & Wellbeing

7.5.1 Oversee the development and delivery of a Trust Staff Health and Well-being Strategy

7.5.2. Review the accessibility and impact of the health and well-being strategy and improvement programmes, in particular, for staff with protected characteristics.

7.6 Other Duties

7.6.1 To refer to the Trust Board or other Board committee and/or the Executive Team any identified unresolved risks arising within the scope of these terms of reference that require Executive action or that pose significant threats to the operation, resources or reputation of the Trust.

7.6.2 To identify, assess and manage strategic risks in relation to the Committee's area of focus via the Board Assurance Framework. Review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Trust Board with assurance on the effectiveness of management of the principal risks relating to the Committee's purpose and function.

7.6.3 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the

Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

7.6.4 To receive and monitor workforce indicators including recruitment, retention/turnover, sickness, appraisals and training in the IPR and Oversight Framework.

7.6.5 To receive and review relevant reports of or relating to the BSW integrated care system and provider collaborative.

8. REPORTING RESPONSIBILITIES

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

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

9. MEETING ADMINISTRATION

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

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

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

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

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. The list of such committees will be:-

- Strategic People & Culture Sub Committee
- Employee Partnership Forum
- Joint Liaison Negotiation Committee
- Medical Staffing Support Group
- Nursing, Midwifery and AHP Workforce Committee
- Inclusive & Health Inequalities Sub-Committee
- HWB Oversight Committee

10.2 The Committee will consider the key assurance reports as outlined in appendix 1.

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

11. REVIEW

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

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

Version Control

Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1	For review	March 2022	Company Secretary	New committee
V1.1	For approval	June 2022	Chair and Director of HR	For approval at first P&CC
V2.0	Annual Review	March 2023	Company Secretary	• Job title changes • Strengthen reference to partnership working • Reference Oversight Framework
V2.0	Approved	June 2023	Board	As above
V3.0	Annual Review	Apr-24	Company Secretary	- 2.3 added the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make. - 10.1 added Strategic People & Culture Sub Committee as feeder groups/forums - Appendix 1 changed name of Chair of PC&C - Appendix 1 changed strategic risks from 1 to 3
V3.1	Updated	Aug-24	Board Meeting	- Amended voting in the event of equality of votes.
V4.0	Annual Review	Jun-25	People & Culture Committee	- Amended strategic goal to align with new Trust Stategy.

Appendix 1 - Summary

Committee	People & Culture
Chair Lead ED	Julian Duxfield, Non-Executive Director Jude Gray, Chief People Officer
Frequency	Bi-monthly
Membership	3 x NEDs 1 x ED (Chief People Officer)
Quorum	3 x members (2 Non-Executive Directors and 1 Executive Director).
Assurance	People Strategy Workforce performance IPR / Oversight Framework Equality, Diversity & Inclusion Nursing skill mix Medical revalidation inc. appraisal/MHPS report/GMC Guardian of Safe Working Staff survey and engagement Job planning compliance Education and Training Gender pay gap WRES performance data WDES performance data Organisational Development Clinical Excellence Awards Voluntary services Compliance with employment legislation Recruitment and retention Workforce digital solutions – e-roster, job planning etc.
Strategic Risk	Workforce (SR2, SR3)

AUDIT, RISK & ASSURANCE COMMITTEE
TERMS OF REFERENCE
2025/26

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

1. AUTHORITY

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

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

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

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

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

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

ROLE

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

2.2 In addition this Committee shall

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

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

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

3. MEMBERSHIP

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

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

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

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

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

4. ATTENDANCE

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

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

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

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

The company secretary may attend meetings.

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

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

4.5 *Voting* - Only the Non-Executive Directors who are members of the Committee or in their absence their substitute may vote. When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

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

5. QUORUM

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

6. FREQUENCY OF MEETINGS

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

7. DUTIES

7.1 Internal Control, Risk Management and Governance

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

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

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

7.2 Internal Audit

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

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

7.3 External Audit

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

- The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process, including the review of the work, findings and management responses to the work. This will be achieved by:

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

The Committee will:

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

7.4 Financial Reporting

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

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

The Audit, Risk & Assurance Committee will also:-

- Monitor the integrity of the financial statements and any formal announcements relating to financial performance, reviewing any significant financial reporting judgements.
- Ensure that the systems for financial reporting to the Board, including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

7.5 System Working, Managing Change & Transformation

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

7.6 Other Assurance Functions

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

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

8. REPORTING RESPONSIBILITIES

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

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

8.3 The Chair of the Committee reports to the Council of Governors through the statutory annual report and accounts process, and in relation to the performance of the external auditor to enable the Council of Governors to consider whether or not to re-

appoint the external audit firm. In addition, the Chair of the Committee will report any other significant issues to the Council of Governors.

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

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

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

9. MEETING ADMINISTRATION

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

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

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

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

10. REPORTING/PROVIDING ASSURANCE

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

11. REVIEW

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

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

Document Control

Version Control				
Version	Status	Date	Meeting/Persons	Summary of Change
V1.0	For annual review	July 2022	Audit, Risk & Assurance Committee	• 2.3 added • EPRR paragraph deleted as moved to PPPC • FTSU paragraph deleted as moved to Q&SC • 8.3 amended reporting process to CofG • Information Governance deleted as moved to FIDC • 3.1 added 'Trust' before Chair

V2.0	Annual Review	Mar-23	Company Secretary	• Job title changes • Change to NHS England from NHS Improvement due to legislative change • Added areas of assurance to summary box
V2.0	Approved	May-23	Board	As above
V3.0	Annual Review	Jun-24	Company Secretary	• 1.5 added following review of NHS Audit Committee Handbook (2024) • 1.6 added – added to all tofr in line with Board commitment to ED&I • Company Secretary added as regular attendee following review of NHS Audit Committee Handbook (2024) • 8.4 added – following review of NHS Audit Committee Handbook (2024) • Appendix 1 updated • Appendix 2 updated • Amended membership to 4 NEDs • Amended voting in the event of equality of votes.
V4.0	Annual Review	Jun-25	ARAC	• Delete reference to Wiltshire Health & Care LLP as ceased on 1 Apr-25

Appendix 1 - Summary

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

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

Report Title	**Quality Account 2024/25**				
Meeting	**Trust Board**				
Date	**10/07/2025**	**Part 1 - Public**	✓	**Part 2 - Private**	☐
Accountable Lead	Rayna McDonald – Deputy Chief Nurse				
Report Author	Sharon Keene – Compliance & Legal Services Manager				
Appendices	Quality Account 2024-25				

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 Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017, the Trust is compliant each year with the regulatory requirements

Report

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

This report presents the final draft of the Quality Account and the chosen quality priorities for 2025/26.

Introduction

The quality account is an annual report for the public that focuses on the quality of the services the trust delivers, the ways in which the trust demonstrates that it frequently checks

on the quality of those services and that the trust's staff are committed to continually improve the quality of those services.

All providers of NHS healthcare are required to publish a Quality Account each year. These are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended (the quality accounts regulations'). The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017.

Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. Each year the Trust agrees a set of Quality Priorities aligned to the three quality domains set out in the national document High Quality Care for all as follows:

- Patient Safety (how we keep our patients free from harm)
- Patient Experience (what the process of receiving care feels like for the patient, their family and carers
- Clinical Effectiveness (the standards of care we provide for our patients)

The three priorities are informed by the quality and safety information that has been gathered over the last year, this includes:

- Clinical audit data
- Results from national In-patient surveys
- Local and national audit
- Reporting against National priorities e.g., Learning disabilities
- Analysis of incidents
- Analysis of complaints

Once approved the Quality Account will be submitted to NHS England and will be available for the public to view from the 30th June 2025 via a link on the Trust 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		
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 committee is asked to approve the final draft of the Quality Account.

Accountable Lead Signature	Luisa Goddard.
Date	**12/06/2025**

NHS
Great Western Hospitals
NHS Foundation Trust

Quality Account 2024-25

Contents

About the Quality Account

Our Quality Account is our annual report to the public about the quality of the services we deliver as a health care provider. The Quality Account describes our approach to quality, and provides an opportunity for scrutiny, debate and reflection by the public and also encourages us to focus and be completely open about service quality and helps us develop ways to continually improve.

Each year, our Quality Account is both retrospective and forward looking. We look back at the year just passed and present a summary of our key quality improvement achievements and challenges.

We look forward and set out our quality priorities for the year ahead, ensuring that we maintain a balanced focus on the three key domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Our quality priorities are chosen following a process of review of current services, consultation with our key stakeholders and most importantly through listening to the feedback from our service users and carers.

Some of the content of the Quality Account is mandated by NHS England and /or by The NHS (Quality Account) Amendment Regulations 2012, however other parts are determined locally and shaped by the feedback we receive.

Statement on quality from Chief Executive
Cara Charles-Barks

I am pleased to present our Quality Account for 2024-25 for Great Western Hospitals NHS Foundation Trust (GWH), which shows how we have performed against our priorities this year and sets out the main areas of focus on quality for 2025-26.

This is the first set of accounts I have had the pleasure of presenting as the Chief Executive of GWH – which is now part of the Bath and North East Somerset, Swindon and Wiltshire (BSW) Hospitals Group along with the Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust.

The year saw significant development of the collaboration between the three hospitals with the creation of our hospitals group. The new collaboration means that in the coming years staff working across our hospitals will work together, improve together and learn together to deliver modern effective and quality care to the communities we serve.

Quality improvement is something we strive for every day, and we have made great progress using our Improving Together methodology to improve ways of working here at GWH as well as sharing best practice and learning with our partners.

There are three domains of quality – patient safety, clinical effectiveness, patient experience – and each year we set priorities for each of these three, in line with the aims and objectives of our Quality Strategy for 2022-26.

Our progress against last year's priorities is detailed later on in this Quality Account.

The report also outlines a new set of priorities for this year, explaining why we have chosen them and how we plan to go about making improvements. These priorities are:

- Patient safety – Measuring and improving compliance with the Sepsis 6 Bundle – we will focus on ensuring staff use the bundle, a set of six evidence-based actions that should be initiated within one hour of identifying sepsis
- Patient experience – Putting the hospital to bed – we will focus on improving the night time environment for patients by increasing awareness of the impact of noise levels and night time patient transfers have in disrupting sleep for patients.
- Clinical effectiveness – Supporting patients to self-administer their own medications – we will focus on maintaining independence for those adult inpatients who meet the assessment criteria to administer their drugs as they would at home.

On behalf of the Trust Board, I would like to thank all our staff in all professions who every day work together to deliver compassionate and high quality care to our patients, regularly going above and beyond to do their best for our communities.

