Great Western Hospitals NHS Foundation Trust

TRUST BOARD

Thursday 11 September 2025, 9.30am to 1.00pm

By MS Teams

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** Steve Haig, Helen Spice	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 • 10 July 2025 (draft)	8 – 18	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	19	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	LC	-	-
6.	**Staff Story – Improving Together** Emily Beardshall, Acting Chief Officer of Improvement & Partnerships, Sue Morgan, Associate Director of Health, Safety, Fire and Security and Kathryn Harrison, Delivery Suite Manager to present	20 – 25	EB/SM/ KH	Receive	9.35
7.	**Chair's Report** Liam Coleman, Chair				10.05
	• Chair's Report	26 – 29	LC	Note	
	• BSW Hospitals Group Partnership Agreement – revised	30 – 46	LC	Approve	
8.	**Chief Executive's Report** Cara Charles-Barks, Chief Executive & Lisa Thomas, Managing Director	47 – 55	CCB/ LT	Note	10.15
9.	**Integrated Performance Report**				10.30
	• Performance, Population & Place Committee Board Assurance Report (July & August) – Bernie Morley, Non-Executive Director & Committee Chair	56 – 60	BM	Assurance	
	• Quality & Safety Committee Board Assurance Report (July & August) – Claudia Paoloni, Non-Executive Director & Committee Chair	61 – 66	CP	Assurance	

		PAGES	BY	ACTION	TIME
	• People & Culture Committee Board Assurance Report (August) – Julian Duxfield, Non-Executive Director & Committee Chair	67 – 69	JD	Assurance	
	• Finance, Infrastructure & Digital Committee Board Assurance Report (July & August) – Faried Chopdat, Non-Executive Director & Committee Chair	70 – 73	FC	Assurance	
	• Integrated Performance Report	74 – 128	All	Receive	
BREAK (10 minutes) at 11.05 to 11.15am					
10.	**Charitable Funds Committee Board Assurance Report (August)** Julian Duxfield, Non-Executive Director and Committee Chair	129 – 130	JD	Assurance	11.15
11.	**Audit, Risk & Assurance Committee Board Assurance Report (September)** Faried Chopdat, Non-Executive Director and Committee Member	Verbal	FC	Assurance	11.25
12.	**Learning from Deaths Annual Report 2024/25** Tobenna Onyirioha, Deputy Chief Medical Officer *(received at Quality & Safety Committee 21 August 2025)*	131 – 143	TO	Assurance	11.35
13.	**Freedom to Speak Up Annual Report 2024/25** Luisa Goddard, Chief Nurse *(received at Trust Management Committee 22 May 2025)*	144 – 149	LG	Assurance	11.50
14.	**Improving Together Year 3 Review** Emily Beardshall, Acting Chief Officer of Improvement & Partnerships	150 – 189	EB	Receive	12.10
15.	**Inclusion & Health Inequalities Annual Report 2024/25** Sharon Woma, Head of EDI & Health Inequalities *(received at People & Culture Committee 27 August 2025)*	190 – 259	SWoma	Approve	12.30
16.	**Health, Safety, Fire and Security Annual Report 2024/25** Simon Wade, Chief Financial Officer *(received at Trust Management Committee 19 June 2025 and Finance, Infrastructure & Digital Committee 28 July 2025)*	260 – 282	SW	Approve	12.45
CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**					
17.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	None	CC	Approve	12.55
18.	**Responsible Officer Annual Report** Tobenna Onyirioha, Deputy Chief Medical Officer *(approved by Quality & Safety Committee 17 July 2025)*	283 – 301	TO	Approve	-
19.	**Committee Effectiveness Review 2024/25** Caroline Coles, Company Secretary	302 – 314	CC	Approve	-
20.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-

		PAGES	BY	ACTION	TIME
21.	**Date and time of next meeting** Thursday 10 November 2025 at 9.30am, Great Western Hospital, Swindon	Verbal	LC	Note	-
22.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	13.00

Great Western Hospitals NHS Foundation Trust

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

Present:

Liam Coleman (LC)	Chair
Emily Beardshall (EB)	Acting Chief Officer of Improvement & Partnerships
Cara Charles-Barks (CCB)	Chief Executive
Faried Chopdat (FC)	Deputy Chair/Non-Executive Director
Julian Duxfield (JD)*	Non-Executive Director
Luisa Goddard (LG)	Chief Nurse
Benny Goodman (BG)	Chief Operating Officer
Steve Haig (SH)	Acting Chief Medical Officer
Bernie Morley (BM)	Non-Executive Director
Claudia Paoloni (CP)*	Non-Executive Director/Senior Independent Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Simon Wade (SW)	Acting Managing Director / Chief Financial Officer

In attendance:

Caroline Coles (CC)	Company Secretary
Jonathan Hinchliffe (JH)	Group Chief Transformation & Innovation Officer (Interim)
Claire Warner (CW)	Deputy Chief People Officer (deputising for Jude Gray)
Deborah Rawlings (DR)	Board Secretary
Tania Currie	Head of Patient Experience & Engagement (agenda item 047/25)
Jade Pearce	Learning Disability Nurse (agenda item 047/25)

Apologies

Jude Gray (JG)	Chief People Officer

Number of members of the Public: There were 3 members of public in attendance (Chris Shepherd, Governor; Vivien Gibbs, Governor, and Kathryn Bateman, Chief Medical Officer (Designate)

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
042/25	**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.	
043/25	**Declarations of Interest** There were no declarations of interest.	
044/25	**Minutes of the previous meeting (public)** The minutes of the Board meeting held in public on 8 May 2025 were adopted and agreed as a correct record.	
045/25	**Outstanding actions of the Board (public)** The Board received and considered the outstanding action list. The following update was noted:-	

Minute	Description	Action

017/25 : Quality & Safety Committee (Q&SC) Board Assurance Report : Patient Information Leaflets – It was noted that an external audit to review compliance around patient leaflets has been commissioned and the results would be presented through the Q&SC.

046/25 **Questions from the public to the Board relating to the work of the Trust**

There were no questions from the public to the Board.

047/25 **Care Reflection – Improvements in care for patients with a Learning Disability, staff awareness and training**

Tania Currie, Head of Patient Experience & Engagement and Jade Pearce, Learning Disability Nurse joined the meeting to present this item.

The Board received a film about Danny who had a learning disability (LD) and had attended hospital on many occasions. During those admissions, it was found that staff did not understand Danny's specific needs, in particular how best to communicate with him and how to support his anxieties. A charity had now been set up to provide distraction and support resources to support adults with learning disabilities. Jade Pearce shared examples of improvement work that was ongoing across the Trust to increase staff awareness and ensure standards of care would be raised for patients with LD and their families.

The Board reflected on the culture and leadership within the organisation around respect, kindness, compassion and empathy to respond appropriately to the needs of patients with a learning disability. There was also a need to ensure that all patients with learning disabilities or extreme anxieties were being listened to. The film from Danny's mother would continue to be shared within the organisation for learning. The expanded use of volunteers to support both patients and staff was to be explored further.

Cara Charles-Barks, Chief Executive suggested that a kindness and civility toolkit developed at the Royal United Hospital Bath and recognised nationally as an approach around cultural change could be utilised for shared learning.

The care of patients with a learning disability and continuous health issues who transition from Children's to Adult Services from aged 18 was also discussed and it was confirmed that a Children's Forum was being set up to address the needs of patients and families during that transitional period.

The Board thanked Tania and Jade for their presentation and especially to Maria, Danny's mother, for sharing her personal experiences.

The Board **noted** the staff story.

048/25 **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 May and June 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.

It was noted that the Annual Report & Accounts 2024/25 had been 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 was for it to be laid to Parliament before it can be published and presented at the Annual Members' Meeting.

Minute	Description	Action

Liam Coleman, Chair outlined the changing landscape and challenging targets for the NHS as part of the implementation of the 10 Year Plan, alongside the recently announced strike action by Resident Doctors. The Chair and Chief Executive had been asked to attend a series of meetings with NHS Central about performance and deviation from operating plans.

The Board **noted** the report.

049/25 **Chief Executive's Report**

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

Urgent and Emergency Care Plan 2025/26

The Urgent and Emergency Care Plan 2025/26 had recently been published and outlined how patients would receive better, faster and more appropriate emergency care as the Government sets out reforms to shorten waiting times and tackle persistently failing trusts. The Trust was currently in the bottom 10 for its urgent and emergency performance which would result in further scrutiny under the NHSE Oversight Framework and a potential deterioration of its SOF (strategic oversight framework) rating. However, it was noted that this had been based on data for April and May and that recovery plans now in place had shown that improvements had been made across June.

National Maternity Investigation Launched to Drive Improvements

A rapid national investigation into NHS maternity and neonatal services had been announced by the Health and Social Care Secretary and this investigation would be comprised of two phases. The first phase would investigate up to 10 maternity and neonatal services, and NHSE had yet to confirm which trusts would be involved, and the second phase would undertake a system-wide review of maternity and neonatal care.

It was noted that the current rating for GWH Maternity and Neonatal services 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 was fully complaint with year 6 against the Clinical Negligence Scheme for Trusts and 94% compliant for Saving Babies' Lives Care Bundle and had made significant improvements within the service since the visit. Best practice was to be shared across the Group to drive further improvement.

NHS Oversight Framework 2025/26

The new NHS Oversight Framework 2025/26 had recently been published with a range of agreed metrics. The Great Western Hospital had received its SOF rating as 3 and that GWH was placed at number 57 out of 134 trusts nationally which provided assurance that this Trust was in a good position comparatively nationally but also helped the Board to focus on those critical issues that needed to be resolved.

Leadership Team – Confirmation of Managing Director Appointments

Three new substantive Managing Directors across BSW Hospitals Group had now been appointed and would all start on 1 September 2025. Lisa Thomas would be the new Managing Director for the Trust from that date.

Interim Chair & Vice Chair Appointments

Liam Coleman had been appointed as interim Joint Chair for RUH and GWH, Eiri Jones had been appointed as interim Chair in SFT, and Faried Chopdat as Vice Chair in GWH and Sumita Hutchison as Vice Chair in RUH.

Latest operational position

It was noted that in May GWH had delivered 99% of the elective and outpatient operational planned activity, which equated to 105% of the 2019/20 activity and 92% of the 2024/25 activity. The overall waiting list continued to reduce and focus remained on reducing the

Minute	Description	Action

amount of time that patients were waiting for treatment. The number of patients staying in hospital for 21 days or longer remained a challenge; however the number of non-criteria to reside patients had shown significant improvement within Wiltshire.

Mental health transformation
GWH has 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 while in an episode of crisis. The new partnership will look at improving the overall patient experience and seeks to strengthen and encourage cross system working.

Recognition for Pad Project
The Pad Project, a Trust improvement initiative focused on the reduction of inappropriate use of continence pads on hospital wards, had been showcased in the Nursing Times. Alongside improving the safety and quality of care for patients, financial savings had been achieved and a positive environmental impact through the reduction in waste.

Finance
It was noted that across the BSW Hospitals Group had a deficit of £16.7m and the deficit position for GWH currently stood at £5.6m. Key to the delivery of our plan for the year was the achievement of the efficiency savings target. In response to increased financial oversight, several financial controls had been put in place which included tightened expenditure controls, enhanced security of recruitment and agency use, stricter sign-off procedures for non-essential spending and robust divisional accountability frameworks. Corporate savings plans had also identified additional savings towards closing the £ gap for the Group. A Recovery Director was also in place to identify new opportunities for the delivery of the existing operational plan and pace around that.

Simon Wade, Chief Financial Officer advised that there had been significant improvement in the System deficit for month 3 and that a Group Recovery Plan would be submitted to NHSE by end July 2025.

GWH Performance and Recovery Plan Overview
Benny Goodman, Chief Operating Officer provided a presentation on data for the ambulance handover times and 12-hour wait in the Emergency Department and provided an overview of the key actions underway to address performance and to drive improvement within the new bed configuration. The UEC programme would support these actions with regular reporting to the Performance, Population & Place Committee. It was also reported that ongoing changes of practices and processes for non-criteria to reside (NCTR) patients had begun to show some improvement and that this would continue to be measured.

In response to a question asked by Helen Spice, Non-Executive Director on the 'drop and go' practice by the South Western Ambulance NHS Foundation Trust (SWASFT), it was confirmed that this practice had been applied to GWH as from 1 July 2025. Data around this practice would continue to be captured and optimised to inform future system discussion with SWASFT on dynamic conveyancing and how this can be influenced to maintain patient safety.

Never OK campaign
A refreshed campaign to stop the abuse of our staff was launched – 'Never OK'. Wiltshire Police had 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.

Leadership Conference – Leading Differently
The Trust had held a leadership conference on 'Leading Differently' on 26 June which had been well received and attended by staff. The agenda included anti-racism and system leadership, and the Trust's new Our Behaviours Framework.

Minute	Description	Action

The Board **noted** the report.

050/25 **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 May 2025 (April 2025 for Cancer).

Quarterly Pillar Metric deep dive

The quarterly deep dive of breakthrough objectives and pillar metrics were presented, with a particular focus on the past 12 months trends. The revised NHS Oversight Framework was to be reflected and updated into the IPR to enable pillar metrics to be refreshed and provide committee oversight around performance.

Our Care

Luisa Goddard, Chief Nurse reported that the total number of harms had continued to reduce over the last year. The reduction in falls and falls with harm remained the current breakthrough objective with the aim to reduce total falls by 30% over three years, reduce the number of patients who had experienced moderate harm and above by 10% each year and reduce the number of patients who had fallen more than once by 20%.

The falls rate per 1000 bed days had decreased over the reporting period, with improvement initiatives showing early positive impact. Hotspot wards and key contributing factors had been identified and that focused work was underway to drive improvement. Risks included limited access to frailty services and rising ED attendances. Deconditioning of patients remained a theme and that deconditioning training continued to be rolled out within the organisation with auditing and weekly meetings to monito and to sustain improvement actions. A3 methodology goals to reduce falls by 30% over three years were underway, with strong staff engagement noted.

For 2025/26, the Trust overall complaint response rate had been identified as the new pillar metric replacing the Friends and Family Test for the patient experience metric. The Trust's objective was to maintain a consistent Trust-wide complaint response rate of 80% and upwards. During Q1 (April-June 2025), the Trust received 182 complaints, with a growing trend in June and key themes included concerns around care quality, communication, and staff attitude. Timely response rates fluctuated, with notable improvement in June (78%) using A3 methodology to drive improvement with complaint management, including new accountability frameworks, extension dashboards, and support/training initiatives.

Our Performance

Benny Goodman, Chief Operating Officer reported that the non-elective length of stay had continued to reduce. An Urgent Care and Flow transformation programme had been set up with the goal to reduce levels below 2024/25 for six consecutive months. The programme of work included workstreams around pre-admission, admission, and transfer of care and an overview of the actions was noted.

The overall RTT PTL continued to reduce and overall RTT performance within 18 weeks was reported at 59.56%, an increase from the previous month and above target. Good progress had continued on the reduction of the RTT waiting list size but challenges remained to eliminate long waits over 65 weeks in the Planned Care & Surgery Division, particularly Plastics, T&O (foot and ankle surgery), Urology and General Surgery where outpatient capacity remained a constraint and where risks remained in relation to requirement for surgery. Recovery plans remained in place to eliminate 65 week waits by the end of June. Cara Charles-Barks, Chief Executive requested that initiatives implemented for rapid improvement at GWH be shared with the Royal United Hospitals Bath NHS Foundation Trust to support the work underway to drive improvement around this metric at the RUH.

Minute	Description	Action
	Action: Chief Operating Officer	BG

Our People

Claire Warner, Deputy Chief People Officer reported that in relation to the pillar metric 'Recommending as a place to work', the Q1 2025/26 Pulse survey results had shown an improvement to the number of staff would recommend the organisation as a place to work compared to Q4 2024/25, but remained below the Annual Staff Survey result and the overall trend would suggest an overall decline in the number of staff recommending the organisation as a place to work.

The pillar metric in relation to the staff survey question 'I receive the respect I deserve from my work colleagues' had shown a slight decline in the Q1 2-25/26 Pulse survey against this question. Staff were asked to provide how they would demonstrate respect and the top answers related to active listening and support. However, when asked what respect would look like to them, the top answers were kindness, listening, support and feeling valued. This data would now help to inform the Clever Together work underway at the Trust.

Sickness absence had been identified as a new pillar metric for 2025/26, which had replaced staff turnover, and rates had continued to improve with intensive support focused in hotspot areas to improve department level short-term sickness-rates. The Absence Management (Sickness) Policy had also been revised to enable managers to take the right approach and actions to support staff.

Use of Resources

Simon Wade, Chief Financial Officer reported on the financial breakthrough objective to remain within the Trust's overall deficit plan by month for 2025/26, having improved the underlying financial deficit position by the financial year and through delivery of recurrent CIP.

It was noted that as at Month 2 2025/26, the Trust was £5.6m overspent against budget. The key driver of this was an underperformance of £3.5m against the efficiency savings programme, delivering £1.8m year-to-date against a target of £5.3m, and of the £1.8m delivered, 72% was recurrent. The underlying position remains challenging and the objective for all divisions and specialties was to find recurrent saving schemes. Enhanced care for patients with mental health issues and escalation costs remained high.

However, it was noted that the run rate position for month 3 had shown improvement and progress and traction against the CIP programme could also be demonstrated.

For non-pay, the immediate focus was to implement Trust-wide controls to help stabilise and reduce run rate. It was noted that key measures being implemented were the review requisitioning controls, freeze/restrict use of codes in relation to discretionary spend, continued work on stock labelling using posters in ward/clinical areas highlighting produce usage, associated cost and lower cost alternatives, and wastage bins to enable more accurate monitoring by the Materials Management team on stock expiry and wastage levels.

Task & finish groups including Finance, Procurement and Specialty leads were to continue for Theatres and Cardiology. The plan was to roll these out for further specialties with higher trending run rate as the year progressed.