Cara Charles-Barks
Chief Executive

About us and the service we provide

Our Trust provides acute services to a geographical area which covers Swindon and parts of Wiltshire, Bath and North East Somerset, Hampshire, Dorset, Oxfordshire, West Berkshire and Gloucestershire, serving a population of more than 1.3m people.

We run the Great Western Hospital, which opened in 2002 and provides emergency care, elective (planned) surgery, diagnostics, paediatrics, maternity (both midwife and consultant led), and outpatient and day case services. Until the end of 2024-25 we also ran adult community services in Swindon.

At the Great Western Hospital, there is a purpose-built centre for elective surgery called the Brunel Treatment Centre, which enables us to separate emergency from elective surgery.

Our Board, along with the Boards of Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust agreed to form a group in 2024.

Our three Trusts have long acknowledged that we can achieve far more to support and empower people by collaborating than by operating independently. We are working together as a group to better enable us to deliver high quality care for our population. Through working as a group we increase our ability to improve patient care and how we use our resources.

We are part of the Bath and North East Somerset, Swindon and Wiltshire (BSW) system, working collaboratively with the Integrated Care Board and three local authorities, alongside other partners, to deliver the priorities set out in the local Integrated Care Strategy.

Our Quality Strategy

The Quality Strategy sets out our aims and objectives for 2022-26. It follows our overarching Trust strategy and describes the elements that drive our approach to quality. The strategy includes 'Improving Together' – an ambitious transformation programme to embed a culture of continuous improvement across the Trust.

Our strategic pillars

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 well-being, 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 our local communities.

Sustainable future
Maximise research, innovation and digital opportunities, spend wisely, and deliver on carbon net zero.

Our key achievements

April 2024

- New Community Diagnostic Centre opens

June 2024

- 400 staff members attended our 80's themed Staff Excellence Awards

July 2024

- Sustainability team shortlisted for the BBC Make a Difference Green Award
- Local voluntary group, Brighter Futures Blanketeers, shortlisted for the BBC Make a Difference Carer Award
- Cardiology team rated best team in the UK for teaching by specialist registrars in district and general hospitals
- Adult inpatient survey published, showing improvement in 20 questions

August 2024

- New Intranet launches to support staff resources
- Reaccredited Veteran Aware organisation
- Cardiac Physiology completed the UK's first implant of a new heart monitoring technology
- Our outpatient hypertension pathway was selected by Health Innovation West of England to be rolled out across the west

September 2024

- Our new Emergency Department opens
- Fourth Great West Fest held at Town Gardens
- Finalist in the prestigious HSJ Patient Safety Awards for Improving Together

October 2024

- Trust chosen as first NHSE exemplar organisation for sustainable practice
- Anaesthetics awarded the prestigious Anaesthesia Clinical Service Accreditation
- Graduation of our first cohort of Equality, Diversity, and Inclusion (EDI) Champions

November 2024

- Opening of new Children's Emergency Unit and Medical Assessment Unit
- Cara Charles-Barks appointed Chief Executive Officer of BSW Hospitals Group
- Trust Board approved £1m investment for theatre services
- Our first Equality, Diversity, and Inclusion (EDI) conference held in Swindon

December 2024

- Localisation workshops for the Electronic Patient Record programme begin
- 1,000 staff complete Improving Together training

January 2025

- Her Majesty The Queen visits Great Western Hospital to open the new Emergency Department
- Construction completes on Pharmacy Aseptic Unit
- Trust hosts Swindon Community Careers Fair
- New mentoring programme opens to staff

March 2025

- Highest ever response rate of 71% in staff survey
- Improving Together shortlisted in the HSJ Partnership Awards
- 50+ staff become Equality, Diversity, and Inclusion (EDI) champions

Listening to patients and their families

The focus over the past year has been listening to patients, families, and carers to understand the key themes that are important and where we need to make improvements. The Friends and Family Test (FFT), complaints, concerns, compliments, national and local surveys, direct patient engagement, and incidents provide a rich source of feedback that we have been able to review to recognise where we should target improvement action as we strive to provide the highest quality care for our patients.

This has helped inform our improvement work to ensure the patient voice is heard, and we proactively engage, involve, and work in partnership where possible. Some examples of our engagement work include:

Engaging with our local communities

We continue to reach out to local communities, particularly those who we do not always hear from through our usual feedback mechanisms. We have connected with a variety of local community groups, attended events, and built strong links to support collaborative working and two-way communications. This includes developing opportunities to gain feedback from minority ethnic groups, those living in poverty, carers, military personnel and disability groups, to understand their unique needs and share our work.

We have implemented patient and public involvement groups across the Trust and have embedded lay members as equal partners at specialty committees, adding a unique lived experience perspective.

Maternity Services

Working closely with the local Maternity and Neonatal Voices Partnership (MNVP), we are actively engaging with local communities to inform our improvement work and have included refugees and asylum seekers who require specific care and support.

We have listened to feedback about our maternity dashboard publications and adapted the content to meet the wishes and needs of birthing people, support groups, and other interested parties.

Change the Narrative

A public storytelling engagement opportunity was held in October, inviting local people to attend to discuss the challenges they face when accessing health care. The event was attended by board members and involved actively listening to feedback. The key themes related to communication, understanding of specific needs, and lack of compassion. We continue to discuss ways the board can hear directly from patients, families and carers.

Integrated Front Door Engagement

A significant amount of patient and public engagement helped inform the design of our new front door services. This included engagement work with parents, children, and young people and going out into the local community to share our plans and gain views and insight into what is important to the public. We spoke with people with sensory loss, learning and physical disabilities, and we visited schools and community groups to gain feedback to ensure the design and environmental elements were carefully considered.

Learning Disability and Autistic Spectrum Disorder

We have been working with the mother of a patient with a Learning Disability (LD) to better understand the needs of adults with LD and make improvements to how our staff communicate with patients and their carers. Working in partnership, we have shared this very personal experience with staff, providing an extremely impactful account of how we interact with patients and where we can make improvements.

This has led to the introduction of new resources across the Trust to support distraction, communication, and assist with keeping patients calm and occupied. The resources are held in our Emergency Department, with our Learning Disability nurses, and are also available on request from our Patient Advice and Liaison Service. Our LD nurses visit patients in the Trust and can recommend the appropriate resources for each individual patient.

Interpreting and Translation Services

We have seen a rise in demand for our interpreting and translation (I&T) services and are working with clinical divisions to ensure that we are providing equitable access to all patients. Our Patient Advice and Liaison Service are working proactively to identify the need for interpretation where possible so that advance planning can be put in place. We reviewed our local demographic data and I&T requests to better understand the demand and how we can

use the resources available in the most effective and efficient way.

We have worked closely with the deaf community, proactively promoting our Sign Live service and have also purchased new digital amplifiers and a portable hearing loop that can be taken to wards and departments to support patients with hearing difficulties.

Spinal Cord Injury (SCI)

Work that commenced in 2023, to better support patients with historic spinal cord injury, has progressed. A patient passport, care pathway, bowel care policy, and staff training are now in place. The co-production group that was set up to review the patient feedback and concerns continues with a focus now on raising awareness amongst staff and patients.

We continue to work collaboratively with Salisbury Spinal Injury Unit, the Spinal Injury Association, and patient partners to deliver staff training and attend community events to support awareness raising. The patient voice with lived experience has provided an invaluable dynamic to help staff to understand the specific and vital care needs of these patients.

Dining Companions

Following an initial trial, we launched dining companions across ten of our wards. These are staff members who have expressed an interest in the role, some as a development opportunity and some to enhance their understanding of patient care and working in a clinical environment. The role includes preparing the patients to eat, delivering trays, cutting up food, opening packets, and providing companionship and encouragement.

Care reflections

Our patient experience films share the stories of patients, families, or carers. The stories were shared with our Trust Board as an opportunity to hear directly from people about their experience of care, where things have gone well and where improvements can be made. The films include staff reflection that are used as part of clinical governance meetings, individual or group reflections, and staff training.

Veteran Aware

Following a re-accreditation process, and meeting of the necessary standards, we have successfully maintained our Veteran Aware status and continue to work in collaboration with

the Defence Medical Welfare Service to identify, support, and signpost patients who may otherwise be disadvantaged due to their military status.

Cancer Partnership Group

The group which consists of patients, carers, and healthcare professionals, reviewed the ten lowest scoring questions from the National Cancer Experience Survey. This review is being used to devise a list of important information that patients need to receive. This will include production of a "Ten Top Tips" sheet that is visually impactful and easy to read to display in patient areas, to share on social media, and to put in new patient information packs.

Engagement with carers

Criteria issued in October has supported the use of the carers support passport and staff decision making. Our Carers Café is held weekly at Great Western Hospital. Carer information packs are being rolled out to wards, and carers training has been delivered to Health Care Support Workers. The Head of Patient Experience and Engagement attended community events as part of carers awareness week including a local support group for carers of patients with significant mental health illness. Concerns raised regarding delays in provision of critical antipsychotic medications, has been reviewed by pharmacy colleagues so that issues leading to the delays are identified. Solutions have been presented back to the support group and has been discussed at our Mental Health Committee meeting.

Communication resource packs

These new packs provide communication tools and signposting for the ward staff to facilitate better communication with patients who may have additional needs. To support the packs, training is also being rolled out across the Trust.

Great Care

Care with compassion, getting the fundamentals right and keeping the patient front and centre is our starting point. We want every patient to have the best possible experience when using our services. We recognise that every staff member plays a vital part in ensuring all our patients receive great care.

Delivering and aspiring to deliver great care is now embedded into existing and new improvement projects, our aims as outlined in our Quality Strategy 2022-26 remain,

- Deliver great care to every patient all the time, and seek to continually improve the care we provide to patients
- Receive regular feedback from patients, their families and carers
- Engage and empower staff to deliver great care.

Developing and implementing our Ward Accreditation programme is pivotal to us delivering great care and will be at the centre of our improvement work in the coming year. Ward accreditation is a tool that allows us to measure the quality of care being delivered in a clinical area and to demonstrate improvement in patient outcomes and increase patient satisfaction and staff experience.

Delivering Great Care means keeping the patient at the very centre of all that we are trying to do. This means proactively collecting feedback and listening intently to our patients and their families and carers and responding in a timely and effective way to ensure a positive and sustainable impact on their care experience.

Improving together

Improving Together is our Trust-wide approach to change, innovation and continuous improvement. This year we have matured our consistent methodology across Bath and North East Somerset, Swindon and Wiltshire so that improving becomes something we all do the same way.

Three years since Improving Together was introduced, over 1,000 staff have taken part in our tailored training which is empowering teams to make improvements in their own areas. Since 2021, this unique way of working has been embraced by multidisciplinary teams across the Trust. Staff are using the entire Improving Together approach or certain aspects or methods to deliver improvements. We have adapted our training to best suit people's needs. The uptake and feedback from the latest Fast Track training has been positive and helps smaller teams to tailor their learning. Sixteen teams have received Fast Track training in the last year.