Board Assurance Reports

Our Performance

Performance, Population and Place Committee Chair Overview

Minute	Description	Action

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meetings on 28 May 2025 and 25 June 2025 the following was highlighted:

- There were two items for escalation to the Board:-
    - The importance of looking at individual functions when considering how the BSW Hospitals Group interfaces with the regional clinical networks and how this would look going forward and a stocktake of partnership arrangements with a view to the most amenable shared representation/ leadership. In response, Cara Charles-Barks, Chief Executive confirmed that a new ICB cluster arrangement would be in place by April 2027 to provide greater clarity around performance management.
    - Population health required more focus at Group level. It was noted that the Group Strategy would pick how best to understand population data and the opportunities.
- PPPC had proposed to streamline the number of watch metrics overseen by the committee.
- It was also proposed to reduce the frequency of meetings to bi-monthly to enable better monitoring of performance data and trends. This proposal had been supported by the Board and that the terms of reference would be amended to reflect this change.

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 22 May 2025 and 19 June 2025 and the following was highlighted:

- The committee had discussed reduction in the frequency of meetings to bi-monthly to enable better monitoring of data and trends, as it was considered that the committee had a much better understanding and good assurance around quality metrics. However, monthly meetings were to remain for the time being.

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 24 June 2025 and the following was highlighted:

- PCC had approved the work being progressed on the leadership and management frameworks. This would provide a much clearer articulation of the Trust's values, behaviours and competencies, and would be supported by a clearer training and development framework which would be developed in collaboration with SFT and RUH.
- A comprehensive summary of employee relation cases over the last year had been received which provided assurance around the processes being applied were clear and robust.
- PCC was assured on good data on performance management around the reduction of absence management levels.
- Concern had been raised around the Trust's probationary policy and that the vast majority of people with terminated contracts at the end of the probation period were

Minute	Description	Action

from BAME backgrounds. This was to receive closer monitoring by People Services to ensure that staff were being appropriately supported. The Board would consider this further at the EDI Board Workshop in August 2025.

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 27 May 2025 and 23 June 2025 and the following was highlighted:

- The BSW finance position as at Month 2 was adverse to the plan by £13.5m. The NHSE has withdrawn 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 remains extremely challenged in 2025/26 and there needed to be a greater degree of confidence in the deliverability of efficiency and workforce plans in all BSW organisations. This was being monitored on a fortnightly basis by the BSW Strategic Recovery Board. It was noted that the committee's assurance rating of 'Limited' was based on the scale of the risk, lack of independent challenge at Group level and immature, albeit evolving, governance processes.
- A comprehensive Green Plan for 2025-2028, along with detailed actions, was received and approved. However, concerns were raised on the delivery of the plan, given the challenges around funding, to ensure that actions would be adequately and effectively addressed.
- FIDC also debated reduction in the frequency of meetings to bi-monthly. However, it was agreed that this would require a wholesale change in the agenda and this proposal would only be considered alongside the Group governance arrangement proposals to be introduced in April 2026 to allow for structuring and alignment of meetings. Monthly meetings were to remain for the time being.

The Board **noted** the report.

051/25 **Charitable Funds Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) at its meeting on 14 May 2025 and highlighted the following:

- A proposal was agreed to accrue a portion of funds quarterly to projects which CFC had approved, but which could not currently be funded in their entirety with the available fund balance. This allocation method would enable the sustainable funding of larger projects without disrupting ongoing charitable spending and ensure financial flexibility while safeguarding strategic initiatives.
- The Committee received an outline of the plans to rationalise the 98 charitable funds and a report on the charitable funds rationalisation process was to be received at the Board meeting in September 2025 for the Trustees to approve.

The Board **noted** the report.

052/25 **Audit, Risk & Assurance Committee Board Assurance Report**

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

- The Committee received the ISA 260 Report from the external auditors, Deloitte, for 2024/25 and their Value for Money Review.

Minute	Description	Action

- The Annual Report and Accounts for 2024/25 was approved. The considerable work undertaken by the Finance Team and Company Secretary was formally acknowledged by the Board.
- The KPMG Internal Audit Annual Report for 2024/25 was received which rated The Head of Internal Audit Opinion as one of 'Significant assurance with minor improvement opportunities'.
- The final Internal Audit report on Medical Rostering had provided an opinion of 'partial assurance with improvements required'. Actions to improve processes were in place and that a follow up review would be conducted early 2026/27 to ensure that actions were embedded.
- The final Internal Audit report on the implementation of the EPR Programme conducted across all three trusts in the BSW had provided an opinion of 'significant assurance with minor improvement opportunities. However, ARAC had raised concerns as actions that were identified as part of the review were significant, had deadlines of 30 June 2025 had not yet been implemented and could have a significant impact on the project. ARAC had therefore rated this review as 'Limited' and that it required immediate action by management to provide assurance that the actions would be addressed swiftly.
- A report on clinical negligence claims activity for 2024/25 had been received for the first time and that understanding of the Trust's claims activity by ARAC would continue to be embedded.
- Actions and processes being undertaken by management to review risk across the organisation was received. ARAC was assured that processes were in place and effective although risks with no actions remained. ARAC would continue to monitor the impact of the newly established Group on local risk management processes.

The Board **noted** the report.

053/25 **Safe Staffing review for Nursing, Midwifery & AHP**

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

The report provided assurance around the safe staffing across Acute Wards compliance with national guidance; Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations; and a sustainable AHP workforce. Good governance and oversight of staffing and escalation processes in place could be demonstrated.

The Acute Ward Nursing report highlighted compliance against the National Quality Board Safe, Sustainable and Productive staffing recommendations of Right Staff, Right Skills and Right Place and Time. All wards were now funded to be compliant with the 1 nurse to 8 patient ratios. In relation to Emergency Department staffing, and the introduction of the timely handover process which aims to improve handover standards and reduce delays, significant pressures have been added to the ED team. In recognition of this, the ED establishment had been increased to reflect the required skill mix in triage and to allow safe staffing of an ambulance handover space ensuring patient safety. However, the continued pressure and stress being experienced by ED staff had been recognised and that plans were in place to drive improvements around patient flow and to create a better environment for our nursing staff.

The Trust's midwifery and neonatal staffing had continued to improve over the last six months by the identification of different staffing models and recruitment, and increased number of band 5 registered nurses that hold the qualified in Speciality (QIS) course.

The AHP workforce was at its strongest recruitment position in 18 months. A long-term workforce plan was in place which focused on training, retention and workforce reform. Capacity and demand modelling was integral to ensure a sustainable AHP workforce.

Minute	Description	Action

The Board noted that the Trust continued to make good progress in the delivery of safe staffing across acute, midwifery and AHP. Work on recruitment and retention could be demonstrated in improvements in workforce metrics and supported the drive to improve patient care.

The Board **noted** the report.

054/25 **Research Annual Report 2024/25**

The Board received and considered the Research Annual Report 2024/25 which demonstrated the Research Department's performance against all indicators and identified strategic next steps for sustainable growth and improvement. The report also provided details on the financial position for research activity at the Trust. The Board also discussed the Trust's commitment to ongoing research activity and that it was vital to demonstrate a track record to attract recruiting consultants into roles.

The Board also noted that it had been nationally agreed that spending on research innovation could continue and should not be part of the financial work restriction and would remain under separate contract.

The Board **noted** the report.

Consent Items

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

055/25 **Ratification of Decisions made via Board Circular**

None.

056/25 **Committee Effectiveness Review 2024/25**

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

- Each Board Committee had undertaken an open discussion to consider their effectiveness, including terms of reference.
- There were no issues or concerns to draw to the attention of the Board.
- The terms of reference of the Committees were circulated showing minor amendments.
- Frequency of meetings had been discussed in relation to the move to the new Group governance model, however it was considered not appropriate at this stage with the exception of the Performance, Population & Place Committee who had considered that moving to bi-monthly was appropriate and the terms of reference had been amended accordingly.

RESOLUTION:
The Board approved the Terms of Reference for each Committee as circulated within the Board papers.

057/25 **Quality Account 2024/25**

Minute	Description	Action
	The Board was requested to ratify the Quality Account 2024/25 for publication on the Trust's website in order to meet the deadline of 30 June 2025, noting that it had been reviewed and approved by the Quality & Safety Committee at its meeting on 19 June 2025. ***RESOLUTION:*** ***The Board approved the Quality Account 2024/25 for publication on the Trust's website before the deadline of 30 June 2025.***	
058/25	**Urgent Public Business (if any)** None.	
059/25	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 11 September 2025 at 9.30am at the Great Western Hospital, Swindon.	
060/25	**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 12.50hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – September 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**
10 July 2025	050/25	**Integrated Performance Report – Quarterly Pillar Metric Deep Dive – Our Performance** Initiatives implemented for rapid improvement at GWH be shared with the Royal United Hospitals Bath NHS Foundation Trust to support the work underway to drive improvement around this metric at the RUH.	Chief Operating Officer	

Future Actions				
None				

Report Title	**Improving Together Staff Stories**				
Meeting	**Trust Board**				
Date	**11/09/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Emily Beardshall, Interim Chief Officer – Improvement & Partnership				
Report Author	Emily Beardshall, Interim Chief Officer – Improvement & Partnership				
Appendices	Improving Together Year 3 Review including Appendix 1 – Improving Together Staff Story summaries				

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 paper does not have an assurance rating as it supports the staff stories which is a reflection/discussion agenda item to support sharing the lived experience of our staff.

Report

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

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

The staff members are

- Sue Morgan, Associate Director of Health, Safety, Fire and Security
- Kathryn Harrison, Delivery Suite Manager

The attached slides give a short overview of the Improving Together management system and an overview of reflections from staff on recent Improving Together training. Sue Morgan attended a recent Bootcamp before requesting Fast Track support for her teams, Kathryn also attended a Bootcamp and is leading a team who were part of Cohort 6 of the Frontline Team training.

We are keen to build on reflections of staff to improve and refine our approach, understanding how it feels for staff to implement Improving Together in different environments is important and supports us maximising sustainability and benefits whilst also learning about the areas we need to adapt or increase support. Over time we aim for the staff stories to provide perspectives from a range of professions and roles.

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)	Improving Together is a key part of mitigation to BAFS1 – Outstanding Patient Care	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement		
Next Steps		

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

Explanation of above analysis:

Explanation of above analysis: The subject of this paper is the roll out of an operational management system that places quality improvement at the heart of the work of the Trust. As such it has no directly positive or negative impact on protected groups, but there is an opportunity through the recommendation to increase patient and public voice to consider traditionally under-represented groups

Recommendation / Action Required

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	
Date	**01/09/2025**

Great Western Hospitals
NHS Foundation Trust

Improving Together Staff Stories

Trust Board 11th September 2025

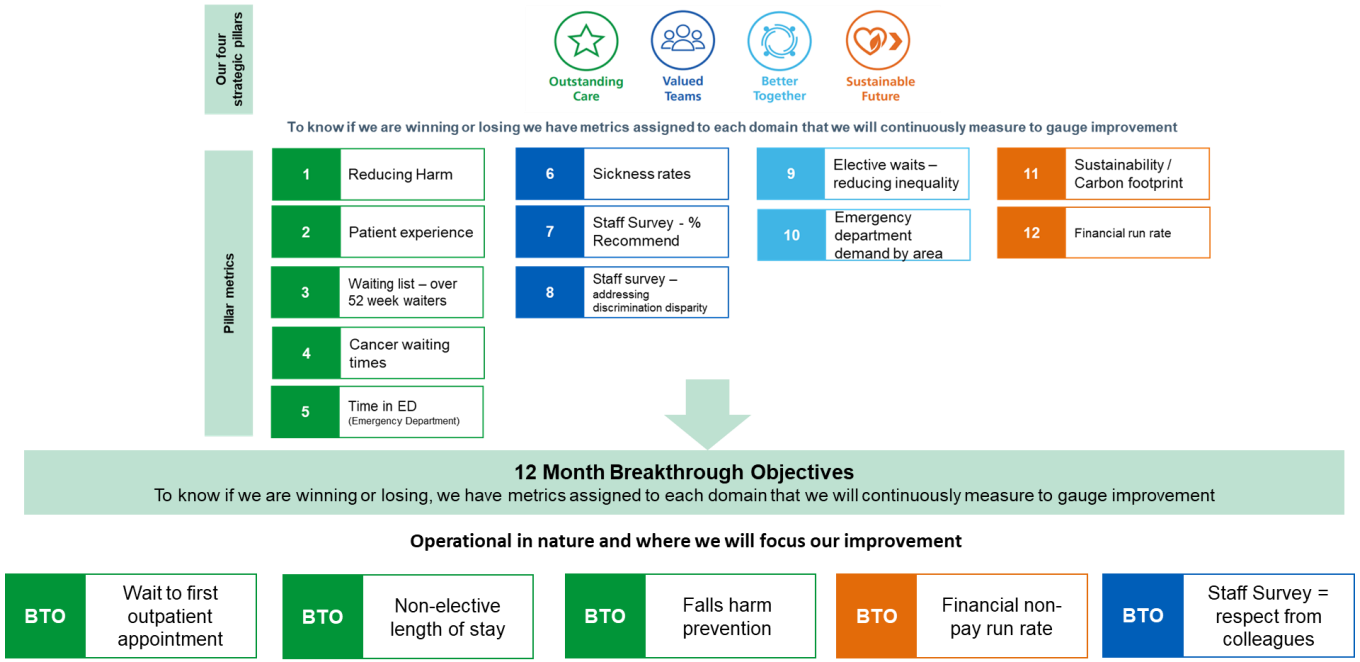
Improving
together

What is Improving Together?

Our Improvement Approach

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

NHS
Great Western Hospitals
NHS Foundation Trust



Can you say….

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

Staff Stories - Sue

NHS
Great Western Hospitals
NHS Foundation Trust

Cohort: Fast Track Training

Estates team: Health, Safety, Fire and Security

Role: Associate Director of Health, Safety, Fire and Security

There was also a noticeable boost in team enthusiasm as members became more engaged with the process, began to see its potential, and actively shared and implemented ideas.

Challenges

- Adapting to a new approach to problem-solving that required a shift in mindset initially felt unfamiliar and complex. It was essential to not only grasp the theoretical framework but also to understand how to apply it practically within the team.
- Learning and mastering this new concept thoroughly enough to confidently share it with the rest of the team to ensure effective communication and practice.
- Comprehending the full scope of the information needed. Gathering and interpreting information accurately was critical to ensure the solutions devised were based on a complete and precise understanding of the issues at hand.

Early Benefits

- Enabled the team to get together more frequently to foster a stronger sense of collaboration and open communication.
- Working through the A3 problem-solving framework and revisiting it consistently helped clarify the complexities of the issues faced and how to improve them. This iterative review process allowed the team to refine their understanding and approach, leading to more effective problem resolution.
- Contributed to stronger team building. The shared challenges and collaborative efforts helped develop trust and camaraderie among team members

It was challenging to Understanding how to complete tools such as the A3 in its entirety to ensure no critical information for improvements was overlooked.

Initial improvement made

- Challenge: Many staff in high-risk areas were not trained in emergency evacuation, fire safety, and HTM0501 compliance, risking patient and staff safety. Training records were unclear, and many sessions were frequently cancelled.
- Actions: We worked with People Operations to update the staff list, visited all departments to identify ward areas, and created a training schedule covering both day and night shifts. We also consulted with SFT to improve training delivery.
- Results: Training compliance improved with better tracking, fewer gaps, and increased oversight. Staff morale in the Health &Safety team increased, and collaboration ensured training reached more colleagues, helping the organization meet fire safety and HTM0501 standards.

Staff Stories - Kathryn

Great Western Hospitals NHS Foundation Trust

Cohort: Bootcamp

Improvement: Implementing staff huddles and theatre caps diversity project

Role: Delivery Suite Manager

Bootcamp Training Experience

- Bootcamp was insightful and provided a deeper understanding of organisational processes, strategy, and how things work beyond the clinical setting. It offered valuable context on the Improving Together approach and what it aims to achieve and I left wanting a more in-depth session on some of the tools introduced.
- Following bootcamp, we used the Improving Together approach to launch an initiative to provide appropriate theatre hats/bonnets to accommodate diverse styles and cultures, for both patients and staff in Maternity services.

Early Challenges

- Initially, most project actions sat with the manager, which made progress difficult.
- The wider team struggled with ownership, and while the improvement board helped us visualise and track progress, updates became repetitive; often highlighting the same actions without resolution.

Early Benefits

- Built connections with colleagues that the department wouldn't normally work with which increased awareness of available support.
- More ideas emerged from the team leading to colleagues feeling empowered, heard, and more involved.

Future Plans

- Following this project we have reviewed and reduced stock in delivery rooms which likely wouldn't have happened without the Improving Together approach.
- We plan to roll out the 'hats' initiative in theatres, using this project as a springboard to spread knowledge and inspire other improvement efforts.

Patient Feedback – "Great that my partner had his hat fitted by the midwife as he has very long dreadlocks. We felt this was an amazing idea and he even had Birth Partner on which made him feel so involved"

Patient Feedback: "*I knew to ask questions too as the staff had badges on their hats*"

The manager's hands-on leadership and collaborative approach made colleagues more confident in sharing ideas and engaging with improvements

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**11/09/2025**	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 is a regular report for information and accountability, summarising Chair and Non-Executive Director (NED) activities and key events relating to the governor activities for the period July-September. Activities relating to formal Committees of the Board are reported through custom reports.

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 and update
- Non-Executive Directors Update
- Strengthening Board Oversight

- Trust Chair - Key Meeting Dates
- BSW Hospitals Group Update

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	**15/08/2025**

Chair's Board Report

This is a regular report for information and accountability, summarising Chair and Non-Executive Director (NED) activities and key events relating to governor activities for the period July-September. Activities relating to formal Committees of the Board are reported through custom reports.

1. Council of Governors

1.1 The Notice of Elections was published on the Trust's website on 1 August 2025 to indicate that nominations were open from that date. There are 10 public governor seats and 3 staff governor seats up for election. The elections will run from August to September 2025.