2025/26 will see us come towards the end of our frontline team cohort training as we take our penultimate cohort of teams through this route. We're building our approach to support sustainability with teams through ongoing coaching and support these changes will mean that our improvement facilitators are spending more time in clinical areas and offer a flexible approach to learning sessions. Teams we are working with include: the Surgical Assessment Unit, Children's Ward, and Medical Assessment Unit.

We have continued to increase patient, family and carer input into Improving Together ensuring that teams are using patient feedback to inform the priorities they set and are actively involving patients and carers in improvement ideas and changes.

Improving Together is transforming how we bring people together, how we communicate and helps to put improvement at the heart of everything we do. We are aligning our priorities across our BSW Hospitals Group focused on delivering a vision of "Working together, learning together and improving together to provide excellent care for our population".

Recent staff survey results show improvements in the Medicine and Surgery, Women's and

Children's division for the number of staff that feel able to make improvements at work although there has been a slight dip among all our staff. We focus on celebrating successes by sharing case studies and stories; Improving Together has been a finalist for an HSJ Patient Safety Award and HSJ Partnership Award. Examples of both small changes and larger scale transformations are regularly celebrated.

We have seen good progress in our Trust level pillar metrics* and breakthrough objectives**:

- Sustained reduction in the total harms from incidents throughout 2024/25. The average from September 2024 has been a 20% reduction below the historic average and a 45% reduction from its peak in January 2022.
- This has been supported by work to reduce pressure harms and patient falls. The medicine division has seen a 25% reduction in pressure harms during 2024/25 and the former Integrated Care and Community Division has had a 70% reduction in pressure harms in our community patients.
- There has continued to be an increase in positive responses from patients on the Friends and Family Test with recent months being about 90% positive.
- The length of time patients wait for care in the Urgent Treatment Centre has seen good reductions despite increasing numbers of people attending.
- The voluntary turnover rate of our staff has reduced to a new average of 8.5%, well below our target of 11%.

During 2024/25 we moved to new breakthrough objectives which focus on reducing ambulance handover times, reducing harm from falls, increasing the number of staff feeling they receive respect from colleagues and financial recovery. The first phase of this work has been understanding the current situation and making smaller scale changes to test improvements that might work. During 2025/26 we will continue to focus on showing greater progress in these areas.

We have updated our approach to how we support Rapid Improvement Events within the organisation with an emphasis on patient, family and carer involvement.

Within teams we have seen the following real successes:

- Cancer services focusing on early recording of cancer diagnosis so that patients can receive support as quickly as possible

- Implementing a new location for the maternity triage which has supported a reduction in the average time from arrival to triage from 54 minutes 13 minutes; this means pregnant women get rapid assessment of their needs on arrival
- An increase in outpatient productivity including increasing in-session clinic utilisation from an average of 87.5% in 2022 to an average of 91.6% in 2024/25
- Hospital at Home increased its occupancy rate to 90% for the first time in December 2024, a 10% increase from its target of 80%. Hospital at Home is a service that provides services to patients in their own home as an alternative to being admitted to hospital.
- Continued decrease in spend on agency staff across nursing and medical staff.

Looking ahead, we will continue to teach, share and support the Improving Together approach until improvement becomes an integral part of our Trust's culture and just the way we do things. Several of our improvement priorities for the coming year focus on the experience and care of patients in our admission areas alongside: increasing our productivity, reducing things that don't add value to staff and patients and using our resources in a more sustainable way. Increasingly we are working together across the BSW Hospitals Group to share our improvement work and transformation resources so that we can support the biggest impact of patients, carers and staff.

*Pillar metrics – our 12 metrics tell us whether we are doing well on driving forwards our vision and strategy. These last for the duration of our strategy (3-5 years).

**Breakthrough objectives – our areas for focused improvement, we should be able to see a 20–30% improvement over a 12-18 month period and they should be the focus of our improvement energy. They are likely to be top contributors to driving improvement in one of our pillar metrics.

Priorities for improvement

Results and achievements for the 2024-25 Quality Account Priorities

1 Reducing falls and falls with harm

Why was this a priority?

Inpatient falls are one of the most frequently reported patient safety incidents in the Trust. In 2023, on average 119 inpatient falls were reported each month. Whilst most falls result in no harm, occasionally a fall will result in more significant harm, such as a head injury or hip fracture. Harm may also be exhibited through psychological impact, prolonged hospital stays, and delayed recovery.

As we age the risk of falling increases, however falls are not an inevitable part of getting older. There are many reasons why someone might fall, these may include; impaired balance, confusion or disorientation, medication side effects, vision problems, or a sudden drop in blood pressure on standing up. Whilst it is not possible to prevent all falls, evidence shows that through effective multifactorial risk assessment and individualised interventions, a person's risk of falling can be reduced.

What we said we would do

- Reduce the number of patients who have more than one fall in hospital
- Improve compliance with falls prevention actions such as identifying patients with postural hypotension (where the blood pressure drops on standing) and supporting those patients that require enhanced care

What we did

The Trust commenced several quality improvement projects during 2023/24 aiming to improve training for staff, patient risk assessment, and care provision. These projects have contributed to a reduction in inpatient falls, the average number of inpatient falls reported each month has reduced from 119 to 103 falls per month.

Mandatory Training

Falls training is mandatory for all clinical staff. In 2023/24 the mandatory training module was updated to include the new national E-Learning for Health Fallsafe / Carefall module. The current Trust-wide compliance with falls mandatory training is 90.87%.

Lying and Standing Blood Pressure Assessment

Postural hypotension is an abnormal drop in blood pressure on standing. This condition commonly affects older adults and is associated with an increased risk of falls. NICE guidelines recommend that on admission to hospital all patients over the age of 65, and those that have been judged to be at risk of falls due to their medical condition, should receive a lying and standing blood pressure assessment on admission.

In May 2023 a Trust-wide project was commenced to improve compliance with lying and standing BP assessment on admission. Through development of training resources provided to all ward teams, and monthly audit data shared with frontline managers, compliance has improved from 64% in May 2023 to 86% in October 2024. The project continues to progress with the development of new patient information and a clinical guideline on the management of postural hypotension.

Enhanced Care

Being admitted to hospital can be a disorientating and distressing experience for a person. Some people are at increased risk of coming to harm or causing harm to others whilst they are in hospital. Enhanced Care is a closer level of supervision which may be put in place for some people who are at increased risk of harm. Enhanced Care enables staff to monitor a person's physical, psychological and emotional well-being while they are in hospital, to reduce the risk of harm to themselves or others.

Learning from incidents in the Trust demonstrated that there was an inconsistent approach to identifying those patients that required enhanced care and ensuring that the correct level of support was maintained.

In October 2023 a project commenced to develop a new enhanced care assessment tool, and a clear definition of the levels of supervision. This assessment was first trialled on paper in a number of pilot wards, and then in Spring 2024 a daily risk assessment for all adult inpatients was implemented on the electronic record system across all inpatient wards. This daily assessment enables a Trust-wide oversight of our most vulnerable patients, and the level of care they require to support safety.

Alongside implementation of the new assessment, training was provided for all nursing staff

on the inpatient wards. In addition, a new full day enhanced care study day has been developed and launched in April 2024 to provide training on provision of person-centred care to patients with complex needs.

Compliance and progress with the use of the assessment is monitored through ongoing monthly audits which commenced in September 2024. The most recent audit in March 2025 has demonstrated a 96% compliance with accurate assessment.

Deconditioning Prevention – Get up, Get Dressed, Keep Moving

Activity and movement are key factors to improve health and wellbeing, aid recovery and rehabilitation, and help patients to return home sooner. To support this the Trust launched a campaign 'Get up, Get Dressed, Keep Moving' in September 2023.

The Trust ran a 'Tour de Swindon' event, supporting patients to cycle or walk a virtual route around Swindon. The event promoted the campaign and encouraged activity and movement on the wards. A total of 94.4 miles was achieved by patients across six inpatient areas.

Following the campaign the Trust launched several new initiatives:

- Purchase of new moving and handling equipment
- Purchase of riser recliner chairs for inpatient wards for patients who require specific seating to meet their needs
- Development of a Bedside Mobility Assessment Tool (BMAT) to provide guidance to nursing staff on safe assessment of a patient's level of mobility, reducing delays in getting patients up out of bed after admission
- Training on deconditioning and BMAT delivered to over 150 staff.

How will we continue to monitor and measure our progress?

Implementation and progress of the falls improvement plan is monitoring by the Trust Falls Improving Together Group.

2 Improving the experience of carers by delivering responsive support and information

Why was this a priority?

We know that carers play a key role in helping people to get better; they know so much about the person being cared for, and what can help them recover. We aim to improve the experience of carers to acknowledge the importance to our patients, involving them in care and recognising their contribution to care, and we are committed to finding new ways to support and empower them.

What we said we would do

- Monitor compliance with the carers passport by producing monthly data to show how many passports are being handed out
- Roll out the new visiting guidance and associated support and conduct an evaluation after six months
- Reach out to community organisations to promote the carers support available across the Trust and measure the impact through carers surveys

What we did

A carers survey was undertaken in August 2024 which included awareness and use of the carer's passport.

As a result of the survey criteria has now been developed to support staff when issuing the passport. Carers awareness raising has continued with trolley dashes to ward areas, a stand at stop the pressure day, marking of carers awareness day with a stand in the atrium and promotion of our services via our weekly Carers Café, ward information boards and new information packs.

Data on issuing of the passport is collated by the Patient Advice and Liaison Service. More flexible visiting was rolled out in May 2024. We now offer open visiting across the Trust, welcoming visitors between 8am and 8pm on most of our wards.

We are continuing to encourage carers to identify themselves, key messages are now displayed on the Urgent Treatment Centre and Emergency Department television screens, further public facing communications have been promoted and there have been visits to various community forums and events to raise the profile of the work that the Trust do to support unpaid carers.

Events attended include Mental Health carers meeting, Swindon Carers Centre community event, public carers meeting, community dementia event, local community cafes and cultural events. Communications are also regularly shared with community organisations and GP practices

3 Improving initial assessment of patients on front door services

Why was this a priority?

Obtaining accurate patient assessments is essential to determining the status and needs of our patients and delivering appropriate patient care. By conducting timely and accurate patient assessments, the quality of service and patient safety can be improved.

What we said we would do

- Develop a triage working group ahead of the Integrated Front Door (IFD) to ensure a robust process for triage, which will be standardised across the Emergency Department and Urgent Treatment Centre
- Embed triage courses to improve compliance and ensure staff are aware of expectations and what the process involves
- Children's Emergency Department will ensure all staff have completed a training and competency framework
- Ensure all maternity patients that need urgent review are seen in a timely manner in a dedicated triage service
- Ensure patients that attend the Acute Medical Unit and Surgical Assessment Unit are seen and assessed a timely manner in line with national guidance.

What we did

- Triage Training ongoing within ED coupled with developments for new EPR system which will formalise Triage process across IFD, utilising Manchester Triage
- Rapid Assessment group meetings to develop process for assessment of arriving ambulances
- An emergency physician in charge is based in the Rapid Assessment whose role is to rapidly assess patients to ensure early intervention of shared decision making
- Additional triage capacity and training within the Urgent Treatment Centre
- Navigator role maintained and ongoing
- Band 7 Nurse Manager recruited for Children's Emergency Unit, giving oversight to all training and development
- Clinical Practice Educator role in Paediatrics (new)

- All staff working in Children's Emergency Unit have undertaking extended Paediatric competencies
- Specific Triage Training package in place.

How will we continue to monitor and measure our progress

As well as regular reporting, we have real time information in place for ambulance and Emergency Department waiting times so immediate actions can be taken as soon as a patient is ready to move on.

We are also using patient experience feedback within the Emergency Department to ensure that the changes we make are improving the patient experience.

Our priorities for 2025-26

The following priorities have been agreed by the Trust for 2025-26. These will be reported in full in the 2025-26 Quality Account with six-monthly reporting to the Governors People and Quality Group, the Patient Quality Sub-Committee and Quality and Safety Committee.

The following sources were used to identify potential improvement priorities:

- Data showing our top contributing problems for our priority areas which shows us where to focus
- Stakeholder and regulator reports and recommendations
- Clinical audit data
- Results from national in-patient surveys
- Local and national audit
- Feedback from Healthwatch through partnership working
- Care Quality Commission (CQC) inspection report and CQC insight reports
- Feedback from our Trust Board
- Emerging themes and trends arising from complaints, serious incidents and inquests
- Complaints, concerns and Friends and Family Test responses.

The progress against 'what will success look like' outlined against our quality priorities will be monitored by the Patient Quality Sub-Committee.

1 Patient safety

Measuring and improving compliance with the Sepsis 6 Bundle

Why is this a priority?

Compliance with the Sepsis 6 Bundle is crucial for improving patient safety because early recognition and intervention in sepsis significantly reduce morbidity and mortality.

The Sepsis 6 Bundle is a set of six evidence-based actions that should be initiated within one hour of identifying sepsis. Early identification and treatment are essential to prevent further sepsis-related morbidity and mortality.

What are our aims for the coming year?

To participate in the national audit program to monitor compliance against the Sepsis 6 bundle, the outcome of the audit will support development of an improvement plan in relation to the management of sepsis.

What will we do?

- We will complete the Sepsis 6 Bundle audit by participating in the National programme
- We will measure compliance against actions undertaken in the critical “Golden Hour” for high-risk sepsis patients
- We will develop an improvement plan once the audit is complete.

2 Patient experience

Putting the hospital to bed

Why is this a priority?

Getting a good night's sleep is important for patient recovery, this is why we have launched the putting the hospital to bed project. Our inpatient survey results, along with a review of complaint themes demonstrated that patients are telling us that they are receiving different levels of care at night time. Themes have emerged relating to a lack of care and compassion, poor sleep environment and inconsistency between the day and night. Patients have told us they are unable to seek support from their relatives or carers overnight and are experiencing delays in responsiveness from staff in comparison to daytime hours.

What are our aims for the coming year?

We will improve the night time environment for patients by increasing awareness of the impact of noise levels and night time patient transfers have in disrupting sleep for patients.

What will we do?

- We will ensure senior oversight of improvement actions including a number a of “go and see’s” across the year
- We will review and improve the level of senior cover across the acute wards
- We will work to reducing the number of non-urgent bed moves at night and reduce the number of non-urgent medical interventions after the hours of 11pm
- We will ensure teams who are working overnight are supported to provide consistent high levels of care
- We will provide support to allow open visiting for patients and to ensure carer support is provided at the same levels as day light hours.

3 Clinical effectiveness

Supporting patients to self-administer their own medications

Why is this a priority?

A number of hospital in-patients are often on long term medications which they are able to take independently at home. If it is possible to maintain patient self-administration during hospital admission this should always be explored. This will assist in maintaining patient independence for those adult inpatients who meet the assessment criteria.

This will also give maximum therapeutic benefit for those patients who require relief medications at short notice or are on complex timed regimes that do not correspond with the timings of the traditional drug round.

What are our aims for the coming year?

We will develop a programme that will support competent adult patients to safely self-administer their medications.

What will we do?

- We will develop a standard operating procedure (SOP) for patient self-administration of medication
- We will pilot the SOP on wards
- We will train pharmacy, nursing, and medical staff on patient self-administration.

Statements of assurance from the Board

Information on the Review of Services

During 2024/25 Great Western Hospitals NHS Foundation Trust provided and/or subcontracted eight relevant health services. The Trust has reviewed all the data available on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2024/25.

Clinical audit and national confidential enquiries

During 2024/2025, 69 national clinical audits and two national confidential enquiries covered relevant health services that the Trust provides.

During that period, the Trust participated in 99% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2024/2025 are as follows alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1: Participation in national clinical audits and confidential enquiries

Audit Title	Participation	Data Submission
NRAP - Secondary Care Adult COPD 2024	Yes	In Progress
NRAP - Secondary Care Adult Asthma 2024/25	No	No
National Paediatric Asthma - Secondary Care 2024/25	Yes	In Progress
NRAP - Pulmonary Rehabilitation 2024/25	Yes	In Progress
Sentinel Stroke National Audit Programme (SSNAP) 2024/25	Yes	In Progress
Sentinel Stroke National Audit Programme (SSNAP) 2024/25	Yes	In Progress
MBRRACE-UK 2024 : Maternal Morbidity confidential enquiry	Yes	In Progress
MBRRACE-UK 2024 : Maternal Mortality confidential enquiries	Yes	In Progress
MBRRACE-UK 2024 : Maternal Mortality surveillance	Yes	In Progress
MBRRACE-UK 2024 : Perinatal Mortality and serious morbidity confidential enquiry	Yes	In Progress
MBRRACE-UK 2024 : Perinatal Mortality Surveillance	Yes	In Progress
MBRRACE-UK 2024 : Perinatal Mortality Review Tool	Yes	In Progress
National Paediatric Diabetes Audit (NPDA) 2024/25	Yes	In Progress
National Pregnancy in Diabetes 2024	Yes	In Progress
National Gestational Diabetes Mellitus Audit	Yes	In Progress
NDA - National Diabetes Core Audit 2024/25	Yes	In Progress
NDA - National Diabetes Inpatient Safety Audit (NDISA) 2024/25	Yes	In Progress
NDA - National Diabetes Foot Care Audit 2024/25	Yes	In Progress
NDA - Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	In Progress
NCEPOD - Child Health Programme - Emergency surgery in children and young people	Yes	In Progress
NCEPOD - Acute Limb Ischaemia	Planned to start	Planned
NCEPOD - Blood Sodium Study	Yes	In Progress
NCEPOD - Managing acute illness people with learning disability	Planned to start	Planned
National Major Trauma Registry (prev TARN)	Yes	In Progress
National Case Mix Programme 2024/25	Yes	In Progress
National Emergency Laparotomy Audit - Yr 11 NELA 2024/25	Yes	In Progress
National Emergency Laparotomy NoLap Audit - Yr 1 NELA 2024/25	Yes	In Progress
National Joint Registry - NJR (2024/2025) (2024 data)	Yes	In Progress
National Ophthalmology Audit - Adult Cataract Surgery Audit (Data period 2024/25)	Yes	In Progress
Age-related Macular Degeneration Audit (AMD) 2024/25	Yes	In Progress
National Cardiac Arrest Audit NCAA 24/25	Yes	In Progress
National Acute coronary syndrome or Acute myocardial infarction (MINAP) 2024/25	Yes	In Progress
National Cardiac Rhythm Management (NACRM) 2024/25	Yes	In Progress
National Audit of Percutaneous Coronary Intervention (NAPCI) 2024/25	Yes	In Progress

Audit Title	Participation	Data Submission
National Heart Failure Audit (NHFA) 2024/25	Yes	In Progress
National Falls and Fragility Fractures Audit Programme (FFFAP) 2024/25 - Hip Fracture Database	Yes	In Progress
FFFAP - National Audit of Inpatient Falls 2024	Yes	In Progress
RCEM Mental Health Self Harm 2024/25 (Year 3)	Planned to start	Planned
RCEM Care of Old People (COP) 2024/25 (Year 3)	Planned to start	Planned
RCEM Adolescent Mental Health 2024/25	Withdrawn by National Audit Organisers	NA
RCEM Time critical medications 2024/25	Planned to start	Planned
NATCAN - National Lung cancer Audit (NLCA) 2024/25 (2024 data)	Yes	In Progress
National Prostate Cancer Audit (NPCA) 2024/25 (2023/2024 data)	Yes	In Progress
National Bowel Cancer Audit Programme (NBCA) 2024/25	Yes	In Progress
NATCAN - National Oesophago-Gastric Cancer Audit (NOGCA) 2024/25	Yes	In Progress
National Audit of Metastatic Breast Cancer 2024/25	Yes	In Progress
National Audit of Primary Breast Cancer 2024/25	Yes	In Progress
National Ovarian Cancer Audit (NOCA)	Yes	In Progress
National Kidney Cancer Audit (NKCA)	Yes	In Progress
NATCAN - National Non-Hodgkin Lymphoma Audit (NNHLA) 2024/25	Yes	In Progress
NATCAN - National Pancreatic Cancer Audit (NPaCA) 2024/24	Planned to start	Planned
National Early Inflammatory Arthritis Audit (NEIAA) 2024/25 (Year 7)	Yes	In Progress
National Audit of Care at the End of Life 2024/25 (NACEL) - (2025 data) Round 6	Yes	In Progress
Society for Acute Medicine Benchmarking Audit (SAMBA) 2024	Yes	In Progress
NAD: Care in general hospitals 2024/25 - Round 7	Planned to start	Planned
LeDeR Programme 2024/25	Yes	In Progress
National Maternity and Perinatal Audit (NMPA) 2024-2025	Yes	In Progress
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme 2024	Yes	In Progress
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) - 2024/25 - Cohort 7	Yes	In Progress
National Audit of Cardiac Rehabilitation 2024	Yes	In Progress
National Acute Kidney Injury Audit 2024 (UKKA)	Yes	In Progress
BAUS Impact of DUNC	Yes	In Progress
BAUS Penile Fracture SNAP Audit	Planned to start	Planned
BAUS - ELLA to the bladder cancer pathway Audit	Yes	In Progress
National Obesity Audit (NOA) 2024/25	Yes	In Progress
NCABT - Audit of NICE Quality Standard QS138 2024/25	Yes	In Progress
Non-melanoma skin cancers	Yes	In Progress
Oral and Dentoalveolar Surgery	Yes	In Progress
British Hernia Society Registry Audit 24/25	Planned to start	Planned