1.2 The following table outlines the key meetings, training and events during July to beginning of September 2025 which governors participated:-

July – September 2025 – Council of Governors		
Date	**Event**	**Purpose**
14 July	Governor/Member coffee morning	Falls team attended and Deputy Lead governor presented on up and coming elections. Attended by members interested in becoming governors.
15 July	BSW Hospitals Group Council of Governors Joint Nominations & Remuneration Committee	Inaugural meeting established to lead the recruitment of a BSW Hospitals Group Chair. The Committee agreed the recruitment process and terms of reference.
23 July	BSW Hospitals Group Development and Governance Discussion	Update with Sir David Dalton. Attended by Lead and Deputy Governors.
29 July	Integrated Care Partnership Board	Lead Governors invited to join ICP Board to brief on the details of the 10-yr plan particularly around the future of ICPs
1 August	Briefing meeting of Chair/Lead Governor/Company Secretary	Regular meeting to update and discuss any topical issues
5 Aug	BSW Hospitals Group Joint Council of Governors	Trusts Chairs and CEO to brief the Councils of Governors on the latest context and proposals relating to the development of the BSW Hospitals Group.
3 September	Business & Planning Working Group	To identify key issues to address in relation to the Trust's finances and business planning.
5 September	Council of Governors Nomination & Remuneration Committee	To received NEDs appraisal reports.
8 September	Learning from Death's Committee	Governor representative on Trust's meeting.
10 September	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. An update on EPR and Connect Swindon.

2. Non-Executive Directors

2.1 Chair/NED appraisal discussions are now complete and reviewed by the Council of Governors Nominations & Remuneration Committee on 5 September 2025.

2.2 The interview process for the recruitment of NEDs and ANEDs has been completed.

3. Strengthening Board Oversight & Development

3.1 Board Development - We held a Board Development Workshop on 14 August focusing on ED&I, and the site master plan for the Way Forward Programme.

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

Date	Area	Board Member
7 August 2025	Dietetics	Luisa Goddard, Chief Nurse Bernie Morley, Non-Executive Director
11 August 2025	Endoscopy	Luisa Goddard, Chief Nurse Liam Coleman, Chair
18 August 2025	Children's Services	Jude Gray, Chief People Officer

28 August 2025	Pathology	Luisa Goddard, Chief Nurse Liam Coleman, Chair

4. Trust Chair Key Meetings during July & August 2025

Meeting	Purpose
GWH Board meeting	To chair meeting
RUH Board meeting	To chair meeting
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
1-2-1 meeting with SFT Chair	Regular meeting
1-2-1 meeting with RUH Interim Managing Director	Regular meeting
1-2-1 meeting with RUH Vice-Chair	Regular meeting
Vice-Chairs and Senior Independent Directors	Regular meeting
NEDs' Meeting	Monthly meeting
Finance, Infrastructure & Digital Committee	To attend as an observer
Remuneration Committee	To chair meeting
Joint Remuneration Committee in Common	To chair meeting
BSW Hospitals Group Council of Governors	To chair meeting
ICB & BSW Chairs' meeting	Regular meeting
BSW Chairs' meeting	Regular meeting
BSW Hospitals Group Joint Committee	To chair system meeting
RUH Bath Non-Executive Directors	System meeting
ICB & Acutes – Next Steps Forward	System meeting
Chief Executive appraisal	Yearly appraisal meeting
NED appraisals	Yearly appraisal meeting
Briefing on Target Operating Model and Leadership Structure	System meeting
BSW Hospital Group Assurance Review	System meeting
Group Strategic Clinical Transformation Director interviews	Panel member
Integrated Care Partnership Board	System meeting
Wiltshire and Swindon MPs	Quarterly meeting
Meetings with NED candidates	To discuss NED roles with candidates
NED and ANED Interviews	Recruitment to NED and ANED roles
Meeting with Lord-Lieutenant of Somerset	Network meeting for the RUH

5. BSW Hospitals Group Development Update

5.1 In the July 2025 private Board session the Board considered and approved a proposal to move to a Joint Chair and a General-Purpose Joint Committee (Group Board) by 1 April 2026.

5.2 The Board also approved an immediate first step to strengthen the formal delegations of the existing Special Purpose Joint Committee. Two Schedules in the BSW Hospitals Group Partnership Agreement have been updated in response incorporating these strengthened delegations and the revised Agreement is presented for approval in agenda item 7.2.

BSW Hospitals Group

Report to:	Trust Board	Agenda item:	7
Date of meeting:	11 September 2025		

Report title:	BSW Hospitals Group – Resolution to Update Partnership Agreement, Schedule 3 Joint Functions and Schedule 5, Joint Committee Terms of Reference			
Status:	Information	Discussion	Assurance	Approval
				X
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Ben Irvine, Programme Director, BSW Hospitals Group			
Executive Sponsor:	Cara Charles-Barks, CEO, BSW Hospitals Group			
Appendices	• Appendix A: Schedule 3: Group Joint Functions. • Appendix B: Schedule 5: Joint Committee Terms of Reference			
BAF Risk Link	N/A			

Recommendation:

Following Trust Board agreement in principle (July 2025) to changes intended to provide further clarity regarding delegated functions and Joint Committee Terms of Reference, the Trust Board is asked to **approve** the proposed variations to the May 2025 Partnership Agreement, Schedule 3 - Group Joint Functions, and Schedule 5 - Joint Committee Terms of Reference, of the BSW Hospitals Partnership Agreement.

Executive Summary:

In July 2025, Private Boards of Great Western Hospitals NHSFT (GWH), Royal United Hospitals Bath NHSFT (RUH), and Salisbury NHSFT (SFT) received and approved a proposal to move to a Joint Chair and a General-Purpose Joint Committee (Group Board) by 01 April 2026.

The Boards approved an immediate first step to strengthen the formal delegations of the existing Special Purpose Joint Committee giving it the specific and delegated remit to:

- Develop and approve the roadmap from now to 01 April 26 implementation of the Group Board and Joint Chair
- Develop and approve the Group Board membership (subject to relevant approvals from the Remuneration committees in common and Councils of Governors with respect to NEDs)
- Develop and approve the Target Operating Model for the Group
- Develop and approve the Group's governance and assurance framework
- Develop and approve the Group's OD and engagement plan, including the approach to engagement with the Councils of Governors
- Develop and approve a single financial plan for the Group
- Oversee the development of the Group Strategy (for approval by the Group Board in April 2026)

Two Schedules in the BSW Hospitals Group Partnership Agreement have been updated in response, incorporating these strengthened delegations. **Appendix A** comprises an update to Schedule 3: Group Joint Functions. **Appendix B** comprises a revision to Schedule 5, the Joint Committee Terms of Reference. Revisions in Schedules 3 and 5 are highlighted in red text.

On 16th July the BSW Hospitals Group Joint Committee approved these changes in principle, noting that Clause 18 of the BSW Hospitals Group Partnership Agreement requires:

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

Accordingly, the Trust Board is asked to confirm approval of the proposed variations to Schedule 3 and Schedule 5.

Group Vision Metrics	Select as applicable:
Developing an engaged workforce	x
Making our teams diverse and inclusive	x
Making our services safer	x
Improving timely access to our services	x
Improving the experience of those who use our services	x
Improving our financial sustainability	x
Improving health equity	x

Browne Jacobson

Date **[INSERT DATE WHEN APPROVED]** **2025**

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

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

Version control

[Once approved , Version 2.0]

Schedule 3– Joint Functions

1 Subject to paragraph 2:

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

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

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

3 The matters referred to in paragraph 1.1 are:

3.1 Group Strategy & Planning Framework

- Development, approval and delivery of overarching Group Strategy (by April 2026) and associated specialist development and delivery plans, including Group Clinical, Workforce, Financial Sustainability, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital Plans.
- Development, approval and delivery of Group Strategic Planning Framework and Annual Group-wide Plan.
- Oversight of delivery of Group Strategic Initiatives.
- Management of risk to delivery of Group Strategy

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

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

3.3 Financial Sustainability - Use of Resources

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

3.4 Group Mobilisation & Development

- Oversight of Group Mobilisation & Development. Development and approval of Group Roadmap [June 2025-April 2026] to implementation of a Group Board [by April 2026] and Joint Chair [by April 2026].
- Development and approval of Group Target Operating Model,
- Development and approval of the Group Governance, assurance and accountability framework (including development and approval of Group Board - General Purpose Joint Committee Terms of Reference), and associated Integrated Performance Reporting.
- Development and approval of Group Board membership.
- Oversight of delivery of the Case for Collaboration and emerging agreed priorities. Includes programme oversight of 10x workstreams from case for collaboration – with details, phasing and resourcing agreed in Group annual plan.
- Group Development - Corporate Services – Define objectives, shape and structure of Group corporate services transformation. Approve resourcing of programme.
- Group Development - Develop and approve the Group's Organisational Development and engagement plan, including the approach to engagement with the Councils of Governors

3.5 Achieving Digital Maturity

- EPR Programme – Oversight of Implementation. Approval of new Benefits Profile. Approval of proposals for new Budget.
- Group Digital transformation programme – implementation [x-refer 3.1]

4 The table referred to in paragraph 1.2 is as follows: [Note: Not changed. Refer to original Partnership Agreement]

Browne Jacobson

Date: 22nd May [INSERT NEW DATE WHEN APPROVED] 2025

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

Partnership Agreement

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

Schedule 5. BSW Hospitals Group Joint Committee ToR

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

Version control

Date	Version	Author
18 Feb 2025	001	Browne Jacobson LLP
27 Mar 2025	002	Browne Jacobson LLP
14 Apr 2025	003	Browne Jacobson LLP
12 June 2025	004	Ben Irvine, BSW Hospitals Programme Director [added Partnership Agreement execution date]
26th June	July 001	Ben Irvine.

1 Introduction

1.1 The BSW Hospitals Group Joint Committee is a statutory joint committee of the boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury Hospital NHS Foundation Trust (the Trusts) who have established it under section 65Z6 of the National Health Service Act 2006 to exercise Joint Functions in accordance with the Partnership Agreement entered into by the Trusts dated 22nd May 2025 (the Partnership Agreement).

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

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

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

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

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

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

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

2 Authority & Accountabilities

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

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

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

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

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

3 Reporting Arrangements

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

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

4 Membership

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

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

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

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

4.2.3 All joint Executive Director roles created by the Trusts.

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

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

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

4.5.1 Each Trust appoints the same number of Members

4.5.2 The Chair and Chief Executive Officer are Members

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

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

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

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

5 Attendance

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

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

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

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

6 Chair

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

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

7 Quorum

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

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

7.1.2 At least half of the Members present are Voting NEDs

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

8 Decision making

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

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

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

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

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

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

9 Admission of the public to meetings

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

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

10 Managing Conflicts of Interest

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

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

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

11 Administrative Support

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

12 Annual Workplan

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

13 Frequency of Meetings

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

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

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

14 Papers Publication

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

15 Routines, Behaviours and Standards

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

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

15.1.2 Ensure frequent personal contact to build understanding and trust

15.1.3 Surface and resolve conflicts, not letting them fester

15.1.4 Work collectively for the long-term

15.1.5 Behave altruistically towards partners

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

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

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

15.2.1 NHSE Code of Governance for NHS provider trusts

15.2.2 NHSE Risk Assessment Framework

15.2.3 NHSE Annual Planning Guidance

15.2.4 The Health NHS Board – Principles of Good Governance

15.2.5 Corporate Governance – Principles of Public Life (GP01)

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

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

15.3.1 Create value for the population

15.3.2 Create constancy of purpose

15.3.3 Think systematically

15.3.4 Lead with humility

15.3.5 Respect every individual

16 Standard Agenda

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

16.1.1 Declarations of interest,

16.1.2 Minutes of previous meeting,

16.1.3 Action list

16.1.4 Group Strategy

16.1.5 Performance, Transformation and Benefits Realisation

16.1.6 Reports of committees of the BSW Hospitals Group Joint Committee

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

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

16.1.9 Regular reports to the Trust Boards

16.1.10 Other items as per agreed cycle of business

17 Committees

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

17.1.1 The EPR Committee

17.1.2 Financial Sustainability

17.1.3 Group Development, Strategy & Planning

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

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

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

18 Amendment

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

Date approved:

Date of review:

Annex to BSW Hospitals Group Joint Committee Terms of Reference

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

	Role of the Joint Committee	Role of the Trust Boards
	1. Group Strategy & Planning	
Strategy		
1	Development of BSW Hospitals Group Strategy (for approval by the Group Board in April 2026). The Joint Committee determines the strategic direction, ensuring that collective BSW population interests are paramount.	Responsible for development and delivery of local operational plans aligned to and reinforcing *Group Strategy and Specialist Delivery* Plans.
2	Development and approval of *Specialist Delivery Plans* underpinning Group Strategy; Finance, People, Clinical, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital plans, in accordance with relevant system plans or strategies.	
Planning		
1	Development, approval and delivery of *Group Strategic Planning Framework* and *Annual Group-wide Plan*, reflecting planning guidance and Group Strategy. Set strategic goals and key objectives for upcoming year. Oversee budgeting process, reviewing and consolidating budgets at Group level. Oversight of delivery of *Group Strategic Initiatives.*	Development and delivery of the Trust operational plan aligned to Group objectives.
2	Approval of the overall Group Programme Budget - developing a plan that determines the financial contribution, and pooling of resources to meet financial challenges.	Delivery of the Trust operational plan, incorporating Group programme budget requirements.
3	Development of a Group Board Assurance Framework and Risk Management Framework.	Board Assurance Frameworks and risk management processes will remain in place for each Trust. Enable standardisation and consistency in a controlled and managed approach as determined by the Joint Committee.
4	Review and identification of the risks associated with the delivery of *Group Strategy and Group Annual Plan*.	
	2. Transforming Models of Care for the Population we Serve	

1	Development and approval of a *Group Clinical Services Framework* for the collective population we serve and associated decision-making processes.	Actively engage in co-creation and implementation of the Group Clinical Services Framework.
2	Approval of service/pathway/treatment configuration changes across the Group	
	3. Financial Sustainability – Use of Resources	
1	Development and approval of a single financial plan for the Group.	Responsible for developing and delivering financial plans as determined by the Group. Manage operational budgets.
2	Sets and delivers Group financial recovery and long-term Group financial sustainability.	Responsible for developing and delivering financial plans as determined by the Group. Manage operational budgets.
3	Approval of new capital investment programme for the Group	Responsible for implementing local capital investment plans.
4	Approval of capital limits for each Trust within the Group.	Identifies local priorities for investment within the delegated limit.
	4. Group Mobilisation & Development	
1	Develop and approve the roadmap from June/July 2025 to 01-April-26 implementation of the Group Board and Joint Chair. *Develop and approve the Target Operating Model for the Group, including the Accountability Framework* and associated *Integrated Performance Reporting*. Develop and approve the Group and Trust leadership structures in line with the Target Operating Model (subject to relevant approvals from the Remuneration committees in common). Develop and approve the Group governance and assurance framework (including development and approval of Group Board (General Purpose Joint Committee TORs) and Board committee structure and ToR. Develop and approve the Group Board membership (subject to relevant approvals from the Remuneration committees in common and Councils of Governors with respect to NEDs)	Works within the Group governance structure, assurance and accountability framework to deliver services ensuring that local governance aligns with group governance.

2	Oversight of delivery of the BSW Hospitals Group Case for Collaboration and emerging agreed priorities. Includes programme oversight of workstreams from case for collaboration – with details, phasing and resourcing agreed in *Annual Group-wide Plan*.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight. Delivery of change locally with Partners. Participates in group mobilisation and development workstreams.
3	Defines objectives, shape and structure of Group Corporate Services transformation. Approval of programme resourcing.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight.
4	Develop and approve the Group's Organisational Development and engagement plan, including the approach to engagement with the Councils of Governors	
5	Develop and approve the Group's communications strategy, including key communication tools/ artifacts.	Engagement in and contribution to the development of the Group narrative.
6	Identification and approval of any further opportunities in support of Group Strategy.	Actively identify further opportunities to maximise economies at scale.
	5. Achieving Digital Maturity	
1	Responsible for the strategic oversight of successful delivery of the EPR Programme [via EPR Joint Committee activity]. Approves proposals for new budget and new benefits profile.	Ensures local delivery plans in place and appropriate relevant engagement for successful implementation.
2	Identifies, approves and implements digital transformation initiatives across the Group structure, as described in *Group Digital Delivery plan* [refer 1,2].	Ensures local IT infrastructure supports Group-wide strategy. Ensures local delivery plans in place and appropriate relevant engagement for successful implementation

Report Title	**CEO report**				
Meeting	**Trust Board**				
Date	**11/09/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Cara Charles-Barks, Chief Executive				
Appendices					

Purpose

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

Assurance Level

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

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

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

Report

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

The Chief Executive's report covers:

1. National updates
2. BSW Hospitals Group update
3. Operational position at Great Western Hospital
4. Quality improvements
5. Systems and strategy
6. Workforce, wellbeing and recognition

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

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

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

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

Explanation of above analysis:

The report details how the Care Quality Commission recognised that our staff make reasonable adjustments for patients with disabilities when providing care in our Urgent Treatment Centre and Emergency Department.

Our Staff Excellence Awards include an award for a staff member who has championed equality, diversity and inclusion.

The report also highlights the success of students on Project Search, a programme that supports young people with learning disabilities and autism to gain vital work experience, build confidence, and develop skills for future employment.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	**04/09/2025**

1. National/system

1.1 Approach to Assessing Provider Capability

NHS England wrote to provider Chief Executives on 13 August 2025 providing an update on the approach to assessing provider capability.

As set out in the recently published NHS Oversight Framework (NOF), NHS England will consider not only an organisation's delivery, as evidenced by its NOF segment, but also its capability. The rating of provider capability will help NHS England inform their response to NOF segmentation and may also inform any decisions about entry into the National Provider Improvement Program (NPIP), as well as Trusts being considered for new foundation trust status.

The aim is to ensure that NHS England has a holistic view of providers, not just focussed on delivery of national programmes but also capturing wider information relevant to grip and governance. It is also intended to be a development tool, helping Boards to reflect on their competencies, develop robust approaches to internal assurance, and encourage continuous improvement.

The capability rating will be based on:

- an annual self-assessment by provider Boards and submission to NHS England, with supporting evidence. The assessment will be based on themes from last year's publication of 'The Insightful Board' (https://www.england.nhs.uk/publication/the-insightful-provider-board/)
- a review of the self-assessment, triangulated with the provider's track record to date and any third-party information (including CQC), to provide an overall view on the Board's capability. Whilst ICBs remain jointly responsible and involved in provider oversight NHSE will seek their views on the provider capability self-assessments for the providers in their systems.
- across the year, NHS England will use the capability rating and self-assessment to inform the relationship with the provider, revising the capability rating should events merit it e.g. if an issue emerges that was not foreseen in the self-assessment.