Table 2: Examples of improvement actions taken as a result of participation in national clinical audits reviewed

National Audit Title	Areas/Actions for Improvement (implemented/in progress)
NRAP - Secondary Care Adult COPD 2022 National report/results published: July 2024	1.The service explored ideas to tie in excellent Best Practice Tariff (BPT) performance, to improve the support for COPD, NIV and Asthma Care. This included improvements in data collection to support further learning. Audit results demonstrated Reasonable Assurance – Practice meets the majority of the standards
National Paediatric Asthma - Secondary Care 2022/23 National report/results published: July 2024	1.Improve documentation of parental and child smoking status (11yrs+) 2.Steroids given within an hour of arrival to hospital (with acute asthma exacerbations). 3.Discharge checklist stickers used to ensure standard of care and NRAP recommendations are being met. 4.All children have a personalised asthma action plan prior to discharge. Audit results demonstrated Reasonable Assurance – Practice meets the majority of the standards
NRAP - Pulmonary Rehabilitation 2022/23 National report/results published: July 2024	1.Uptake and retention of patients enrolled for Pulmonary Rehabilitation; a new 'opt-in day' for the rehab course, reducing DNA rates for assessments by 20%. 2.Patients provided with previous CAT scores to encourage accurate completion of their health status questionnaire and prompt discussions when improvements have not been gained. Audit results demonstrated Reasonable Assurance – Practice meets the majority of the standards
MBRRACE-UK 2022: Perinatal Mortality Surveillance National report/results published: July 2024	1.Implemented a Mandatory Field on patient administration system to record Ethnicity. 2.Analysis of all reportable incidents and reported to Divisional Board. Audit results demonstrated Substantial Assurance – Practice fully meets or exceeds standards
National Paediatric Diabetes Audit (NPDA) 2022/23 National report/results published: April 2024	1.Improved data completeness of patient records; administrative support allows for prospective data collection which is reviewed by the Diabetes Clinical Lead prior to submission. 2.Successful business case to improve Consultant MDT clinic time and Psychology time in order to be one of the best units in the country. Audit results demonstrated Limited Assurance – Practice meets some standards
National Severe Trauma Audit - TARN (22/23) National report/results published: May 2024	1.Improved Trauma Unit Ward with proposed new ward layout in collaboration with contractors. 2.Improve the quality of ED documentation using QI/Clinical Audit methodologies. 3.Employ additional staff to support and improve data collection Increase learning and educational courses in ED and Wards using ward and teaching room-based education packages (based on MTN curriculum and TILS courses for ED). Audit results demonstrated Reasonable Assurance – Practice meets the majority of the standards

National Audit Title	Areas/Actions for Improvement (implemented/in progress)
National Audit of Percutaneous Coronary Intervention (NAPCI) 2022/23 National report/results published: April 2024	1.Improved timeliness of treatment to improve outcomes in PPCI/STEMI by reviewing clinical pathways to reverse the increasing CtB times 2.Promoted the use of newer P2Y12 in PPCI Particularly in Prasugrel following a review in clinical pathways to ensure optimal prescribing of newer antiplatelet drugs after PCI for an acute coronary syndrome. 3.Improve accurate recording of devices used to capture DEB use for NICOR data; submission of comprehensive and accurate data on the use of drug coated ballons by operator on CVIS and in NICOR entry, so when cross referenced, they correspond. Audit results demonstrated Reasonable Assurance – Practice meets the majority of the standards
National Case Mix Programme 2022/23 National report/results published: April 2024	1.Improve patient flow by improving communication with Site management to ensure critical care is able to discharge patients appropriately and in a timely manner. 2.Maintain a staffing model by recruiting to Consultant Rota. 3.Work on areas to buffer sudden demands on critical care services particularly Respiratory and Surgical high care. Audit results demonstrated Substantial Assurance – Practice fully meets or exceeds standards
Learning Disability Improvement Standards Audit Survey 2023 National report/results published: June 2024	1.Increased the number of feedback mechanisms into the Divisions re LDA LeDeR learning by creating quarterly LeDeR learning PP for Divisional Governance meetings. 2.Seek solutions regarding the Trust ability to monitor re-admission rates by undertaking a IT capability review. 3.Seek solutions regarding the Trust ability to flag people with LDA on waiting lists for assessment/treatment on internal IT systems by working with the 'improving together' team. 4.Make access to the complaints service (PalS) more accessible to people with LDA by making easy read forms available on the Trust Website, that provides clear information on how to make a complaint and the process involved. 5.Through process development and staff education, increase opportunities for patients to make choices for themselves; continue the roll-out of the OMMT in the Trust. Development an Easy Read/Communications folder in each clinical area. MCA education including Trusted Assessor MCA training, daily walk rounds by ward managers to include conversations with patients and families, update 'Nerve centre' to incorporate patient communication and their chosen reasonable adjustments. 6.Put mechanisms in place to ensure those who need to know understand what support can be provided to carers when loved ones are in the Trust; supported by the Carer Support Passport, Volunteer checks with patients and families to ensure support is being received, and the introduction of flexible visiting. Audit results demonstrated Reasonable Assurance – Practice meets the majority of the standards

CQC registration and statement on CQC reviews or investigations

Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC). Our current registration status is “Requires Improvement”. The Trust does not have any conditions on registration. The Care Quality Commission has not taken any enforcement action against the Trust.

Current CQC rating

Overall rating	Safe	Effective	Caring	Responsive	Well-led
Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

Our Maternity Services were assessed on 6 September 2023 as part of the national maternity inspection programme. This was a focused inspection, evaluating the 'Safe' and 'Well-led' quality statement questions. Following the assessment, Maternity Services were rated as 'Requires Improvement' in both areas. In response, a comprehensive improvement action plan was developed, with regular progress updates shared at the Trust’s CQC quarterly engagement meeting

Our Medical Care Service was assessed between 16 May to 28 June 2024, the CQC looked at the quality statements across all five key questions: Safe, Effective, Caring, Responsive and Well-Led, following the assessment the CQC rated as Good.

Our Surgery Care Service was assessed on 19 and 20 March 2025. The CQC evaluated the quality statements across all five key questions: Safe, Effective, Caring, Responsive, and Well-Led. At the time of this report's publication, the Trust is awaiting the outcome of this inspection.

The Trust has had regular engagement with the CQC Bath and North East Somerset, Swindon and Wiltshire (BSW) inspection team to ensure we keep them informed of our service delivery and of any changes this includes:

- Quarterly engagement meetings with the executive team, this includes updating on the progress of the maternity improvement action plan
- Working closely with our inspectors to respond to all CQC enquires.

Research and development

Health research is vital to generate knowledge and evidence to improve the health and care of patients, service users, carers, and the public as well as improving our health and social care systems.

Our Research and Innovation (R&I) team, comprised of nurses, practitioners, support workers, administrators, and governance staff who work to deliver safe and effective health research. The department is also supported by research posts in both pharmacy and pathology, enabling us to offer our patients access to new and cutting-edge treatment options.

In 2024/25, over 100 research studies have been active in the organization, with more than 350 patients opting to take part across 24 of our clinical specialties. By opening over 20 new studies this year, we continue to offer new treatment options and to support the development of evidence-based healthcare.

In 2024/25, the Trust's contribution to a commercially sponsored trial investigating treatment of heart failure was recognised, with two Cardiology consultants from the Trust being named authors on the published paper. The C-SPOT study aimed to study whether combining conduction system pacing and cardiac resynchronisation improved cardiac function. It was found that all patients showed improvement in function and electrical activation. It was shown that some patients would benefit from this combined approach. Perhaps the most interesting, and intriguing finding, was that the improvement in heart function was much greater than would normally be seen with conventional pacing. Patients also reported much reduced symptoms compared with conventional pacing.

In 2024/25, the Trust has invested in supporting our own staff to develop research ideas that directly address the needs of our patients and services. Including being provided with dedicated time to focus on designing research, and to submit applications for competitive research funding. As a result, we are on track to deliver our first multi-year grant-funded research project in 2025/26.

The R&I team are passionate about the work that they do. In recognition of their dedication

and hard work, one of our research support staff won the Trust's Star of the Month award this year. Furthermore, a Research Nurse won an Equality, Diversity and Inclusion award at the Trust's staff awards, in recognition of the contribution they have made to make research available to local populations who are currently under-served by research, and where the burden of need is the greatest.

This work has involved the research team developing collaborative relationships across Swindon and promoting research across the region by attending local community events to talk about the benefits of taking part in research. Another major success has been the launch of the Improving Together methodology within the research department, where all staff are given a voice in finding ways to enhance our service.

Learning from deaths

During 2024/2025, 1374 of Great Western Hospitals NHS Foundation Trust patients died, 694 case record reviews and investigations have been carried out in relation to the 694 deaths in 2024/25. 50 of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.

Data for Q1-4 2024/25 is presented below:

	Q1	Q2	Q3	Q4	Total
No. of deaths	326	328	379	400	1433
Case record reviews	132	102	190	172	596
Investigations (SJRs related to incidents)	17	7	9	0	33
No. of deaths with problems identified in care	23	8	14	14	59
No. of deaths >50% avoidable	8	1	5	1	15

Medical Examiner

The Medical Examiner Service in Swindon has been scrutinising all hospital deaths since 2020. The aim of this service is to improve the accuracy of completion of the Medical Certificate of Cause of Death, advise on deaths that need coroner referral and establish pathways to alert Trust Mortality and Clinical Governance of any potential learning or need for structured judgement review. The Medical Examiners support families following a bereavement by discussing and explaining the death of their loved ones.

Seven-day service programme

The Trust continues to work towards achieving the standards for seven-day service. The Trust meets three of these standards and therefore our focus continues to be on the following key standard: All emergency admissions must be seen and have thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of

admission to hospital. Previous audits have shown the Trust is not consistently meeting this standard.

The teams are working on matching demand and capacity through team job planning and will be working collaboratively within the Trust and the Acute Hospital Group to ensure services are redesigned to provide the best service we can for all our patients.

The work will be continued in 2025/26 with new national guidance on job planning, as well as a regional focus on service redesign.