It is intended that the capability rating will be published alongside the NOF segmentation.

NHS England confirmed on 26 August 2025 that the first stage of this assessment involves Trust Boards assessing their organisation's capability against a range of criteria derived from last year's Insightful Provider Board document and submitting these self-assessments to regions. Oversight teams in each region will then review these, triangulating with their own views of the provider, its track record of delivery and any relevant information from third parties before assigning a capability rating.

Provider self-assessments are to be completed by 22 October 2025.

1.2 Lead Appointed for National Maternity Investigation

It has been announced that Baroness Amos has been selected to lead the independent investigation into NHS Maternity and Neonatal Care.

The investigation was announced by the Secretary of State in June 2025 and will look at up to 10 services in the country. It will also review the maternity and neonatal system, bringing together the findings of past reviews in to one clear national set of actions to ensure every woman and baby receives safe, high-quality and compassionate care.

It will begin its work this Summer and produce an initial set of national recommendations by December 2025.

1.3 NHS Publishes Strike Impact Data

NHS England published data which outlined the impact of recent industrial action by Resident Doctors, which showed the results of a more robust approach by NHS leaders with staff working around the clock to keep services open for patients.

The data showed that more care was delivered during the July 2025 Resident Doctors' strike than in the five-day June 2024 walkout, with NHS analysis estimating that an additional 11,071 appointments and procedures went ahead. Staff absence due to industrial action was lower during this latest round, with around 1,243 fewer staff absent each day on average compared to last June – a 7.5% drop – helping Trusts to maintain more services and protect patient care.

An overview of the industrial action by Resident Doctors across GWH is shown below:

The priority for Great Western Hospital during the industrial action (IA) period was to maintain patient safety and minimise disruption to both elective and non-elective activity.

Tactical pre-IA meetings chaired by the Chief Medical Officer with Chief Operating Officer and Divisional representation established a cover rota for anticipated gaps in service provision. There was a particular focus in safeguarding cancer pathways and assessing the need for derogations against the following criteria:

- Major Incidents
- Urgent and Emergency Care disruption
- P1 and P2 time critical treatment where delay could lead to harm
- Cancer care maintenance
- Time critical interventions e.g. elective caesarean sections

Attendance by communications ensured consistent messaging within and without the Trust. Note was made of the advisability of supporting PALS to be able to deal with an increased number of patient contacts.

Daily IA-co-ordination meetings took place during the IA period with senior medical and nursing involvement – these meetings were chaired by an incident director from the office of the Chief Operating Officer with Divisional, Communications and workforce intelligence attendance. There was input from site team with real time evaluation of the site sitrep.

During the IA:
- There were no derogations requests submitted
- 243 outpatient appointments were rescheduled – 26 of these consultations were cancer related.
- 49 operations were affected – 13 of these were cancer related

Resident Doctor absence was as follows:

	0700 25/7/25 to 0700 26/7/25	0700 26/7/25 to 0700 27/7/25	0700 27/7/25 to 0700 28/7/25	0700 28/7/25 to 0700 29/7/25	0700 29/7/25 to 0700 30/7/25
Number of resident staff expected to work	187	71	69	178	206
Number of resident staff absent because of IA	95	43	40	100	104
Percentage resident staff absent due to IA	51%	60%	58%	56%	50%

On 28/08/2025 the Great Western Hospital received notice from the BMA of a ballot of Resident Doctors (Foundation Year 1) to take place on Monday 8 September.

1.4 Tiering Approach for Great Western Hospital

NHS England confirmed on 5 August 2025 that following a review of Great Western Hospitals NHS Foundation Trust's urgent and emergency care performance that the Trust will move to Tier 1 for urgent and emergency care for quarter two of 2025/26.

Being in Tier 1 will involve regular meetings with attendance from both regional and national colleagues to discuss delivery progress and any required support from NHS England, including through an offer of direct improvement support from ECIST for a period of up to six months where this will add value.

Performance progress will continue to be formally reviewed and agreed on a quarterly basis between national and regional NHS England teams however in exceptional circumstances, changes to tiering status can be made within quarters.

2. Group update

2.1 Joint Committee & Partnership Agreement

Our second BSW Hospitals Group Joint Committee meeting was held on 16 July in Swindon with the focus being on discussion and approval of the proposed Group Operating Model and Leadership Model. Initial corporate services plans were introduced for priority services – Finance, People, Digital, Estates & Facilities and Capital Planning. Proposed clarifications to the Group Partnership Agreement Joint Functions and Joint Committee Terms of Reference were approved pending ratification by Boards. The establishment of a Group Strategy and Planning working Group was approved. A report from the July Group Joint Committee has been included with September Trust Board papers.

2.2 Leadership Team

September and October will see developments in the Group leadership team. Our three Managing Directors (Lisa Thomas – GWH, John Palmer – RUH, Nick Johnson – SFT),

started in post on 1 September. Following approval of the proposed leadership model by the Remuneration Committees in Common at the end of July a consultation exercise is now underway. The post-consultation report will be considered by the Joint Committee on 29 September. In the short-term we have progressed recruitment to:

- Strategic Clinical Transformation Director. Advertised. Interviews 27 August. Target in-post: September.

2.3 Group Strategy and 2026-27 Planning

The development of our Group Strategy has begun, led by senior responsible officer Joss Foster and coordinated by Trust strategy leads. Our transitional support partner Teneo is supporting this work. The strategy will be developed in close coordination with the 2026-27 planning round.

2.4 Group Governance and Assurance Arrangements and Transition Roadmap

To support safe and effective mobilisation of our new Operating Model by April 2026, the programme team is focused on developing a detailed governance and assurance roadmap in readiness for consideration by the 29 September Joint Committee. The development of our group risk approach and assurance arrangements will form an important part of this roadmap.

2.5 Councils of Governors Workshop

On 5 August the three Councils of Governors came together in Devizes, to start the conversation about opportunities for BSW Hospitals and the 10-Year Plan, to discuss the emerging Operating Model and Council of Governors role. It was agreed that a follow-up meeting would be arranged, so Governors can continue the conversation on Group Development and our response to the 10-Year Plan; this next session will be held on 1 October.

2.6 Board to Board Development

We have begun planning for our next Board-to-Board sessions planned on 2 October and 12 February.

Great Western Hospitals NHS Foundation Trust update

3. Operational update

3.1 Latest operational position

In July we delivered 95 per cent of the operational activity we planned to, and our overall waiting list has increased to 39,242 patients, with the number of patients waiting 52 weeks or more for treatment also rising.

We have seen higher numbers of patients attending the Emergency Department and this has impacted upon our performance against the national four hour standard.

Positively, we have seen improvements to our ambulance handover times, a fall in the number of pressure harms, and a reduction in our non-elective length of stay in hospital.

3.2 Bed reconfiguration

Following an earlier phase of work to ensure patients are treated on the right ward for them, we have undertaken the second phase of our bed reconfiguration.

The latest phase of work involved moving the Gastroenterology beds from Saturn ward to Ampney ward with general medicine patients moving in the opposite direction.

Medical patients being in fewer separate locations will mean we are able to provide improved consistency and continuity of care, leading to improved patient experience, clinical outcomes and a reduced length of stay in hospital for this group of patients.

These moves will also benefit the Surgery and Planned Care division through having the Gastroenterology team co-located with other surgical teams.

4. Quality

4.1 Care Quality Commission inspection reports

Earlier this year the Care Quality Commission (CQC) inspected both Surgery and Urgent and Emergency Care.

The unannounced inspections took place in March and April, with the inspection team speaking to patients, carers, staff and reviewing patient records, various documentation and processes.

Reports of these inspections have now been published, with surgery services rated as Good, and Urgent and Emergency Care services rated as Requires Improvement. The Trust's overall rating remains as Requires Improvement.

In surgical services, the inspection team praised staff for treating patients with kindness, compassion and empathy, and respecting their privacy and dignity.

The service was commended for its safe learning culture, based on openness and honesty, with staff saying they feel able to raise concerns and inspectors seeing evidence that the service understands and manages risks well.

A culture of listening, learning and trust is complimented by leaders and staff having a shared vision and senior leaders being visible to teams.

Care is based on the latest evidence and good practice, with assessments taking account of patients' communication, personal and health needs.

In Urgent and Emergency Care services, the need for improvements was identified in the safe and caring areas of quality, while the effective, responsive and well-led areas were rated as Good.

Staff were praised for treating patients with kindness and compassion and most patients said that communication is good. Inspectors also praised staff for making reasonable adjustments for patients with disabilities and taking time to explain treatments to children.

The service effectively assesses patients' individual health, care, wellbeing and communication needs and staff make sure patients only need to tell their story once.

Areas identified for improvement relate to access to timely care and treatment and staffing challenges, with Bank staff helping to maintain safe staffing while the team is being developed.

4.2 Neonatal transitional care

Maternity staff, local families and charity New Life celebrated the opening of a dedicated neonatal transitional care area at Great Western Hospital.

The new area provides specialised care for babies born between 34-36 weeks prematurely, who need additional feeding support, close monitoring or other specialist support after birth.

It means that babies and mothers can now receive specialist care together, rather than babies being cared for in a different unit.

The specialist area also allows partners to stay next to mother and baby overnight, promoting family bonding.

This new area was made possible thanks to New Life, a charity who raise money to support special care babies across the UK.

5. Systems and strategy

5.1 Finance

Our financial position, like the other Trusts in our Group, presents a significant challenge and we are £7.6m behind where we planned to be at this point in the year.

Key to delivering our plan for the year is achieving our efficiency savings target of £32.4m. So far we have delivered £4.26m of this.

Work continues with our divisions to try to deliver the savings needed and this work is closely monitored by our financial recovery sub-committee.

5.2 Green Plan

We have launched our Green Plan for 2025-28, which sets out our commitments and key actions to help us meet sustainability and net zero targets across the Trust.

The plan focuses on the following areas:

- Estates and facilities: Improving energy efficiency and reducing waste across our buildings.
- Adaptation: Preparing our services to withstand climate-related challenges.
- Travel and transport: Promoting sustainable travel options for staff and patients.
- Supply chain and procurement: Sourcing responsibly and reducing emissions in our supply chain.
- Food, catering, and nutrition: Offering healthier, sustainable food choices.
- Medicines: Minimising environmental impact in prescribing and medicines management.

- Net Zero clinical transformation: Innovating clinical care with sustainability in mind.
- Digital transformation: Using technology to reduce our carbon footprint.
- Workforce and leadership: Engaging and empowering staff to lead on sustainability.

6. Workforce, wellbeing and recognition

6.1 Staff Excellence Awards

More than 270 staff celebrated the success of colleagues at our annual Staff Excellence Awards evening. The 11 winners on the night were:

- Championing Equality, Diversity and Inclusion Award: Kitty Appelby, Senior Healthcare Support Worker
- GWH Rising Star Award: Sarah Coxon, Safeguarding Specialist Children's Nurse
- Hero Award: Beyond the call of duty: Sarah Churchill, Senior Occupational Therapist
- Improving Patient Experience Award: Katie Rix, Nurse Manager
- Sustainability Award: The Endoscopy Team
- Leading the GWH Way Award: Jenny Kear, Head of PALS
- Improving Together Award: Angela Morris, Senior People Partner
- Patient Choice Award: Tim Maughan, Professor of Clinical Oncology, and Charlotte Perry-Bennett, Medical Secretary.
- Lifetime Achievement Award: Dr Kash Aujla, Consultant
- Team of the Year: The Access Team
- Star of the Year: Antenatal Day Assessment Unit (DAU) Team

6.2 STAR of the Month

The recent winners of our STAR of the Month award are:

- Mathew Johnson, Ward Manager and Senior Charge Nurse on the Endoscopy Unit, who consistently demonstrates our STAR values by providing excellent holistic patient care. He was also recognised for being a supportive manager and encouraging everyone to work together to give the best care possible to patients as well as develop new skills.
- Children's Ward – the whole team on the ward was recognised for their extraordinary compassion, resilience and teamwork, through the most challenging times.

6.3 Project Search

We held a celebration for students graduating from Project Search, who throughout the year have gained valuable work experience at the Great Western Hospital, taking on a variety of roles such as porters, mailroom staff, and café cleaners.

Project Search is a programme that supports young people with learning disabilities and autism to gain vital work experience, build confidence, and develop skills for future employment.

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	6th August 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	Partial	
4. IPR – ED / 4 hours	Limited	
5. IPR – Ambulance Handover	Limited	
UEC Plan progress monthly update (verbal)	Noted	
Quarterly risk report	Noted	

POINTS OF ESCALATION	Noted that GWH has been put into Tier 1 for UEC which will result in greater scrutiny and support from the national team.
KEY AREAS TO NOTE	**RTT** Improvement continues on RTT and ahead of operating plan in the month Patients waiting over 52 weeks down from 764 to 679 in June Patients waiting over 65 weeks down to 21 from 31 18 week RTT at 60.8% an increase of 1.2 percentage points from May, and the 2nd most improved nationally since November 2 x 78 Week breaches – both patients have next steps booked in July 52 week PTL is at 1.8% **ED** ED mean wait time at 365 mins, down from 433 mins in May 4 hour performance was 69.1% a slight reduction from 70.3% in May. UTC mean wait time was 177 mins, an increase of 15 minutes from May, largely down to staffing issues and type 1 attendances being 5% greater than plan 12-hour trolley waits decreased from 355 in May to 164 in June. **Ambulance handovers** Average Handover time down by 57% to 48 minutes, with daily handover delays down by 50 hours to 38 hours. Overall flow has improved of late and the current trial of one-directional flow has supported this shift.

	Leadership exchange between SWAST and the GWH hospital clinical and operational leads to review areas for improvement and share best practice held in July. **Wait to 1st Outpatient Appointment Breakthrough Objective** 67% performance, meeting the year end March 2026 target. 16 out of 27 specialities were at 72% and GWH was the 4th most improved nationally according to model hospital data since November 2024. **Diagnostics 6 week-wait performance** Performance has marginally fallen to 84.3% from 85% in May due largely to sickness in the Ultrasound team. **Cancer** 28 day FDS at 77% down from 80.4%. Breaches in Urology, UGI, Colorectal, ENT and Gynae 62 day performance was 69.7% down slightly from 70.9% 31 day performance at 90.3% a further fall from 93.2% and 95.2% in the prior two months Plastics remains a problem but will be supported with outsourcing from mid-August. **Quarterly 15+ Risk Report** Noted that 2 risks were de-escalated from scores of 20 to 16. These are risk 731 (Offloading Ambulances) and 1085 (High occupancy) which has improved due to better flow allowing closure of an escalation ward. One risk has been closed.
BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**RTT Validation** March 2026 targets have been met 9 months ahead of trajectory for both wait to first appointment and RTT 18-week performance
REFERRALS TO OTHER BOARD COMMITTEES	N/A

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

Committee	**Performance, Population & Place Committee**	
Meeting Date	27th August 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	Good	
3. IPR – Cancer Services Quarterly report	Partial	
4. IPR – ED / 4 hours	Limited	
5. IPR – Ambulance Handover	Limited	
UEC Plan progress monthly update & tiering letter	Noted	
BAF	Noted	
Winter Seasonal plan	Approved	
Partnership report	Noted	
NHS assessment framework	Noted	

POINTS OF ESCALATION	Overall 292 appointments were affected by the 5 days of industrial action.
KEY AREAS TO NOTE	**RTT** Improvement continues on RTT and ahead of operating plan in the month Patients waiting over 52 weeks up to 707 from 679 in June Patients waiting over 65 weeks up to 26 from 21 18 week RTT at 61.2% an increase of 0.4 percentage points from June and ahead of the year end target of 60% **ED** ED mean wait time at 398 mins, up from 365 in June 4 hour performance was 68.9% a slight reduction from 69.1% in June. UTC mean wait time was 181 mins, a slight increase of from 177 mins in June, with ongoing staffing issues and higher attendances than plan. **Ambulance handovers** Average Handover time was 53 mins, a slight increase from June at 48 minutes, however the second half of the month a 24 minute average was achieved. Overall flow has improved and Length of Stay has improved by 0.2 days versus the prior year.

	Wait to 1st Outpatient Appointment Breakthrough Objective 67% performance, meeting the year end March 2026 target. **Diagnostics 6 week-wait performance** Performance has increased to 86.4% from 84.3% in June with reduced impact of sickness. **Cancer** Quarterly cancer update received, and noted that GWH is the only TVCA trust not in tiering, and currently helping other trusts in their challenged specialities. £382k funding received from TVCA, a reduction from c£800k in the prior year. 28 day FDS at 79."% an increase from 77%. 62 day performance was 78.2% an increase from 69.7%. Tumour sites challenged Lower GI, Head and Neck, Urology and Skin. 31 day performance at 87.4% - a further slight fall from 90.3% in June. **Seasonal Plan** Draft seasonal plan presented and most significant challenge is bed occupancy. Priority is to generate 60 extra bed spaces (through reduction in LOS etc) to support flow through winter. Full plan to be presented at Board for approval. **Partnership update** The importance of the Swindon ICA winter resilience plans was discussed with further work ongoing in September. Swindon ICA has increased visibility of the allocation of the Better Care Fund which supports joined up pathways and left-shift of care. Swindon Infrastructure delivery plan engagement is ongoing. Noted the inclusion of the shift towards prevention, and the planned residential growth for Swindon (12,100 new dwellings by 2043) **Performance Assessment Framework** Segmentation in future will be based only on delivery metrics with capability assessed alongside delivery. GWH has been placed in segment 3 since organisations in receipt of deficit support funding have their overall segment limited to 3. Before application of the financial over-ride, segmentation score is 2.31 (91 of 205 providers). GWH's top score was 1.8 in the patient safety domain.
BOARD ASSURANCE FRAMEWORK & RISKS	BAF Q1 update was noted, with risk scores remaining the same.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	100th lung cancer referral from the GWH screening service. 3 workstreams to help deliver UEC programme are progressing in the areas of: Pre-admission - patients treated and discharged in 24 hours, Admission – reducing time from admission to discharge ready status Transfer of Care – reducing time between discharge ready and discharge Use of temporary escalation space has reduced further in July

REFERRALS TO OTHER BOARD COMMITTEES	N/A

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

Committee	**Quality & Safety Committee**
Meeting Date	24.7.25
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) 4. IPR concerns and complaints (Non-Alerting Metric)	**Limited**	
5. IPR Maternity	**Good**	
6. Maternity Safety report	**Good**	
7. Perinatal Mortality Review Tool Quarter 1	**Substantial**	
8. Risk Register Report	**Good**	
9. 30 day Readmission Deep Dive	**Good**	
10. Infection Prevention and Control Annual report	**Good**	
11. CQC preparedness report update	**Note**	
12. Safe Staffing Monthly Report 13. Electronic Discharge summary Update	**Note** **Note**	

POINTS OF ESCALATION	
	• **IPR: Reduction Total Harms:** There has been a notable reduction in total harms from 146 to 111, which continues the current trend in reduction of total harms over last 12 months. • **IPR: Infection Control:** C diff cases had reduced slightly in June against May, but GWH still remains above its threshold. • Cannula care practices in preventing MSSA infections remains a focus to reduce the risk of introducing infections into the bloodstream and now MSSA rates are below threshold. • **IPR: Breakthrough Objective: Falls** • A notable reduction in falls in month from 104 (May and April) to 70, with no recorded falls with moderate or higher harm. A discussion was had around the difficulty in seeing the impact of work on the falls incidence as the data is complicated by a number factors including the number of attendances arriving at hospital already with a history of falls and total numbers of attendances. But when comparing overall ratio data since 2022 there is an improvement trend with 351 fewer falls relative to admissions with prior falls than in previous year.if the figure was further extrapolated to include overall oincrease in total admissions, this ratio would be further improved.
	• **Complaints and Concerns Response Rate**. The complaint response rate has notably improved from 53% (May) to 78% Reflecting the on going work on improvement initiatives. . • The presence of a backlog of overdue cases will continue to take time to resolve.

	Maternity Integrated Performance Report • Sustained performance in staffing metrics, reflecting the effectiveness of the escalation policy in ensuring safe care, despite staff acuity metric requirements falling to 71% and no evidence of compromised car. 1:1 care had been maintained and no complaints raised related to staffing numbers. • One case of intrauterine death at more than 24 weeks of pregnancy which is being processed through perinatal mortality review tool(PRMT.) appropriately. • Staff are currently being supported In preparation for an upcoming inquest, involving the perinatal team, the findings of which will be brought to this committee. • 5 complaints received in June which are being reviewed through the Trust triangulation process, themes are related to privacy, staff attitutdes, medical care and staff behaviour. • Feedback from families is being successfully used to drive improvements, e.g introduction of use of an ACORN symbol on the doors of mothers where their baby is on neonatal unit as a sensitive reminder to staff that the baby maynot be present in the room. • Committee received excellent progress report on the success of the use of the Cook's Balloon project for mechanical induction of labour as opposed to medical induction. Excellent feedback received from both patients and staff. • All three Trusts in Group are now live on Badgernet and collaboration across the group is strong. • The committee discussed the ongoing actions around post partum haemorrhage and being an outlier for level of incidence. The committee was assured that widespread comprehensive actions were in process including looking at potential causation of haemorrhage and management thereof.
	• **Maternity Safety Q1 Report** • 2 patient safety incident investigations (PSIIs) were closed, both leading to actionable learning points. • 3 cases reported to MBRRACE-UK (2 antenatal intrauterine deaths and one late fetal loss at 22 weeks, despite this Trust's stillbirth rate remains below the national target. • The UNICEF Baby Friendly Initiative team conducted a follow-up visit to assess progress progress on previously unmet criteria. These standards are now met and there is an expectation of reaccreditation. • New digital Check in system has shown no episodes of non attendance outside resident hours for quarter 1. • Audit will be undertaken to examine the trend of increased serious incidences reported to women of Asian ethnicity.
	• **Perinatal Mortality Review Tool (PMRT) Q1** • GWH is meeting all mandated reporting timelines and is fully compliant
	• **Risk Register Report** • 21 risks on Trust register with 15+ Risk • Of these 4 fall under accountability of this committee • All are being actively managed • All score 16 • 1 risk was closed and 1 risk relates to private Finance which does not fall under this committee remit • The committee is allowing an embedding period of 2 more months of the new system before challenging its effectiveness.
	• **30 day Readmission Deep Dive** • This was undertaken on the request of the committee in response to the 30 day readmission rates being slightly above national average over the year as a sense check.

	• After a comprehensive deep dive, the committee received reassurance that no significant day 60s or incidents had been identified and no notable associations with any other IPR data • A key issue. Identified however, was related to data coding accuracy, specifically , the failure to correctly identify readmissions under certain consultants and this has been flagged as an area for further attention • The conclusion of the deep dive was that GWH 30 day readmission rates are not out of line. With national data **Infection Prevention and Control Annual Report/ Quarterly Infection Deep Dive** • It was with great pleasure the committee received this annual report which indicated for the first time n several years that there is clear and visible progress across multiple categories, reflecting the sustained efforts of the Infection prevention and control team. • This year there has been the decision to introduce internal threshold trajectories, utilising National methodologies but internally such that local impact factors can be better taken into account. • One area of concern remaining is around the Clostridium Difficile rate, whete clusters on individual wards are being observed.no lapses in care n investigation have been observed and it is noted an increase in national numbers in line with this. • Lebsiella rates continue to decline and now well below Southwest average • Pseudomonas has seen a significant improvement and is now below the Southwest average • No MRSA cases for a year • MSSA remain within expected trajectory but slightly elevated to previous performance whilst still below SW average- focussed work on canula and catheter care continues. • The Trust is now in a much stronger position relating to gram negative infections.
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	21.8.25
Committee Chair	Bernie Morley, 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	Partial	
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	Partial	
6. Safer Staffing	Note	
7. Electronic Discharge Summary	Note	
8. Board Assurance Framework	Receive	
9. Clinical Audit and Effectiveness and NICE guidelines Q1	Good	
10. Learning from Deaths	Good	
11. Integrated Front Door Quality Report	Receive	
12. Board Safety Walkarounds	Note	
13. Responsible Officer Annual Report	Approve	
14. Maternity And Neonatal Independent Senior Advocate	Note	

POINTS OF ESCALATION	**Inquest Report** An update on the recent inquest was given verbally with a full report due next month. The inquest highlighted failings in midwifery care and informed consent and actions are underway to address these. The care had been investigated through a Trust patient safety investigation and an MNSI investigation with the learning identified addressed.
KEY AREAS TO NOTE	**IPR: Reduction Total Harms:** • The number of harms has increased slightly in July. **IPR: continued monitoring Pressure Harms:** • There has been a decrease in the number of hospital acquired pressure ulcers to 5. **IPR: Infection Control:** • The focus on infection control was highlighted noting an increase in *C.diff* cases, with no causal links found. Cannula care practices in preventing MSSA infections remains a focus to reduce the risk of introducing infections into the bloodstream. **IPR: Breakthrough Objective: Falls** • A deep dive into Falls was presented which demonstrated good progress with falls reduction and the reduction in harm from falls. There was much greater engagement and ownership of the falls prevention plan across divisions with good learning being identified from the weekly falls panel.
	Complaints and Concerns Response Rate. • The complaint response rate has deteriorated slightly to 72% but remains above previous months. • A deep dive of actions being undertaken will be presented next month but improvement work is ongoing to ensure process and accountability for ensuring complaint responses are completed in a timely manner.

	Maternity Integrated Performance Report • A self-assessment update against the Immediate and Essential Actions from the Ockenden report and three-year maternity & neonatal delivery plan is included. The Trust declared a position of compliance in Year 6 against all ten safety actions and are awaiting rebate funding being issued nationally. CNST year 7 was released in April and maternity and neonatal services will continue to fully engage with the incentive scheme aiming for full compliance. An initial self-assessment has been undertaken against the revised criteria. • Staffing met the acuity requirements 82% of the time during the intrapartum period. 1:1 care in labour was 98.3% • 1 uterine death > 24 weeks of pregnancy was reported in July, however this was a termination of pregnancy. • 2 PMRT reports were completed with learning identified and actioned. • An increase of patient safety incidents graded moderate or above was seen, including 5 PPH incidents, it is likely some will be downgraded after further review. • Training compliance remains at 85%, however fetal surveillance training has been impacted by staffing levels, this has now been addressed and all groups are above 90%. • Childrens level 3 safeguarding is slightly below target with a recovery plan in place. • 3 complaints have been received in July. •
	Safer Staffing • The children ward safe staffing level was highlighted due to vacancies and sickness.
	Update on Integrated Front Door Quality report • Good progress is being made across the quality metrics although a focus remains on patient experience and communication / updates on patients next steps. • An update on the actions being taken to address the concerns raised in the recent UEC CQC inspection report.
	Electronic Discharge Summary update • 24 EDS performance remains stable at 55%. • A decision on the strategy for historic EDS is awaited from the digital steering group.
BOARD ASSURANCE FRAMEWORK & RISKS	**BAF** • The Q1 BAF was presented with agreement that the risk score remains at 16
	Clinical audit and Effectiveness Q1 • Delayed starts reduced from 5 to 2. • Overdue reports and action plan evidence - reduced from 32 to 18. • Governance sign off reduced from 19 to 17. • Risks 3/31 reports identified high risks, 10/31 reports identified moderate risks, 18/31 identified low risks. • Top areas of focus - Paediatrics, Trauma & Orthopaedics, Cardiology, Respiratory/Cancer Services and Stroke Department.
	NICE Guidelines 2025/2026 Qtr. 1 • Trust Compliance with NICE guidelines has reduced from 82%-81%. • There are no existing legacy records to assess; this work is now complete. • There remains a proportion of guidelines that are in implementation where risks are unknown. • There remains a proportion of guidelines deemed non-compliant where risks are unknown. • Number of non-compliant guidelines has increased from 6 to 7:
	Learning from Deaths Qtr1 Report 2025/26 and Annual Report • SHMI shows the Trust to be within 'As Expected' ranges at 1.06. • There is correlation between uncoded spells and the rise in SHMI levels. • Pneumonia and Septicaemia are still alerting; internal reviews and associated improvements remain in progress. • There have been no Telstra reports available to review/report on; the Trust is scheduled to withdraw from the contract as of end of September 2025. • Inpatient deaths were reported to remain in line with average or better; 1.1% of admissions outcomes resulted in death. • Top 3 themes arising from SJRs include, documentation, practice around Respect forms, and gaps around End-of-Life care delivered by specialties.

	• Learning from Deaths Grand Round in April 2025; successful event which prompted further requests to run the event again.
	Board Safety Visit Bi - annual report • A summary of the 9 board safety visits was presented with agreement on how valuable they were found to be and suggestions for future development.
	Responsible Officer Annual Report • Oversight of the appraisal, revalidation process and compliance was presented.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**The first annual report for the Pilot Maternity and Neonatal Independent Senior Advocate Service, May 2025** • The role of the MNISA was presented and discussed. The Trust was engaged well with the MNISA and made more referrals than the other Trusts. • The report identified key family issues including a lack of compassion in care planning or delivery, communication issues, parental understanding and informed consent issues, families not feeling listened to or believed, review or investigation procedures did not meet need and/or caused further harm, services not available or easily accessible for psychological support and difficulty trusting healthcare professionals- the impact on future health and care decision making. • The value of the role in contributing to supporting families was agreed
REFERRALS TO OTHER BOARD COMMITTEES	

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

Committee	**People & Culture Committee**	
Meeting Date	27th August 2025	
Committee Chair	Julian Duxfield, Non-Executive Director	
Link to Strategic Objective	Pillar 2: Valued Teams	
Link to Board Assurance Framework	BAF: SR 2 (Culture), SR 3 (Workforce Planning)	
Improving Together Pillar Metrics	Sickness rates	Staff survey – recommend place to work
	Staff survey – addressing discrimination disparity	
Improving Together Breakthrough Objective	Staff Survey – respect from colleagues	

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. **Staff Survey Progress Update Report: Trust-wide**	Partial	X
2. **Staff Survey Progress Update Report: Corporate**	Partial	X
3. **Staff Survey Progress Update Report: Medicine**	Partial	X
4. **Staff Survey Progress Update Report: Surgery & Planned Care**	Partial	X
5. **Staff Survey Progress Update Report: Family & Specialised Services**	Partial	X
6. **Trust Workforce Recovery (Quarter One): Trust-wide**	Partial	X
7. **Trust Workforce Recovery (Quarter One): Corporate**	Partial	X
8. **Trust Workforce Recovery (Quarter One): Medicine**	Limited	X
9. **Trust Workforce Recovery (Quarter One): Surgery & Planned Care**	Good	X
10. **Trust Workforce Recovery (Quarter One): Family & Specialised Services**	Good	X
11. **Inclusion & Health Inequalities Annual Report April '24 – March '25**	Received	X
12. **Our Behaviours Framework**	Approved	X
13. **Board Assurance Framework BAF2 – Valued Teams**	Received	X
14. **Integrated Performance Report**	Received	X

POINTS OF ESCALATION	None.
KEY AREAS TO NOTE	The most significant portion of the meeting was spent in dialogue with each division to assure progress on improvement actions identified from the 2024 staff survey and progress against workforce recovery targets. The assurance ratings on both these issues for each division were agreed by the committee. The Trust Staff Survey Working Group provides divisions with a clear escalation path for any necessary countermeasures that exceed the scope of division and require Trust-level support. Participation in the mid-year Pulse staff surveys evidence continued engagement by staff with the Trust achieving over 1,000 responses in both Q1 and Q2. A collaborative, system-wide approach to the staff survey is gaining momentum, with survey leads across BSW working together to promote alignment.

	Trust-wide there has been a decline in the 'respect' (staff feeling they receive respect from colleagues) scores, down from 70% in the 2024 survey to 68% in the Q2 survey. Our target is for this breakthrough objective is 75%. The score for 'recommend' (recommending the Trust as a place to work) has fallen from 60% in 2024 to 51% in the Q2 survey, our target for this is 63%. It is important to note that previous pulse survey trend is lower than the annual staff survey, however this would still indicate reduction in performance. The previous rating of 'limited' for Medicine division was uprated to 'partial' which reflects the greater level of focus which the division has brought to its work in this area. Surgery & Planned Care Division demonstrated a very good focus on addressing the 'respect' issue but need to bring more attention to their work on recommending the Trust as a place to work. On workforce recovery GWH achieved a favourable position at the end of quarter one, reporting 5 WTE below plan. This was primarily due to holding vacancies in corporate and administrative roles, which offset higher-than-planned temporary staffing usage. But a significant reduction in temporary staffing, 123 WTE, medical is the highest risk, due to current challenges in hard to recruit vacancies and increased demand from industrial action/escalation Medicine division provided 'limited' assurance, for workforce recovery, good controls seem to be in place but performance improvement is not being evidenced. Surgery and Planned Care have good controls in place and there is clear evidence of reductions with substantive staff numbers being reduced as well as temporary staff. Family and Specialised Services were also judged to be providing a 'good' assurance level with robust controls in place, although bank usage is still relatively high. The annual Inclusion & Health Inequalities Report (April 2024 – March 2025) was received by the committee. This report sets out how the Trust has met the Public Sector Equality Duty, highlighting the work carried out across the Trust to improve inclusion and equity for our workforce and patients. The data included shows incremental progress and highlights areas for improvement which has informed the action plan. The 2025/26 action plan is supported by the engagement with the Trust Board and staff network leads in August. The committee received a paper which summarised the work to a single behavioural model aligned with the STAR values. There has been extensive staff engagement to develop this, much simplified, framework and the originally proposed 12 behaviours have been slimmed down to eight. The committee approved this approach and the implementation plan.
BOARD ASSURANCE FRAMEWORK & RISKS	Strategic risk 3 (If we do not have effective workforce planning, we will have poor recruitment, retention and representation, then this may result in high agency usage and compromised patient safety and suboptimal service delivery.) is clearly impacted by the divisional approach to workforce recovery as described above. Strategic risk 2 (If we are unable to develop and sustain an inclusive, diverse and accountable workplace culture, then this may result in poor behaviours, low employee engagement, poor learning environment and increased turnover which will have a negative impact on the quality of patient care, safety and organisational performance.) will be impacted by our work to respond to staff survey ratings and the new behavioural framework is designed to underpin a range of improvement activities.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The development of the eight behaviours aligned to our STAR values is an significant step forward. This will set the tone for how staff interact with both colleagues and patients, embedding behaviours that strengthen our culture for the future.

	The work within Surgery and Planned Care on reduction initiatives highlights a clear focus on delivery, detailed understanding of data, and strong follow-through on actions. These improvements demonstrate real commitment to quality and sustainable change It was encouraging to hear about the progress being made at group level, including the development of a group-wide approach to the staff survey, policy, and workforce transformation. It is clear that the People Function team are embracing joint working, which places them in a strong position for future transformation
REFERRALS TO OTHER BOARD COMMITTEES	None

Key to committee assurance ratings
Ratings focus on overall assurance over effectiveness of controls'.
Controls : The measures in place to control risks and reduce the impact or likelihood of them occurring.