Commissioning for Quality and Innovation (CQUIN) framework

NHS England is proposing to continue to pause the nationally mandated CQUIN incentive scheme in 2025/26. This will mean that providers' income associated with CQUIN achievement is not at risk, and they are not required to repay any amounts if they do not fully meet the CQUIN criteria. CQUIN funding will continue to be included in prices. The fixed payment must continue to include the 1.25% funding previously identified for CQUIN.

Records submission

The percentage of records in the published data:

- Which included the patient's valid NHS number was: 99.9% for admitted patient care 98.9% for outpatient care and 98.9% for accident and emergency care
- Which included the patient's valid General Medical Practice Code was: 100% for admitted patient care; 100% for outpatient care; and 99.9% for accident and emergency care.

Payment by results

The Trust was not subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission.

Data Quality

The Trust will be taking action to continue to improve data quality, with monitoring reports now being reviewed monthly by the Trust's Data Quality Improvement Group (DQ-IG) and quarterly by the Trust's Information Governance Steering Group (IGSG). Technical changes that impact data in Trust systems and reporting are assessed in the fortnightly Data Quality Change Advisory Board (DQ-CAB).

These reports include data items which have been identified as causing concern. For example, coding completeness and validity, coverage of NHS numbers and ethnic groups, outpatient outcomes, review of external audit reports etc. The reports are used to allow management to improve processes, training, documentation, and computer systems, and will be integral to the preparation of data in advance of the migration to the Shared EPR.

The importance of good data quality has been recognised at Trust Board level. An annual awareness campaign supports members of staff to understand what good data quality is and how everyone is responsible for achieving it. In addition, data quality training has been incorporated into the Trust Information Governance mandatory training module this year, ensuring visibility for all staff across the Trust.

Information Governance

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the NHS England Data Security and Protection (DSP) Toolkit. To maintain integrity, the Trust's DSP Toolkit is subject to an independent internal audit against the standards set by NHS England, on an annual basis.

Great Western Hospitals NHS Foundation Trust DSP Toolkit Assessment for 2023/24 was graded as 'Standards Met', with 108 out of 108 mandatory evidence items provided. The 2024/25 assessment has been substantially changed and is now based on the Cyber Assurance Framework. This assessment is in progress and is also subject to an audit. An interim assessment was published in December 2024, with the final DSP submission in June 2025.

Reporting against core indicators

The following set of national performance core indicators are required to be reported in the Quality Account using data made available to the Trust by NHS Digital.

Summary Hospital-Level Mortality Indicator (SHMI)

The Summary Hospital-Level Mortality Indicator (SHMI) is the NHS' standard measure of the proportion of patients who die while under hospital care and within 30 days of discharge. It takes the basic number of deaths and then adjusts the figure to account for variations in factors such as the age of patients and complexity of their conditions, so the final rates can be compared.

The resulting SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the expected number based on average England figures, given the characteristics of patients treated at the Trust. The expected SHMI is one, though there is a margin for error to account for statistical issues. Summary Hospital-Level Mortality Indicator (SHMI) – deaths associated with hospitalisation, England (NHS Digital national benchmarking):

Table 1: Summary Hospital Level Mortality Indicator

Period	Value	SHMI banding
2023/24	1.04	As expected
2022/23	1.01	As expected
2021/22	1.05	As expected
2020/21	0.89	3 (lower than expected)
2019/20	0.99	2 (as expected)

The data displayed is for the last reported period via NHS Digital.

Table 2: Palliative Care

Period	Value
2023/24	Data not available on NHS Digital
2022/23	2.10
2021/22	1.04
2020/21	0.89
2019/20	0.99

The number of patients who died after being coded as under palliative care – relief of symptoms only – is collated nationally. This can affect mortality ratios, as palliative care is applied for patients when there is no cure for their condition, and they are expected to die. (NHS Digital national benchmarking).

The data displayed is for the last reported period via NHS Digital.

Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective, information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

Patient-reported outcome measures (PROMs) are based on patients' own experiences. People are asked about their health status and quality of life both before and after four types of surgery – hip replacement, knee replacement, varicose vein surgical treatment and inguinal hernia repair.

The scale runs from zero (poor health) to one (full health). The 'health gain' as a result of surgery can then be worked out by adjusting for case-mix issues, such as complexity and age, and subtracting the pre-operative score from the post-operative score.

In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data.

Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a

pause in the current publication reporting series for PROMs at this time.

Period	Procedure	Adjusted average health gain - EQ-5D index TRUST	Adjusted average health gain - EQ-5D index ENGLAND	Adjusted average health gain - EQ-VAS index TRUST	Adjusted average health gain - EQ-VAS index ENGLAND	Adjusted average health gain - Oxford Knee Score index (GWH)	Adjusted average health gain - Oxford Knee Score index (England)
2024/25	Knee Replacement Revision	Not available on NHS Digital	Not available on NHS Digital	Not available on NHS Digital	Not available on NHS Digital	Not available on NHS Digital	Not available on NHS Digital
	Knee Replacement Primary						
	Knee Replacement						
	Hip Replacement Revision						
	Hip Replacement Primary						
	Hip Replacement						
2023/24	Knee Replacement Revision	Not available on NHS Digital	0.30	Not available on NHS Digital	5.50	Not available on NHS Digital	14.8
	Knee Replacement Primary	0.32	0.30	5.005	7.50	14.181	16.8
	Knee Replacement	0.318	0.30	6.378	7.60	14.559	16.5
	Hip Replacement Revision	Not available on NHS Digital	0.30	Not available on NHS Digital	10.20	Not available on NHS Digital	15.2
	Hip Replacement Primary	0.463	0.50	13.879	13.90		22.60
	Hip Replacement	0.471	0.40	15.016	13.60		21.90

Re-admissions

Readmissions can occur for a variety of reasons, including being discharged too early, large numbers of readmissions to hospital after treatment might suggest patients had been discharged too early. Rates are therefore monitored nationally. The published 28-day readmission rate for the Trust is:

Period	Patients aged 0 - 15 (GWH)	Patients aged 0 – 15 (England)	Patients aged 16+ (GWH)	Patients aged 16+ (England)
2024/25	Data not available on NHS Digital			
2023/24	14.1	13.2	15.2	15.1
2022/23	13.1	12.8	15.3	14.4
2021/22	12.4	12.5	15.4	14.7
2020/21	12.9	11.9	16.1	15.9
2019/20	11.7	12.5	14.9	14.7
2018/19	11.4	12.5	15.4	14.6

Responsiveness to the personal needs of patients

The Trust collects information on its responsiveness to patients' personal needs, augmenting the feedback collected as part of the national inpatient survey and Friends and Family Test. Patients are asked five questions to compile an overview:

- Were you as involved as you wanted to be?
- Did you find someone to talk to about worries and fears?
- Were you given enough privacy?
- Were you told about medication side-effects to watch for?
- Were you told who to contact if you were worried?

Period	Indicator value (GWH)	Indicator value (England)
2024/25	Data not available on NHS Digital	
2023/24	Data not available on NHS Digital	
2022/23	Data not available on NHS Digital	
2021/22	Data not available on NHS Digital	
2020/21	71.90%	74.50%
2019/20	63.40%	67.10%
2018/19	65.60%	67.20%

The data displayed is for the last reported period via NHS Digital.

Staff who would recommend the Trust to their family or friends

The staff survey asks how likely staff are to recommend their NHS service to friends and family. The Great Care campaign is focused on improvement projects to address areas of concern identified in the staff and inpatient survey.

Period	Agree (GWH)	Strongly agree (GWH)
2025	Data not available on NHS Digital	
2024	47%	13%
2023	46%	14%
2022	45%	12%

Patients admitted to hospital who were risk assessed for venous thromboembolism

Venous thromboembolism (VTE) is a clot in the deep veins of the leg, which can break off and clog the main artery to the lungs. Known as a pulmonary embolism, this can be serious, or even fatal. It is important to make sure patients do not develop VTE in hospital, where the risk is often greater because people tend not to move around as much, making blood in the veins of the legs more vulnerable to clotting. Patients need to have their VTE assessed, so drugs or stockings can be used to reduce the risks. The patient assessment target is 95%

Period	Agree (GWH)	Strongly agree (GWH)
Q4 2024/25	Data not available on NHS Digital	Data not available on NHS Digital
Q3 2024/25		
Q2 2024/25		
Q1 2024/25		
Q4 2023/24	98.90%	
Q3 2023/24	96.50%	
Q2 2023/24	97.30%	
Q1 2023/24	94.60%	
Q4 2022/23	93.60%	
Q3 2022/23	95.96%	
Q2 2022/23	97.18%	
Q1 2022/23	95.04%	
Q4 2021/22	Incomplete	
Q3 2021/22	Incomplete	
Q2 2021/22	52.30%	
Q1 2021/22	95.15%	

Clostridium difficile infection

Clostridium difficile (C.difficile) is an infection, which can cause serious symptoms and potentially death. Although naturally present in some people, it can spread quickly in a confined environment like a hospital. The Trust has been working hard to combat this infection using different infection control techniques to keep patients safe.

Table: Clostridium difficile infection data

Period	Rate – Total cases per 1000 bed days (GWH)	Rate – Total cases per 1000 bed days (England)
2024/25	Data not available on NHS Digital	Data not available on NHS Digital
2023/24	19.69	18.80
2022/23	15.36	20.28
2021/22	17.20	18.30
2020/21	10.40	17.70
2019/20	13.57	15.46
2018/19	13.49	14.09

Data displayed is for the last reported period via NHS Digital.

Patient safety

The Trust is committed to delivering quality patient care, ensuring high standards of health and safety, by providing a system of incident reporting which allows all staff to record any incident which causes harm, damage or loss or has the potential to do so. Incident reporting presents an important opportunity to explore what happened, to identify learning using a learning response that is proportionate and to amend systems and processes to prevent re-occurrence.

The Trust supports a high reporting culture, encouraging staff to report all such incidents, embracing a just and learning culture approach as part of the patient safety incident review process. The Trust is committed to ensuring that involving the patient, family and staff members throughout the learning process is embedded. This conveys a culture that is honest and open, so lessons can be learned and shared. Only a very small minority of incidents, cause severe harm or death, these trigger the most rigorous of investigations.

There is overwhelming evidence that NHS organisations with a high level of incident reporting are more likely to learn and subsequently increase safety for everyone.