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

Board Committee Assurance Report

Committee	Finance, Infrastructure & Digital Committee	
Meeting Date	28 July 2025	
Committee Chair	Faried Chopdat, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Financial & Recovery Workstreams Update	Limited	x
2. Month 3 Finance Position	Good	x
3. Improvement & Efficiency Program	Limited	x
4. PFI Financial Update	Note	x
5. Costing Engagement & Service Line Reporting	Note	x
6. Commercial Development Partnership Board- Update	Good	x
7. Site Utility & Resilience Update	Partial	x
8. Health & Safety Annual Report	Approve	x
9. Digital Risk Register	Good	x
10. Digital Strategic Plan Update	Partial	x
11. Data Protection, IT Resilience & Cyber Security Update	Good	x
12. 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 3 by **£16m**. The individual organisation positions are as follows: GWH, **£6.8m** off plan; RUH, **£8.8m** off plan; SFT, **£6.0m** off plan; and ICB, **£5.6m** 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 financial position of both the Trust and the wider BSW system is extremely challenged in2024/25. 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 3 Financial Position:** For M03 2025/26, the Trust has an adjusted deficit position of **£6.8m**, representing a **£6.8m** adverse variance to the plan. The income is **£0.8**m behind the plan, with the key driver being the removal of the Trust's deficit funding of **£2.4m**, which was off plan. The pay position is **£3.9m**, adverse to plan. Undelivered CIP accounts for **£5.4m**, 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. 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 3, the programme has delivered **£2.93m** year to date, which is **£5.06m** below the planned **£7.99m** year-to-date (YTD) target, representing 42% achievement. While the Month 3 position demonstrates a significant improvement in delivery and increased recurrent performance, substantial risks remain. 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 is 'Partial' due to 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.
	Site Utility & Resilience Update: GWH Electrical System (electrical incident July 2024) – the generator & electrical system testing planned for June 2025 was postponed due to the generator specialist cancelling at the last minute. New dates are being arranged, but securing a commitment from the generator specialist remains a challenge. Revised dates are now likely to fall in August or September 2025, which is beyond the Trust Board's deadline. In light of the electrical incident (09Jul24) it is considered appropriate to reduce that level of assurance until we have fully investigated all the events & systems associated with the electrical incident. This ongoing investigation is a crucial part of our commitment to ensuring the safety and reliability of our electrical systems, providing the reassurance required.
	Digital 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?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Board Committee Assurance Report

Committee	Finance, Infrastructure & Digital Committee	
Meeting Date	26 August 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. BAF Strategic Risks – Q1	Good	x
2. Finance (incl. Way Forward Program) Risk Register	Good	x
3. BSW Financial & Recovery Workstreams Update	Limited	x
4. Month 4 Finance Position	Good	x
5. Improvement & Efficiency Program	Limited	x
6. Capital Prioritisation	Good	x
7. 2025/26 Seasonal Plan	Approved	x
8. Health & Safety Quarterly Report	Approved	x
9. Update on Procurement	Good	x
10. 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 4 by £18.4m million. The individual organisation positions are as follows: GWH, £7.6m off plan; RUH, £10.1m off plan; SFT, £8.5m off plan; and ICB, £7.7m 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 that exceed the required levels. Mitigating plans are in place to address this to some degree. The financial position of both the Trust and the wider BSW system is significantly challenged in the 2024/25 financial year. 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. 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. We have been assured that governance mechanisms at a Group level are being considered, with a draft TOR being developed for consideration.
POINTS TO NOTE	**Month 4 Financial Position:** For M04 2025/26, the Trust has an adjusted deficit position of £7.6m, representing a £7.6m adverse variance to the plan. The overspend is predominantly due to (1) undelivered CIP, (2) high temporary staffing spend, and (3) the removal of deficit funding, which would amount to £3.2m at the month's end. Income is £1.6m behind plan. Commissioner income accounts for a £1.8m adverse position, driven by the removal of deficit funding (£3.2m). There are favourable positions on high-cost drugs (£0.5m), depreciation income (£0.2m), vaccination income (£0.2m) - all offset by cost. Note that ERF is £0.1m ahead of budget (although the budget is not profiled - when profiling is considered, performance is £0.3m behind). 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 efficiency target for 25/26 is £32.4m. As at M04, actual delivery is £4.3m, which is £6.4m under plan. 64% of the delivery to date is recurrent. Note that in addition to the £4.3m delivered, the Trust has also achieved £1.8m of run-rate savings through prior-year benefits and closure of escalation areas. Key to breaking even with the plan in 2025/26 is delivery against the efficiency savings target of £32.4m. Divisions and services must focus on identifying recurrent savings 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. The assurance level is 'Limited' due to 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. Delivery progress is essential to regain access to deficit funding.
	Finance (incl Way Forward Program) 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?

SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
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Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**11/09/2025**	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 July (June for Cancer) are as follows:

STRATEGIC Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

July's performance shows the total number of patients waiting over 52 weeks at 707, an increase of 28 from last month and the first month on month deterioration experienced in almost a year. The current 52-week PTL remains at 1.8% of the overall wait list size against the target of 1% for March 2026.

The overall RTT PTL also grew in July following a higher number of clock starts than usual and a lower than anticipated number of clock stops, partly impacted by resident doctor strike action.

243 outpatient appointments were rescheduled over a 5 day strike period from 25th to 30th July, 26 of which were cancer related. 49 operations were also affected, 13 of which were cancer related. Overall, 292 appointments were affected.

Overall RTT performance within 18 weeks was 61.2%, an increase of 0.4 percentage points from the previous month, and whilst this is currently ahead of plan the increase in wait list size under 18 weeks will require close monitoring to sustain performance. Patients waiting over 65 weeks at the end of July was 26, with two 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 as quickly as possible, but a small number of exceptions are anticipated between now and September.

- Cancer waiting times

Cancer performance for the 28-day faster diagnosis standard was at 79.2% and therefore 1.9% below the operating plan trajectory for June, although close to the national target of 80%.

62-day performance for urgent suspected cancer referral to treatment recovered this month to 78.2% and is currently 5.5% better than operating plan. 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. An additional insourcing provider has been identified to provide additional capacity in August and BSW Hospitals Group continues to review possibilities of longer term mutual aid, with Salisbury NHS Foundation Trust the most likely option in the medium term.

Cancer 31-day performance was at 87.4% in June, 5.2% under operating plan. Skin pathways and outpatient capacity in Plastics and Dermatology were the main contributors, with skin accounting for almost half of the delays.

- Time in Emergency Department

Combined 4 hour performance was 68.9% in July and 6.9% below operating plan trajectory. Under-performance in Quarter 1 has resulted in GWH being placed into Tier 1 for UEC at a national level, with GIRFT diagnostic support beginning in September.

Overall attendances were 1.5% above plan in month and the highest since May 2024. Average time in department stayed the same for ED and showed marginal improvement in UTC. Triage times also showed some improvement.

However, 4 hour breaches have increased by 50-60% for Type 3 UTC attendances in June and July due to lack of capacity for first assessment. This has been attributed to unplanned sickness affecting UTC practitioner capacity, with attendances also 5% higher than plan in the month. A recovery plan is in place although recovery towards operating plan trajectory is not anticipated until September at the earliest.

Whilst there have been challenges in delivering 4 hour performance, improvement in 12 hour delays in department seen in June has been sustained in July. Performance was at 11.1%, worse than plan by 0.9%.

During July the average ambulance handover time was 53 minutes against the trajectory of 33 minutes, and therefore 8 minutes higher than the national tolerance of 45 minutes. However, 80% of ambulance hours lost in July was experienced in the first half of the month. Following the introduction of a one directional flow ambulance offload approach on 21st July, an average of 24 minutes was achieved for the remainder of the month. This followed a whole hospital response to support decompression of ED with the introduction of a Gold commander rota that is still being piloted.

GWH has also approached BSW to commission a review of ambulance arrivals following a 12.5% increase in conveyances in Quarter 1 compared to the previous year, with a month on month increase of 9% experienced in July.

OPERATIONAL BREAKTHROUGH OBJECTIVES

- Non Elective Length of Stay

Non-elective length of stay was 6.2 days in July, down by 0.4 days from June and 0.2 days better than at the same point last year.

The A3 countermeasures outline the work being undertaken to improve performance and a key milestone was completed in July with the reset of the Medicine specialty bed base to accommodate more patients under the care of the right consultant, first time.

The programme board also highlighted the following key actions for improvement:

- Development of Ward level non-elective length of stay targets for top contributing areas in Medicine and Surgery and Planned Care, with Ward led counter-measures.

- Review of processes and development of KPIs to break down ward referral to transfer of care hub, referral to partner and discharge taking place. Countermeasures will be developed following this.
- The escalation of Pathway 1 Wiltshire delays to the Locality Group / BSW Flow Group in July following consecutive weeks of capacity thresholds for flow not being met.
- Accelerating the review of GIRFT principles for supporting acute patient care and length of stay and support for standardisation of ward processes including completeness of estimated dates of discharge and monitoring of specialty referred response times.

- 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 remained the same. Performance in July was 67%.

16 of the 27 specialties are exceeding the national target of 72%. The workstream have set the next milestone target to align with the national 72% for the Trust. From July, the composition of the working group has been expanded to include specialties that were previously out of scope. To further enhance performance and meet the new stretch target, a digital solution was implemented in July to support duplication within straight-to-test pathways. Additionally, the clinic room sub-group will explore opportunities to increase new slot capacity through regional benchmarking.

It should also be noted that the GIRFT outpatient diagnostic visit was carried out on 14th August in advance of the visit from Professor Tim Briggs in September which is expected to outline where further improvements can be made.

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 – July validated DM01 performance was 86.4%, up by 2.3% in June and above the operating plan trajectory of 85.5%. This follows a period of recovery expected within MRI and CT, and sickness impact reducing within non obstetric ultrasound.

Temporary Escalation Spaces (TES) – The use of TES reduced further in July with escalation areas such as the Discharge Lounge being largely limited to weekend surge planning utilisation. Further de-escalation is predicated on the delivery of a reduced level of patients that do not meet criteria to reside, which currently remains above plan. Delivery of further reduced TES usage will be reviewed in August with the objective to further reduce the Trust occupancy levels. This remains dependent upon progress of actions to reduce the no criteria to reside wait list for community packages of care, especially for Pathway 1 patients in Wiltshire. No criteria to reside remains at 46 patients off the plan trajectory.

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 maintain a consistent Trust wide complaint response rate of 80% and upwards.

The number of harms has increased in July to 121 compared to 115 in June.

The number of falls has increased in month to 87, when compared to June 71. The number of falls with moderate harm or above has increased to four in month.

The number of healthcare-associated infections have remained stable in month, although COVID associated harms are no longer included in the total harm review figures.

C. Difficile infections have decreased to five in month compared to six in June. It has been acknowledged that there has been an increase in Pseudomonas cases (three in month) when compared to previous months.

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 have increased to four in month. The number of patients with two or more falls has remained the same as June with six patients, although the overall trend of patients falling more than once is decreasing.

Alerting Watch Metrics

C.*difficile* numbers have decreased slightly in month to five compared to six in June.

Methicillin-Sensitive Staphylococcus Aureus (MSSA) numbers increased to five in month when compared to one in June. One of the five case has been confirmed as the peripheral line as the source of infection, the other cases are not confirmed However, work is underway to support a review of peripheral line care and amendment of guidelines.

The number of concerns received in month is 431 an increase from 346 received in June.

Non-alerting Watch Metrics

The Emergency Department and Urgent Treatment Centra positive response rate has decreased to 75.6% in month and is below the internal target of 79.4%.

The number of complaints received in month has increased to 81 in month, compared to 67 in June. The number of complaints re-opened has remained the same in month (six).

The overall Family and Friends positive response rate for July is 87.7% a decrease from last month and below the internal target of 90%.

There continues to be zero Methicillin-resistant Staphylococcus aureus (MRSA) cases reported in month. The numbers of Klebsiella cases have decreased in month to one compared to three in June.

The number of hospital-acquired pressure ulcers has decreased in month to five compared to 18 in June.

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

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

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)
  Q2 Pulse Survey: **50.6%** (decline compared to Q1 54.7%)
- **Staff Sickness Absence**
  Target: 3.5%
  June 2025 figure: **4.2%**, (small decline from previous month 4.1%)
- **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, awaiting Q2 results)

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.

The Q2 Pulse Survey closed at the end of July, with results now being analysed to assess progress on staff recommending the organisation as a place to work and feeling respected. To support improvement on this survey question, work to embed 'Our Behaviours', developed with Clever Together, continues with a framework and launch plan developed for October 2025.

Alongside this, planning is underway for the 2025 Annual Staff Survey, launching in September, with a group-based approach being delivered to ensure consistency and parity across the Care Organisations.

Sickness Absence
Sickness absence increased marginally in July to 4.2% (from 4.1% in June), driven by a rise in long-term cases. Targeted interventions delivered in July included focussed People Operations support in short-term sickness hotspots, mental health first aid training for managers, and the appointment of new Health & Wellbeing Champions, alongside Medical staff training to strengthen return-to-work compliance.

Trust-wide initiatives progressing through the sickness absence working group include the rollout of a Health Passport for staff with long-term conditions, tailored wellbeing support for high-pressured teams, and development of a new Group-wide long-term conditions policy.

Vacancy Rate
The overall vacancy rate in July 2025 was 4.25%, remaining well below the 7% target but broadly in line with recent months. The stable vacancy position is supported by recruitment time-to-hire remaining favourable for AFC roles (37.7 days) and Medical posts (49 days).

Nursing vacancies remain minimal, with all nursing groups combined showing an over-established position of 1.2 WTE, sustaining the consistently strong position seen over the past year. Medical vacancies continue to present a challenge at 8.0% (c.60 WTE), remaining above the 7% target despite stability compared to June.

Temporary Staffing Spend
In July, Bank usage was 287 WTE (+63 WTE above plan) and Agency usage 44 WTE (2 WTE below plan).

Bank spend was £0.05M over target, and Agency spend £0.3M above target. Agency spend remained above the spend plan in July but below on WTE usage, highlighting the need to review the cost per WTE being paid for agency workers. Long-term high-cost usage is currently being reviewed through the temporary staffing meetings with flight paths in development to remove or reduce cost of usage.

Workforce Recovery
In July, total workforce usage reached 5,170 WTE compared to a planned 5,120 WTE, resulting in an adverse variance of +50 WTE and representing an 11 WTE increase from June. This reverses the downward trend achieved in the previous month. The over plan position was driven entirely by higher temporary staffing levels, with the most significant impact from Support to Clinical staff, where bank usage was +26 WTE above plan. Medical & Dental also added pressure, recording bank usage +12 WTE and agency usage +6 WTE above expected levels. Although Registered Nursing temporary staffing remained favourable to plan (–33 WTE), this reduction was more than offset by overuse in other staffing groups.

Looking ahead, to deliver the August plan, Bank usage will need to reduce by 104 WTE (from 287 WTE in July to the planned 183 WTE) and Agency usage by 1 WTE (from 44 WTE to 43 WTE). This will require targeted and sustained actions to significantly curtail Bank shifts across all staff groups, with particular focus on the areas showing the greatest variance.

Agency usage is already close to plan, but ongoing close monitoring will be essential to avoid any increase while Bank reductions are implemented.

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

- **Nursing**: Current run rate is 191 WTE (compared to -1.2 WTE vacancy); the August target is 157 WTE meaning a required reduction of 35 WTE
- **Medical**: Current run rate is 91 WTE (compared to 60 WTE vacancy); the August target is 36 WTE meaning a required reduction of 55 WTE

Use of Resources

For M04 2025/26 the Trust has an adjusted deficit position of £7.6m, which represents a £7.6m adverse variance to plan.

Income is £1.6m behind plan. Commissioner income accounts for a £1.8m adverse position, driven by the removal of deficit funding (£3.2m). There are favourable positions on high cost drugs (£0.5m), depreciation income (£0.2m), vaccination income (£0.2m) - all offset by cost. Note that ERF is £0.1m ahead of budget (although the budget is not profiled - when profiling is considered, performance is £0.3m behind budget). Activity at the end of M04 was £1.4m lower than the scenario 2a plan which is a deterioration since June. July activity plan is £1m higher than in Q1 and performance vs plan worsened by £1m. The Trust is now broadly in line with the commissioner affordability cap for M04, having previously been £0.7m over. Other income is £0.2m ahead of plan, with an underperformance against private patients offset by gains on education funding. It should be noted that if the Trust were receiving deficit funding, the overall variance to plan would reduce to £4.4m, reflecting the tangible gap the Trust needs to bridge.

The pay position is £3.9m adverse to plan, with undelivered efficiency savings accounting for £2.9m. This is net of £0.2m of run rate savings relating to the closure of escalation areas and agency framework savings. The pay position also includes £0.2m of industrial action costs and £0.7m of accrued additional pay award uplift, offset by prior year gains of £0.5m. The remainder of the variance is due to the use of ongoing temporary staffing spend, particularly in front door areas. Work focussing on reducing pay spend, particularly temporary staffing, is beginning to deliver. Monthly run rate has reduced by £0.3m from M2, driven by nursing bank reductions.

Non-pay is £2.0m adverse to plan. Undelivered CIP (net of £0.3m of run rate savings) accounts for £2.1m while drugs are £1.1m adverse, £0.8m of which relates to passthrough drugs and offsets the £0.6m favourable income position. The net driver of the drugs overspend is PbR drugs. Offsetting this are £0.7m of prior year benefits and a further £0.5m of underspends across outsourcing, education and finance related costs. Non-pay savings are focussing on areas where run rate is trending upwards, along with broader grip and control measures such as clinical supplies and drug usage on the wards and reducing discretionary spend.

Key to breaking even with plan in 2025/26 is delivery against the efficiency savings target of £32.4m. At M04 the Trust has delivered £4.5m against a target of £10.6m, giving a shortfall of £6.4m. However, the Trust has also delivered £0.9m of run rate savings. 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 to contribute towards the delivery of the £32.4m efficiency savings programme.

As at M04 the Trust is £7.6m overspent against budget. The key driver of this is an underperformance of £6.4m against the efficiency savings programme, delivering £4.3m year-to-date against a target of £10.6m. Of the £4.3m delivered, 64% was recurrent. It should be noted that the Trust has also delivered £1.8m of run rate reductions due to prior year benefits taken in year and exiting escalation areas. While not removing budget, they are crucial in helping to reduce the overspent position. 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. Tracking 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 Management Committee	
Next Steps		

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	✓	☐	☐
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	**04/09/2025**

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

August 2025

July 2025 & June 2025 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

Section & purpose	Slides
Key indicators This is the NHS Oversight Framework indicators for 2025/26 and provides a summary of our performance against national standards	3-4
Executive summary This provides an overview of the targets, performance and countermeasures (remedial actions) for each of our pillar metrics	5-12
Breakthrough objectives This provides a more detailed analysis of performance and risks related to the 4 key metrics for improvement: Patients Developing Pressure Ulcers; Emergency Department - Clinically Ready to Proceed; Implied Productivity and Staff Survey Results	13-17
Our Care This includes key indicators and watch metrics related to our care of patients, as assured by the Quality & Safety Committee	18-20
Our Performance This includes key indicators and watch metrics related to our access performance, as assured by the Performance, Population & Place Committee	21-25
Use of Resources This includes key indicators and watch metrics for finance as assured by the Finance, Infrastructure & Digital Committee, and is also subject to a separate board report	26
Our People This includes key indicators and watch metrics for our workforce, as assured by the People & Culture Committee	27-32
Explaining the IPR This section explains how the work of front line teams to drive improvement connects from 'ward to board' through our operational management system, and the business rules we apply to support that.	33-45

Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Target/Thres.	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Percentage of RTT patients treated within 18 weeks		51.5%	51.4%	52.1%	53.1%	54.2%	54.8%	56.9%	58.0%	57.8%	59.6%	60.8%	61.2%
Percentage of RTT patients waiting over one year		4.8%	4.5%	3.9%	4.1%	3.5%	3.2%	3.1%	2.5%	2.2%	2.0%	1.8%	1.8%
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	75% (Nat)	81.8%	78.8%	79.5%	78.9%	79.5%	80.2%	86.2%	83.5%	80.4%	76.8%	79.2%	Reported one month behind
Percentage of patients treated for cancer within 62 days of referral	85% (Nat)	70.3%	70.8%	78.1%	70.4%	73.4%	75.3%	72.7%	82.1%	70.8%	69.7%	78.2%	Reported one month behind
Percentage of Emergency Attendances within Four Hours	95% (Nat)	79.4%	77.2%	72.6%	74.0%	72.1%	73.4%	72.3%	69.9%	69.5%	70.1%	69.0%	68.9%
Percentage of Emergency Attendances over Twelve Hours	2% (Nat)	2.8%	3.8%	5.8%	7.3%	7.9%	10.1%	8.9%	8.3%	9.0%	8.5%	5.6%	5.6%
Planned surplus/deficit		-1033	-801	-200	-683	-610	-482	74	690	-2149	-3476	-1173	-801
Rate of productivity		-15.0%	-13.0%	-11.0%	-14.0%	-15.0%	-14.0%	-13.0%	-14.0%	-11.0%	-13.0%	-13.0%	-8.1%
Readmission rate		16.0%	14.8%	13.7%	14.0%	14.5%	15.0%	14.6%	15.4%	15.3%	16.0%	15.3%	17.0%
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 behind	Reported five months behind	Reported five months behind	Reported five months behind	Reported five months behind
Average number of days between planned and actual discharge date		2.5	2.0	1.9	2.2	2.4	2.3	2.7	2.7	2.6	2.4	2.2	2.3
Percentage of inpatients referred to stop smoking services		13.0%	12.5%	12.2%	12.5%	12.5%	11.3%	10.0%	11.1%	11.5%	11.9%	12.0%	11.9%
Percentage of people waiting over six weeks for a diagnostic procedure or test	99% (Nat)	76%	80%	88%	89%	85%	86%	88%	91%	85%	85%	84%	Reported one month behind
Rates of MRSA		0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.5	0.0	0.0	Two month behind	Two month behind
Rates of C-Difficile		11.8	48.8	55.5	17.2	38.8	22.2	24.6	27.7	28.1	48.9	Two month behind	Two month behind
Rates of E-Coli		29.5	42.7	55.5	40.1	33.3	16.6	43.0	33.3	56.1	43.4	Two month behind	Two month behind
Percentage of NHS Trust staff to leave in the last 12 months	14.8% (Int)	11.0%	10.6%	11.0%	9.7%	9.9%	9.0%	10.4%	10.9%	10.3%	11.7%	11.6%	One month behind
Sickness absence rate	3.5% (Int)	4.5%	4.3%	4.9%	4.9%	4.9%	5.1%	4.9%	4.5%	4.1%	4.1%	4.2%	Reported one month behind
Rate of annual growth in under 18s elective activity		17.9%	20.0%	23.3%	32.6%	31.5%	31.9%	30.9%	27.7%	16.4%	11.8%	9.6%	4.9%

Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Metrics	2019	2020	2021	2022	2023	2024
NHS staff survey engagement theme score	6.96	6.96	6.67	6.70	6.80	6.82
NHS Staff Survey – raising concerns sub-score	-	-	6.40	6.42	6.49	6.48

Metrics	Published Date	Score / Rating
CQC inpatient survey satisfaction rate	21st August 2024	8.0
CQC National maternity survey score	28 November 2024	8.6
CQC safe inspection score	09 July 2025	Requires improvement

For each question in the **survey**, people's responses are converted into scores, where the best possible score is 10/10. - www.cqc.org.uk

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
- Medication 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.

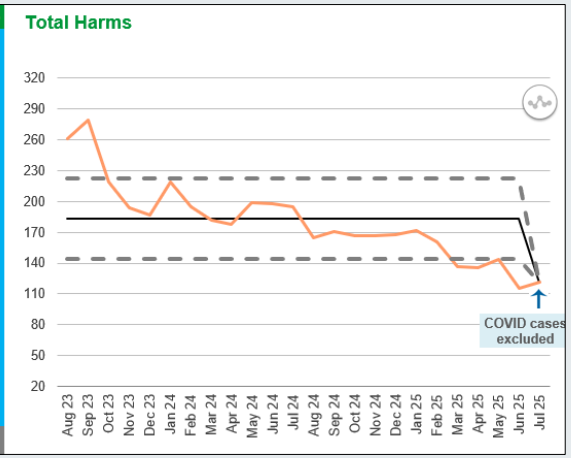
This metric reflects the Trust's commitment to learning from patient feedback and ensuring timely, high-quality responses to concerns raised.

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.

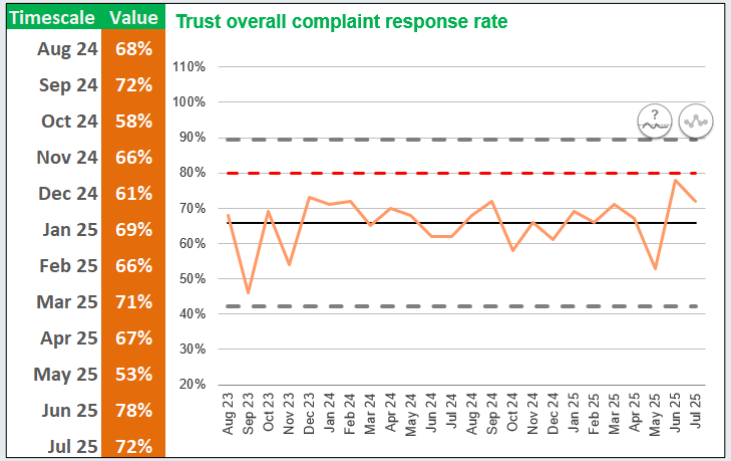
Total Harms
To achieve and sustain zero avoidable harm.

Timescale	Value
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	144
Jun 25	115
Jul 25	121



Trust Overall Complaint Response Rate
To achieve consistent Trust overall complaint response rate of 80%.

Timescale	Value
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%
Jun 25	78%
Jul 25	72%



Counter Measures

The total number of harms has increased in month to 121 compared to 115 in June.

C. diff numbers has reduced further to five in month from six in June. MSSA numbers have increased in month to five from one in June. Peripheral line care continues to be an area of focus for improvement.

There has been a decrease in the number of Hospital Acquired Pressure Ulcers, five in month compared to 18 in June.

The number of falls has increased in month to 87, compared to 71 in June. There has been four falls recorded with moderate harm or above in July.

The Trust's complaint response rate for July was 72%, a slight decrease from 78% in June but remaining above previous months, with 67% in April and 53% in May. The dip may be linked to seasonal annual leave and the impact of operational vacancies. Improvement work continues including two complaint response writing sessions to support new or less practiced staff to meet Trust standards. Work is also underway to extend existing accountability frameworks. Structured tracking and early notification alongside streamlined digital processes are helping to maintain momentum and support sustained progress, within a landscape where PALS contacts are growing month on month.

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 June, 55 pathways breached the standard resulting in 43.5 being allocated to GWH resulting in performance of 78.2%. Of these 69% are attributed to the Urology, Plastic, Colorectal pathways. These pathways are seeing issues with capacity for appointments and diagnostics.

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 June Plastics was responsible for 17% of breaches, without these performance would have been 82.0%

RTT: Number of patients waiting over 52 weeks

RTT performance increased by 0.44% in July delivering 61.22% compared to 61.22% in June. The total number of patients waiting over 52 weeks in June was 707, with a increase of 28 from the previous month.

There were 26 patients reported at 65 weeks at the end of July. 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 2 x 78-week breaches reported in July 2025. These were in Plastics and Urology (capacity). An alternative provider was sought for the Plastics patient.

A level of risk remains for August 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.

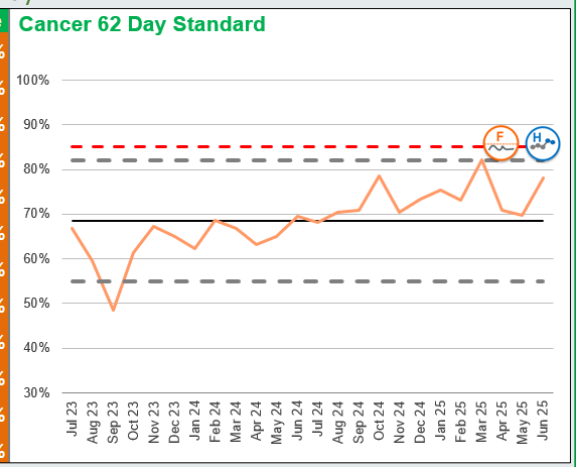
Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

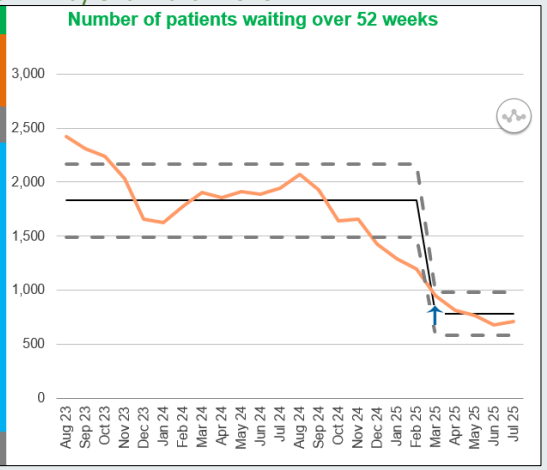
Timescale	Value
Jul 24	68.1%
Aug 24	70.3%
Sep 24	70.8%
Oct 24	78.5%
Nov 24	70.4%
Dec 24	73.4%
Jan 25	75.3%
Feb 25	73.1%
Mar 25	82.1%
Apr 25	70.9%
May 25	69.7%
Jun 25	78.2%



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
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
Jun 25	679
Jul 25	707



Counter Measures

Risk: Urology Pathways are impacted by delays in Radiology (capacity & vacancies)
Mitigation:
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

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

A slight decrease in NCTR can be seen in July, however overall NCTR LoS DRD has reduced. Countermeasures that have been introduced are:

- Wiltshire In reach processing of referrals prior to NCTR working in partnership with Therapist/wards commenced 28/07/25
- Early escalation of barriers in CTR now on Nerve Centre for monitoring
- Length of Stay reviews twice weekly to continues system wide.

NCTR breakdown/performance:

PW0's - 79% leaving on day 0 – has increased slightly on last month by 1%. Mean Average discharge ready (DRD) to discharge performance 0.9 - target 0.5

PW1's – 29% leaving on day 1 – increase from June by 5%. . Mean Average DRD performance is 4.5 days target is 2 days. This is a 50% decrease on last month.

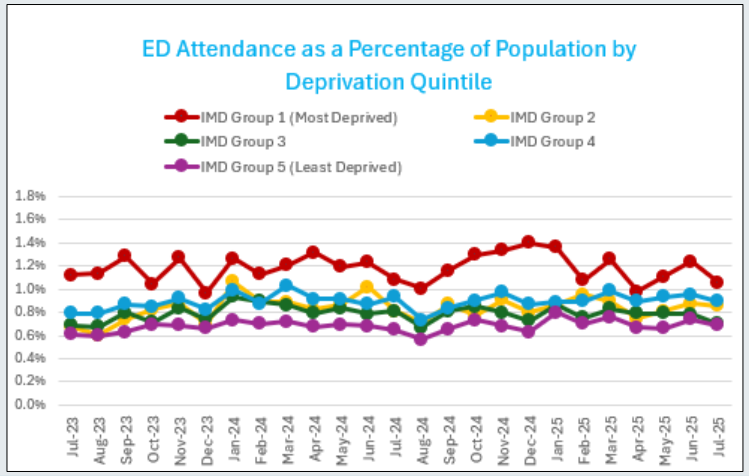
PW2's – 35% leaving on day 2 - this is an significant increase of 10% on last month. There is continued improvement needed with community providers and processes needed. Mean Average DRD to discharge performance 5.8 days target 2 days.

PW3's – 33% discharged on day 3 (KPI is 7 days locally) – this is a slight decrease on last month's performance. PW3's continue to be have closer monitoring for all geographical areas. Mean DRD has risen to 16.9 days which follows the patten low one month then an increase. The numbers for PW3 rose in July – which has continued into August.

Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

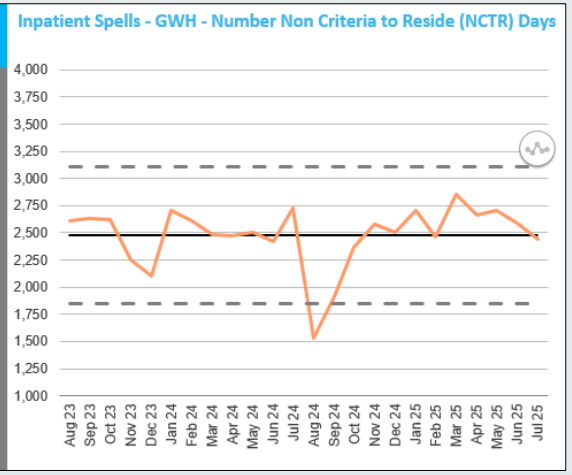
ED Attendance as a Percentage of Population by Deprivation Quintile



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

To treat the right patients in the right place, to ensure delivery of high-quality care.

Timescale	Value
Aug 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
Jun 25	2,594
Jul 25	2,439



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. There difference in access between people from the most deprived quintile and the rest of the population has continued in June. 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.

We are working with Swindon Integrated Care Alliance and our high intensity user team to develop a dialogue with our population. We are keen to review outputs of 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 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:

- Trajectories for NCTR to commence June and continue reporting into System being reported on daily – weekly report sent .
- 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 – Massive reduction in DCL being utilised for overnight escalation which has increased usage – highest in July.
- KPMG - Audit being carried out on CTH/NCTR in July – report to be received
- Power BI report with themes for delays finalised to be trialled

Reflections:

- Applying improving together methodology to change initiatives.
- Workforce planning to improve alignment of Acute Medical clinical Workforce to demand.
- Winter planning internally & system wide commenced – for sign off at TMC
- 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

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 July 2025 was 398 minutes against the national standard of 240 minutes, consistent with June and best performance since September 2024. Mean LOS has been affected by continued flow across the organisation throughout July, leading to ED outward flow and capacity to manage incoming patients.

There has been ongoing work to proactively manage ward discharges and promote earlier transfers out of ED. This has been coupled with a drive within ED for early decision making and highlighting when patients are 'Clinically Ready to Proceed' (CRTP).

Emergency Care – Urgent Treatment Centre - Mean Stay

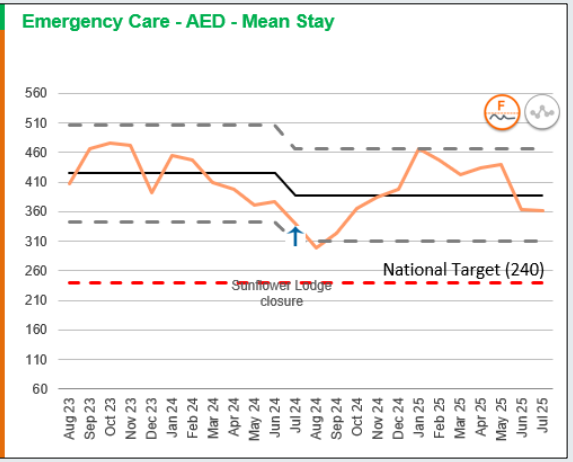
The total attendance mean time wait for a patient in June 2025 was 181 minutes against the national standard of 240 minutes, similar to performance in June. Staffing and acuity have continued to be challenging leading to periods with longer LOS, sometimes with 4hrs wait to be seen although discharge 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.

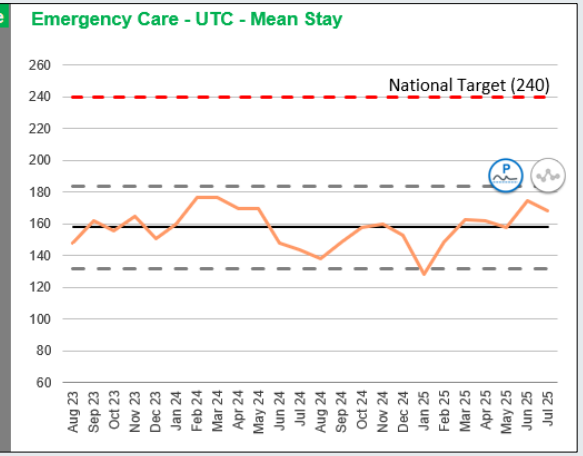
Timescale	Value
Aug 24	299
Sep 24	324
Oct 24	365
Nov 24	384
Dec 24	397
Jan 25	467
Feb 25	447
Mar 25	423
Apr 25	433
May 25	440
Jun 25	364
Jul 25	361



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
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
Jun 25	175
Jul 25	168



Counter Measures

- Recruitment of substantive Registrars in ED – will give increased 'Senior Decision Maker' cover
- 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. Reviewing process for continued utilisation
- 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
  - July UTC Momentum Push (JUMP) - review of issues identified and practice change

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 June 2025 was 4.2%.

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.