Table 1: Overview of Patient safety incidents

	Apr – Jun	Jul – Sep	Oct – Dec	Jan – Mar
Patient Safety Incidents 2021/22	3013	2896	3141	3299
Patient Safety Incidents 2022/23	3125	2534	2590	2912
Patient Safety Incidents 2023/24	2874	3120	3176	3492
Severe / Death 2021/22	18	21	26	28
Severe / Death 2022/23	20	25	35	29
Severe / Death 2023/24	11	19	14	8
Rate of patient safety incidents per 1000 bed days 2021/22	64.28	59.39	61.76	67.10
Rate of patient safety incidents per 1000 bed days 2022/23	62.20	49.48	49.00	57.01
Rate of patient safety incidents per 1000 bed days 2023/24	57.12	60.81	61.71	67.73
Rate of incidents resulting in severe harm or death (per 1000 bed days) 2021/22	0.38	0.43	0.51	0.57
Rate of incidents resulting in severe harm or death (per 1000 bed days) 2022/23	0.40	0.49	0.66	0.57
Rate of incidents resulting in severe harm or death (per 1000 bed days) 2023/24	0.22	0.47	0.27	0.16

Patient Safety Incident Response Framework (PSIRF)

The framework sets out the NHS' approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety (NHS England, 2022). It represents a significant shift in the way the NHS responds to patient safety incidents, from the Serious Incident Response Framework to a framework that is focused on compassion, engagement and involvement, utilising a range of system-based approaches to identify learning from patient safety incidents.

Developing processes to ensure the approach is considered and proportionate in response and using a supportive oversight process that focusses on strengthening the system and improvement. The Trust went live with PSIRF in April 2024 and ceased reporting patient safety incidents as Serious Incidents to Strategic Executive Information System (STEIS). The Trust has embraced the ethos of PSIRF, including development of a robust plan and policy that sets out how learning will be achieved.

The Trust transitioned to the Learn from Patient Safety Events (LFPSE) service, an NHS system for the recording and analysis of patient safety events that occur in healthcare.

Freedom to Speak Up

The Trust has developed the Freedom to Speak Up (FTSU) service and has increased the dedicated Lead Guardian role to four days per week from March 2025. In addition, new Guardians have been recruited throughout 2024, with the current number of Guardians at ten, with further recruitment planned for January 2025.

Staff who have concerns or issues they wish to raise have a number of channels available to them to use to support speaking up, particularly those relating to quality of care, patient safety, and bullying or harassment. The Trust encourages and invites staff to speak up and contribute to discussions and activities to improve both patient and staff experience.

The Trust has identified the following development areas for the coming year

- Develop key performance indicators to monitor the effectiveness of the service
- Develop a process of review following the closure of each concern to assess if any detriment occurred and to develop a process to address any concerns
- Develop a survey to test key aspects of the Freedom to Speak Up service including ability to access the policy
- Recruit further guardians and expand the service to include FTSU Ambassadors
- Provide support sessions for Guardians
- Benchmark and assess the service to ensure it meets the needs of the Trust.

Learning Disability and Autism (LDA) Practice 2024 – 2025

The Trust employs two Learning Disability (LD) nurses who job share. In 2024/25 the LD nurses supported staff in delivery of high quality, adjusted care for patients. Much of the activity has been day-to-day advice and support and direct ward care and effective discharge planning for people with complex needs. The work also includes a high level of advocacy, supporting the wards to be legally compliant with Mental Capacity Act process, human rights are protected, and ensuring the patient and families voice is heard and listened too.

The Trust continues to take part in the annual National NHSE LD and AS Improvement standards audit programme and receives annual outcome reports. The most recent report for the Trust was received in the Autumn of 2024.

The audit benefits from a triangulated data collection method, organisational data, staff survey and patient survey data and practice and the patient experience is reviewed under three headings: Respecting and protecting rights, inclusion, engagement, and workforce. Learning from the findings of the report are used to form the basis of the content of the annual Learning Disability Forum workplan thus ensuring the voice of patients and staff, alongside operational data inform the direction of quality and safety improvement projects.

The current focus is on projects to ensure that systems and processes are better able to identify vulnerability which enables staff to understand and provide personalised reasonable adjustments to care. The current projects are also focussed on ensuring equal access to diagnostic tests and services.

In 2024 the Trust held workshops with people with LD to help with design elements of the Emergency Department build project and members of the Trust regularly visit day service providers in Swindon in support of getting direct feedback regarding our service from those who use it. Further patient engagement and feedback projects are planned.

Consolidated annual report on rota gap for medical staffing including internal factors

The Trust currently has a total of 54.05 WTE vacancies across all grades and specialties of medical staff, this figure also includes doctors appointed pending start dates and candidates that are filling roles on a fixed term basis.

Internal factors:
Over the last 12 months the Trust has continued to focus on enhancing its social media advertisement of vacancies, reviewing job descriptions and adverts to ensure they are comparable with local organisations. In addition, the Trust has focused on utilising recruitment agencies to support with hard to recruit roles within the Trust. In particular working with candidates to understand their motivations and where possible introducing dual roles or flexible job plans.

The Trust continues to hold a British Medical Journal subscription and have a lead account manager supporting the advertisement of our roles. This subscription enables national and international advertising of all medical vacancies via their online portal and the advertising of Consultant vacancies in the BMJ printed journal. The Trust social media networks are also used for the advertising and promotion of medical opportunities.

Vacancies are reviewed during the Weekly and Monthly Medical Control Meetings and a regular review is in place for the use of all agency staff being used to fill vacancies within departments.

The Trust continues to use SARD (Secure Appraisal Revalidation Database) as a software solution to manage both medical revalidation and medical e-job planning. A full job planning cycle 24/25 has been loaded onto SARD for all specialties. In addition, the medical roster roll out has taken place with the majority of specialties actively using the rostering system for rotas and requesting of annual leave. In addition, the Trust has rolled out Loop allowing employees to access their rotas and leave requests via mobile devices.

Medical Roster Administrators are now in place within the Medicine and Surgery Divisions to support with the maintenance of the roster and processing leave requests. Monthly oversight takes place with reports of progress/learning discussed at the Medical Staff Support Group (MSSG).

There has been a focus on improving work schedule timescales and ensuring this information is transferred directly to the rostering system allowing ease of access to rosters ahead of starting rotations for Resident Doctors.

Performance against key national priorities

An overview of performance in 2024/25 against the key national priorities. Performance against the relevant indicators and performance thresholds are provided.

Measure	National Target	Local Target 2022/23	Performance 2023/24	National Target	Local Target 2024/25	Performance 2024/25
ED 4 hours Q1	95%	76%	75%	Data not available on NHS Digital	Data not available on NHS Digital	Data not available on NHS Digital
ED 4 hours Q2	95%	76%	75%			
ED 4 hours Q3	95%	76%	73%			
ED 4 hours Q4	95%	76%	73%			
Stroke	N/A	C	C			
RTT Waiting List	WL at Jan 2021	35,012 (Feb 24 Plan)	32, 674			
RTT 52 Weeks	0	1,687 (Feb 24 Plan)	1900			
DM01 performance Q1	99%	99%	52%			
DM01 performance Q2	99%	99%	46%			
DM01 performance Q3	99%	99%	47%			
DM01 performance Q4	99%	99%	66%			
Cancer performance (62 days) Q1	85%	85%	62%			
Cancer performance (62 days) Q2	85%	85%	69%			
Cancer performance (62 days) Q3	85%	85%	74%			
Cancer performance (62 days) Q4	85%	85%	72%			
Cancer performance (2WW) Q1	93%	85%	41%			
Cancer performance (2WW) Q2	93%	93%	66%			
Cancer performance (2WW) Q3	93%	93%	83%			
Cancer performance (2WW) Q4	93%	93%	63%			

Statements from Integrated Health Boards, local Healthwatch organisations, and scrutiny committees

Statement from Healthwatch West Berkshire

Healthwatch West Berkshire welcomes the opportunity to comment on the Quality Account for Great Western Hospitals NHS Foundation Trust 2024–25 period.

While we have not received any direct feedback from the public regarding the Trust's services during this reporting period, we continue to value our ongoing relationship with the Trust. Healthwatch West Berkshire has maintained regular meetings with the Trust, which provide valuable opportunities for updates, information exchange, and collaborative discussion on key priorities impacting local people.

We appreciate the Trust's openness and willingness to engage with Healthwatch and other stakeholders. This regular engagement supports transparency and ensures there is consistent focus on patient voice and experience at the heart of service development, and we commend the efforts being made to improve quality, safety, and patient experience in what remains a challenging healthcare landscape.

We look forward to continuing to work with the Trust over the coming year and will support opportunities to gather and share patient experiences as part of ongoing service improvement and assurance.

Fiona Worby
Lead Officer, Healthwatch West Berkshire

Statement from Healthwatch Wiltshire and Healthwatch Swindon

Healthwatch Wiltshire and Healthwatch Swindon welcome the opportunity to comment on the Great Western Hospitals NHS Foundation Trust (GWH) Quality Account for 2024/25. We appreciate the Trust's continued commitment to transparency, patient-centred care, and quality improvement.

Positive Developments

We commend the Trust for several key achievements:

- Community Engagement: The Trust's efforts to engage with diverse communities, including people with learning disabilities, carers, and those with sensory impairments, are commendable. Initiatives such as the "Change the Narrative" event and the Cancer Partnership Group reflect a genuine commitment to listening and learning from lived experiences.
- Improving Together: The continued rollout of the "Improving Together" programme is encouraging. The reduction in patient harms, increased outpatient productivity, and improved staff engagement are positive indicators of a culture of continuous improvement.
- Support for Carers: The expansion of the Carers Passport, open visiting hours, and community outreach to raise awareness of carer support are welcome developments. These efforts reflect a growing recognition of the vital role carers play in patient recovery and wellbeing.
- Learning Disability and Autism (LDA) Practice: The Trust's work to improve care for people with learning disabilities and autism, including the use of easy-read materials, patient engagement workshops, and the Learning Disability Forum, is commendable.
- Night-Time Care: The "Putting the Hospital to Bed" initiative is a thoughtful response to patient feedback and demonstrates a commitment to improving the inpatient experience.

Areas for Continued Focus

While we recognise the Trust's progress, we encourage further attention to the following areas:

- Emergency Department Performance: The Trust continues to face challenges in meeting the four-hour ED target. We support the ongoing work to improve triage and patient flow and encourage continued investment in staffing and infrastructure to reduce waiting times.

- Sepsis Management: We welcome the focus on improving compliance with the Sepsis 6 Bundle. We encourage the Trust to ensure that learning from the national audit is translated into timely and measurable improvements in clinical practice.
- Patient Feedback and Complaints: While the Trust has made efforts to gather feedback, we encourage further work to ensure that all patients, including those from underrepresented groups, can easily share their experiences. We also recommend greater transparency in how feedback leads to change.
- Mortality Reviews: We support the Trust's efforts to strengthen learning from deaths and encourage continued focus on improving clinical governance and safety culture.
- CQC Ratings: The Trust's overall rating of "Requires Improvement" highlights the need for sustained focus on leadership, safety, and responsiveness. We look forward to seeing the outcomes of the recent inspection of surgical services and the impact of the maternity improvement plan.

Looking Ahead

We are supportive of the Trust's priorities for 2025/26 and we look forward to continuing our collaborative relationship with GWH.

We thank the Trust for its openness and for the opportunity to contribute to this important document.

Jody Clark

Chief Operating Officer, Healthwatch Wiltshire and Healthwatch Swindon

Statement from the Council of Governors

The governors are of the opinion that the Quality Account presented is a realistic representation of the Trust's performance in 2024/2025.

In 2024, the Board of Great Western Hospitals NHS Foundation Trust, together with the Boards of Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust, agreed to form a Group. As Governors, we were fully involved and consistently consulted throughout this process, just as we have been in the development and communication of the Trust's local strategic direction, through virtual and face-to-face meetings.

The Council of Governors supports this document and proudly endorses the remarkable dedication shown by all members of staff, both now and in the future.

The Trust's priorities for quality improvement last year were:

- Reducing falls and falls with harm.
- Improving the experience of carers by delivering responsive support and information.
- Improving initial assessment of patients on front door services.

Over the past year, the Trust has made it a priority to actively listen to patients, families, and carers to better understand the issues that matter most and identify areas for improvement. This effort included reaching out to communities, especially those who may not typically have access to conventional feedback channels.

Through direct engagement with local communities, valuable insights were gained, leading to meaningful improvements in services, such as maternity care and front door operations. These are just a few examples of the positive changes implemented over the year.

As the Council of Governors, we have closely monitored these initiatives, received regular updates and sought assurance from the Non-Executive Directors (NEDs) that the quality agenda is being addressed and that outcomes are being carefully reviewed and evaluated.

The looking forward section of the Quality Account focuses on its main priorities for the coming year. These areas are:

- Patient safety: Measuring and improving compliance with the Sepsis 6 Bundle
- Patient experience: Putting the hospital to bed
- Clinical effectiveness: Supporting patients to self-administer their own medications

The governing body was consulted on these priorities and is fully supportive of their role as key quality markers for the year ahead. We will continue to monitor progress closely and provide appropriate challenge to ensure that meaningful change is delivered – always with the highest standard of care for patients and the wider public.

Natalie Titcombe
Lead Governor on behalf of the Council of Governors

Statement from NHS Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board (ICB)

NHS Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board (ICB) on the Great Western Hospitals NHS Foundation Trust's Quality Account for 2024/ 2025. In so far as the ICB has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the ICB via contractual monitoring and quality visits and aligns to NHSE Quality Account requirements.

BSW ICB notes the comprehensive overview of the Trust's achievements, challenges and future priorities, aimed at providing continued delivery of high-quality care.
It is the view of the ICB that the Quality Account reflects the Great Western Hospitals NHS Foundation Trust's ongoing commitment to continuous improvement in patient care and safety, and recognises the Trusts key achievements in the following areas:

- Sustained reduction in the total harms from incidents throughout 2024/25. The average from September 2024 has shown a 20% reduction below the historic average and a 45% reduction from its peak in January 2022
- Continued quality improvement focus to reduce pressure harms and patient falls. The medicine division has seen a 25% reduction in pressure harms during 2024/25 and the former Integrated Care and Community Division reported a 70% reduction in pressure harms in community patients
- A continued increase in the number of positive responses from patients that have completed the Friends and Family Test
- A noted reduction in the length of time patients wait for care in the Urgent Treatment Centre, noting there has been an increase in the numbers of people attending
- The voluntary turnover rate of staff has reduced to a new average of 8.5%, well below the target of 11%
- Improving timely initial assessment of patients at front door services, with additional triage capacity and training implemented within the Urgent Treatment Centre
- The move to the new national Patient Safety Incident Response Framework (PSIRF) in April 2024, with a focus on learning from safety incidents that has engagement and involvement at its heart.

BSW ICB also recognises the breakthrough objectives and areas identified for further

development during 2025/26, with a focus on reducing emergency department ambulance handover delays; further reductions in the number of reported inpatient falls and an overall continued increase in the number of patients reporting a positive experience of care.

We look forward to seeing progress with the quality priorities identified in this Quality Account, in conjunction with the continued maturity of PSIRF and the Trust's contribution to system wide learning and improvement.

NHS Bath and North East Somerset, Swindon and Wiltshire ICB are committed to sustaining strong working relationships with the Great Western Hospitals NHS Foundation Trust and together with our wider stakeholders will continue to work collaboratively to achieve our shared priorities as an Integrated Care System in 2025/26.

Yours sincerely

Gill May
Chief Nurse Officer, BSW ICB

Statement of Directors' responsibilities for the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

In preparing the quality report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account is not inconsistent with internal and external sources of information.
- The Quality Account presents a balanced picture of the organisation's performance over the period covered.
- The performance information reported in the quality account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with National Health Service (Quality Accounts) Regulations 2010.
- There is no longer a national requirement to obtain external auditor assurance on the Quality Account. Therefore, no limited assurance report is available on the Quality Account report in 2024/25.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

Liam Coleman, Chair

Cara Charles-Barks, Chief Executive

Glossary

Term	Definition
Autistic Spectrum Disorder (ASD)	A developmental disability caused by differences in the brain. People with ASD often have problems with social communication and interaction, and restricted or repetitive behaviours or interests.
Breakthrough objective	These are the areas for focused Trust-wide improvement, we should be able to see a 20-30% improvement over a 12-to-18-month period and they should be the focus of our Trust-wide improvement energy. They are likely to be top contributors to driving improvement in one of our pillar metrics.
Care Quality Committee (CQC)	The independent regulator of health and adult social care in England.
Carers UK	Carers UK is there to listen, to give expert information and guidance, to champion individual rights and support in finding new ways to manage at home, at work.
Clinical Audit	Clinical audit is a way to find out if healthcare is being provided in line with standards and allows care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients.
Clinical Governance	Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.
Clinical Quality Indicators	Metrics used to assess the clinical effectiveness, safety, and patient experience of healthcare services. Clinical quality indicators may include mortality rates, infection rates, waiting times, and patient satisfaction scores.
Clostridium difficile infection	Also known as C. difficile or C. diff, is a bacterium that can infect the bowel and cause diarrhoea.
Commissioners	Responsible for assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes.
Dining Companions	Assist ward staff and patients during mealtimes, which includes feeding some patients who need extra help.
Elective Surgery	Means that the surgery isn't an emergency and can be scheduled in advance. It may be a surgery you choose to have for a better quality of life, but not for a life-threatening condition.
Emergency Care	Emergency care involves life-threatening illnesses or accidents which require immediate treatment.
Freedom to Speak Up Guardian	The National Guardian's Office leads, trains and supports a network of Freedom to Speak Up Guardians in England and provides support and challenge to the healthcare system in England on speaking up.
Friends and Family Test (FFT)	Feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
Healthwatch	Obtain the views of people about their needs and experience of local health and social care services.
Hospital Episode Statistics (HES)	A curated data product containing details about admissions, outpatient appointments and historical accident and emergency attendances at NHS hospitals in England.
Information Governance (IG)	The framework for handling information in a secure and confidential manner that allows organisations and individuals to manage patient, personal and sensitive information legally, securely, efficiently and effectively in order to deliver the best possible healthcare and services.
Integrated care boards (ICB)	Partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities.
Integrated Front Door (IFD)	The point of contact for enquiries and referrals relating to children and young people made by professionals, families and the public.

Glossary

Interpreting and Translation services	A professional interpreter will convert spoken words from one language to another in real-time.
Learning Disability (LD)	Disorders that affect the ability to: Understand or use spoken or written language.
LeDer	Integrated care systems are responsible for ensuring that LeDeR reviews are completed based on the health and social care received by people with a learning disability and autistic people (aged four years and over) who have died, using the standardised review process.
Maternity and Neonatal Voices Partnership (MNVP)	The (MNVP) listens to the experiences of women and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity.
Medical Examiner	Medical examiners are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties.
National Health Service (NHS)	The government-funded medical and health care services.
NHS England	NHS England leads the National Health Service (NHS) in England, ensures that the healthcare workforce has the right numbers, skills, values and behaviours to support the delivery of excellent healthcare and health improvement to patients and the public.
'NHS@Home' / Hospital at Home	This service is a joint initiative by local NHS organisations that offers hospital-level care and remote monitoring in an individual's home, providing an alternative to hospital admission, or helping them to return home promptly following an inpatient stay.
Paediatrics	Paediatrics is the branch of medicine dealing with the health and medical care of infants, children, and adolescents from birth up to the age of 18.
Patient Advice and Liaison Service (PALS)	The service offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.
Patient passport	The aim of the Hospital Passport is to provide our staff with information about yourself and your carers during a hospital visit
Patient Reported Outcome Measures	Patient reported outcome measures.
Patient Safety Incident Review Framework (PSIRF)	An approach to responding to patient safety incidents. Compassionate engagement and involvement of those affected by patient safety incidents.
Patient surveys	Surveys conducted to gather feedback from patients about their experiences with healthcare services. Patient experience surveys assess various aspects of care delivery, including communication, accessibility, and responsiveness to patient needs.
Pressure ulcers	Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are sometimes known as bedsores or pressure sores.
Pillar metrics	These are our 12 metrics that tell us whether we are doing well on driving forwards our vision and strategy. These last for the duration of our strategy (3-5 years).
Salisbury Spinal Unit (SCI)	The centre focuses on the care and rehabilitation of persons with spinal cord injury.
Spinal cord injury (SCI)	Spinal cord injury (SCI) is a serious medical condition, which often results in severe morbidity and permanent disability.

Glossary

Summary Hospital-level Mortality Indicator (SHMI)	Summary Hospital-level Mortality Indicator (SHMI) – Deaths associated with Hospitalisation.
Surgery	The branch of medical practice that treats injuries, diseases, and deformities by the physical removal, repair, or readjustment of organs and tissues.
Swindon Borough Council (SBC)	The local authority of the Borough of Swindon. It is a unitary authority, having the powers of a non-metropolitan county and district council combined.
The Commissioning for Quality and Innovation (CQUIN)	The framework supports improvements in the quality of services and the creation of new, improved patterns of care.
The NIHR Clinical Research Network (CRN)	Supports patients, the public and health and care organisations across England to participate in high-quality research, thereby advancing knowledge and improving care.
Tissue viability	A growing speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration.
Triage	To decide the order of treatment of patients.
Venous thromboembolism (VTE)	Venous thromboembolism (VTE) is a condition that occurs when a blood clot forms in a vein. VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE).
Volunteers	Support staff by undertaking activities and tasks on the wards or within hospital teams.
Ward Accreditation Programme	A structured framework used in hospitals and healthcare settings to assess and improve the quality of care delivered in specific wards or clinical areas.