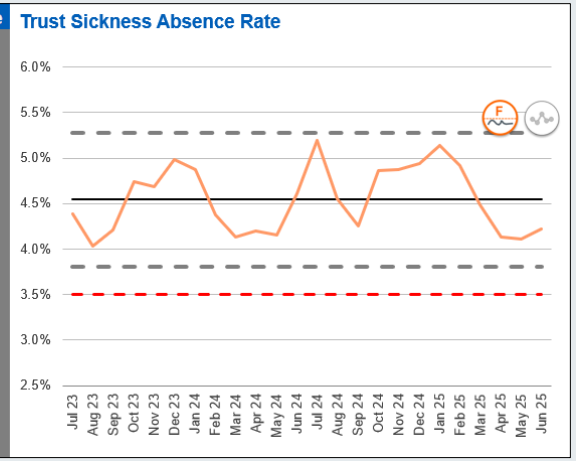
Whilst a small decline was seen in this metric throughout the year, the 2024 Annual Staff Survey results show a sustained result at 59.6%.

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
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%
May 25	4.1%
Jun 25	4.2%



Staff % recommend the organisation as a place to work

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

Counter Measures

Sickness absence rose slightly in M3, from 4.1% to 4.2%, driven by an increase in long-term cases. To strengthen managerial ownership and capability, a focus of the Absence Management Working Group, July actions included:

- 62.5 hours of targeted on-site support from the People Operations Team in short-term sickness hotspots.
- 14 managers trained in mental health first aid, and 4 Health & Wellbeing Champions appointed to support early intervention in stress/anxiety/depression-related absence.
- Training at the Clinical Lead Network on the sickness absence process for Medical staff, emphasising return-to-work interviews.
- Planned MHFA training in August for newly appointed Clinical Teaching Fellows ahead of supporting the 2025/26 student cohort.

- Q2 Pulse Survey results indicate a decline in staff recommending the organisation as a place to work, falling to 50.6%. Detailed analysis will follow in late August to inform targeted engagement actions.
- The 2025 Staff Survey launches in September with a coordinated Group-wide campaign to maximise participation and standardise the approach across the Care Organisations.
- The Trust's fifth annual 'Great West Fest' takes place on 6th September, offering an opportunity for 4,500 staff and families to attend. Promotion will continue in the lead-up to support engagement ahead of the survey launch.
- The Staff Excellence Awards were held in July, recognising the achievements from colleagues across the Trust and celebrating 11 winners nominated by colleagues and patients.

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.

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 has been a longstanding issue in the NHS, the GWH NHS Staff Survey results 2024 highlights highlight that 18.6% of Ethnic and Minoritized staff have experience discrimination compared to 6.7% 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

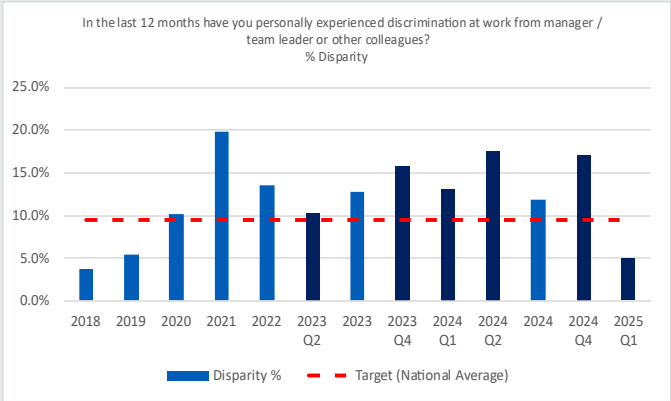
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

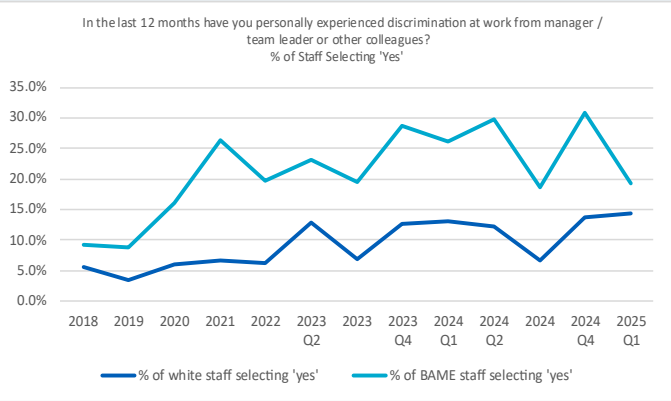
The Trust ambition in 2023 was to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

Disparity has improved in the 2024 staff survey results, reducing from 12.7% in 2023 to 11.9% in the 2024 Staff Survey – although remains above the national average of 9.4%.

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

- Expanding Awareness & Access – EDI Champions and volunteers distributed mentoring, EDI Champions, and Safe to Speak leaflets to 46 staff rooms across the Trust and Commonhead's open plan office (22 July). Wider distribution at the Orbital is planned for early August to further extend reach.
- Engagement – The COO and CNO conducted a Go & See visit to Beech Ward, engaging directly with staff, including internationally educated nurses who have reported harassment and abuse from patients. Insights from this and other engagement activities will be reviewed by the Board in January 2026.
- Direct Staff Support – A new online booking page is live via the EDI intranet page, enabling staff to schedule one-to-one appointments for advice and guidance from the EDI Lead.
- Strategic Reporting & Planning – The draft EDI and Health Inequalities Annual Report (including Workforce Disability Equality Standard and Workforce Race Equality Standard data) will be presented to TMC and P&C in August. These insights will inform the 2025/26 action plan, with discrimination, harassment, bullying, abuse, and equal opportunities identified as priority areas for improvement across all staff groups.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

For M04 2025/26 the Trust has an adjusted deficit position of £7.6m, which represents a £7.6m adverse variance to plan.

Income is £1.6m behind plan. Commissioner income accounts for a £1.8m adverse position, driven by the removal of deficit funding (£3.2m). There are favourable positions on high cost drugs (£0.5m), depreciation income (£0.2m), vaccination income (£0.2m) - all offset by cost. Note that ERF is £0.1m ahead of budget (although the budget is not profiled - when profiling is considered, performance is £0.3m behind budget). Activity at the end of M04 was £1.4m lower than the scenario 2a plan which is a deterioration since June. July activity plan is £1m higher than in Q1 and performance vs plan worsened by £1m. The Trust is now broadly in line with the commissioner affordability cap for M04, having previously been £0.7m over. Other income is £0.2m ahead of plan, with an underperformance against private patients offset by gains on education funding. It should be noted that if the Trust were receiving deficit funding, the overall variance to plan would reduce to £4.4m, reflecting the tangible gap the Trust needs to bridge.

The pay position is £3.9m adverse to plan, with undelivered efficiency savings accounting for £2.9m. This is net of £0.2m of run rate savings relating to the closure of escalation areas and agency framework savings. The pay position also includes £0.2m of industrial action costs and £0.7m of accrued additional pay award uplift, offset by prior year gains of £0.5m. The remainder of the variance is due to the use of ongoing temporary staffing spend, particularly in front door areas. Work focussing on reducing pay spend, particularly temporary staffing, is beginning to deliver. Monthly run rate has reduced by £0.3m from M2, driven by nursing bank reductions. Non-pay is £2.0m adverse to plan. Undelivered CIP (net of £0.3m of run rate savings) accounts for £2.1m while drugs are £1.1m adverse, £0.8m of which relates to passthrough drugs and offsets the £0.6m favourable income position. The net driver of the drugs overspend is PbR drugs. Offsetting this are £0.7m of prior year benefits and a further £0.5m of underspends across outsourcing, education and finance related costs. Non-pay savings are focussing on areas where run rate is trending upwards, along with broader grip and control measures such as clinical supplies and drug usage 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 posters have been placed in ward and clinical store cupboards to drive awareness of cost control. These will be reported on and measured as a breakthrough objective for 2025/26.

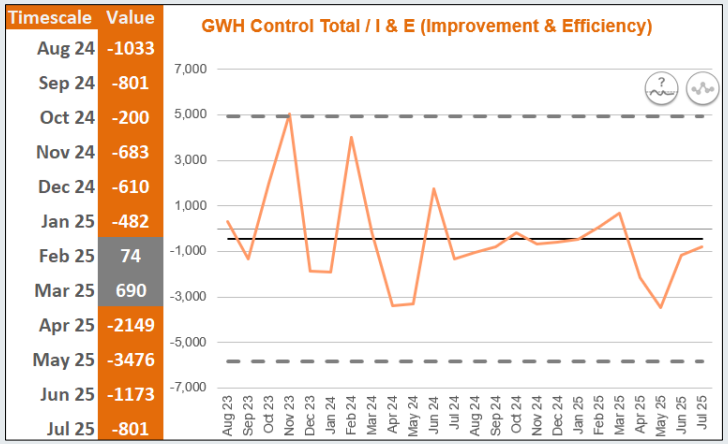
Key to breaking even with plan in 2025/26 is delivery against the efficiency savings target of £32.4m. At M04 the Trust has delivered £4.5m against a target of £10.6m, giving a shortfall of £6.4m. However, the Trust has also delivered £0.9m of run rate savings. Divisions and services must focus on finding 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
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	-3476
Jun 25	-1173
Jul 25	-801



Counter Measures

- Efficiency savings were £1.0m below target in month. Actual savings delivered were £1.6m against a plan of £2.6m. Pay was £0.7m under plan and non-pay £0.5m. Recurrent delivery was 54% in month and is 64% year-to-date. Note that the Trust has also made run rate savings of £1.8m at M04 relating to prior year benefits transacted in-year and the closure of escalation areas. 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

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.

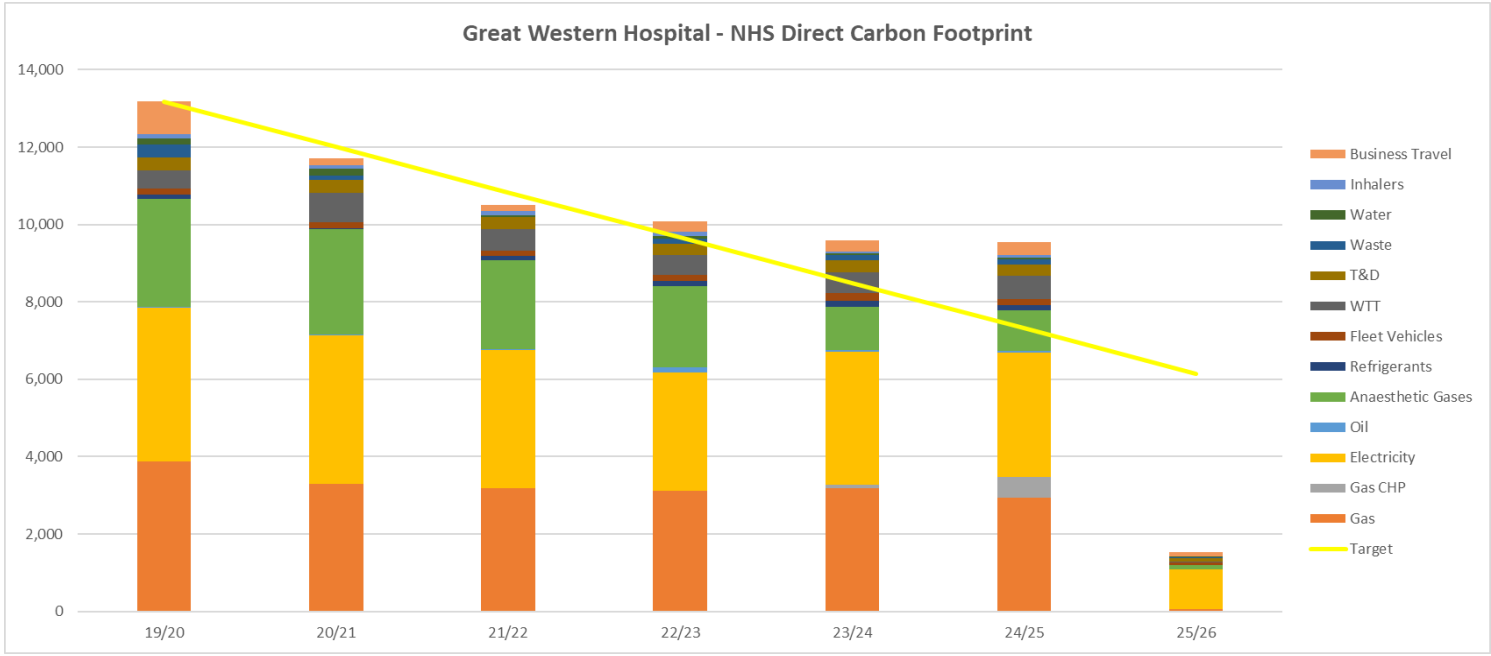
Great Western Hospital's 2024-2025 Carbon Footprint:

Last year Great Western Hospitals saw a small decrease in the Trusts' Direct Carbon Footprint of -0.57% compared to the 2023-2024 Carbon Footprint. We saw a reduction in gas (-7.7%), Electricity (-6.5%), Anaesthetic Gases (-5.89), Refrigerants (-23%), Fleet Vehicles (-15%), T&D (-4.7%), Water (-13%).

However, the Trust had an increase emissions in the following areas, Gas CHP (+516%) , Oil (+2.3%), WTT (+12%), Waste (+2.3%), Inhalers (+19%) and Business Travel (+16.7%)

Note:
Gas CHP usage in 2024-2025 was up by 2,431,005 kwh which reflects the rise in carbon emissions. Data for the latest financial year 2024-2025 has been confirmed and the data for 2025-2026 is draft and only shows data for quarter 1 (April – June 2025).

Simon Wade
Chief Financial Officer



Counter Measures

Great Western Hospitals NHS Foundation Trust's Green Plan for 2025-2028 has been approved. 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.

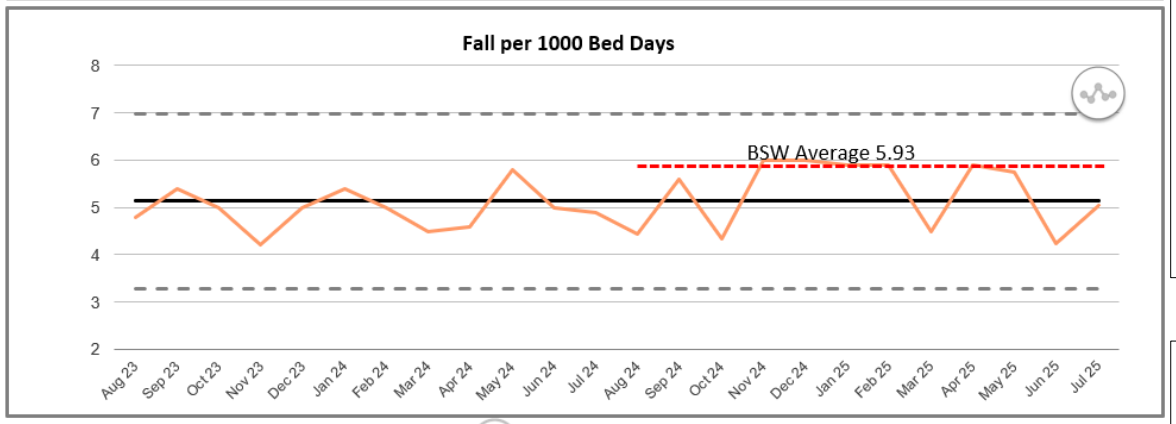
Please see the Green Plan for the full list of actions proposed.

2025/26 Breakthrough Objectives

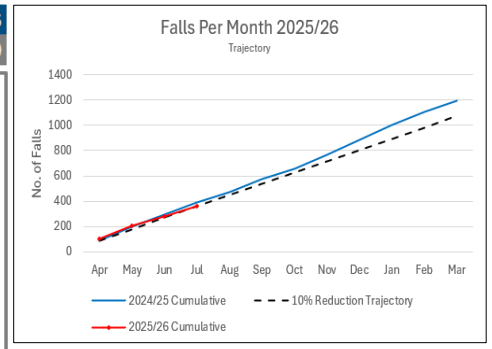
Reducing Falls & Falls With Harm

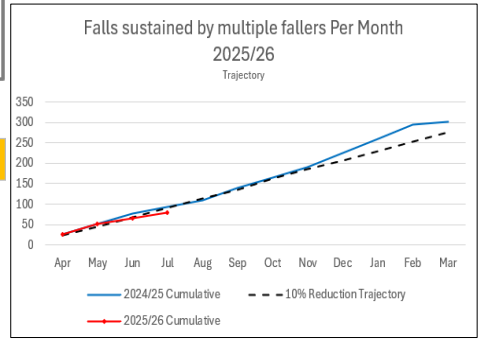
Great Western Hospitals NHS Foundation Trust

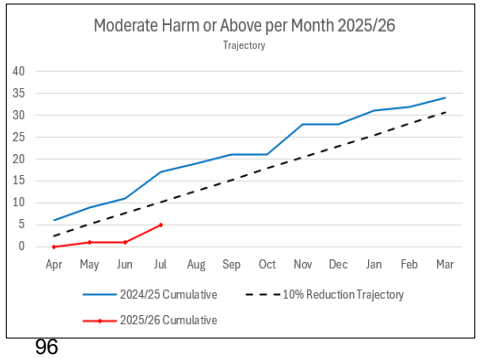
Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
4.4	5.6	4.3	6.0	6.0	5.9	5.9	4.5	5.9	5.8	4.2	5.0



Common cause - no significant change







Understanding the Data

Falls per 1000 bed days will be monitored quarterly to provide benchmarking data. There has been a decrease 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

The number of falls in month is 87 which has increased from the 71 reported in June. Four falls resulted in moderate harm or above for July an increase from June that had no patients experiencing moderate harm or above following their fall.

Falls sustained in patients who have fallen more than once has remained the same as June with six in month, although there is a steady downward trend overall. Since May 2025, 73 falls cases have been reviewed at a weekly falls panel, revealing key themes that will be taken forward across quarter two and monitored through the A3 meetings

Improvement Actions completed:
Training on the incident reporting and the debrief process for staff has taken place on one ward. This also includes asking the patients to recall what happened to ensure a round picture of the events.

A relaunch of stay in the bay has been completed with posters and badges in all areas. This is to raise awareness of the requirements from the policy regarding handing over the responsibility of the enhanced care role prior to leaving patient (e.g during shift change, breaks etc).

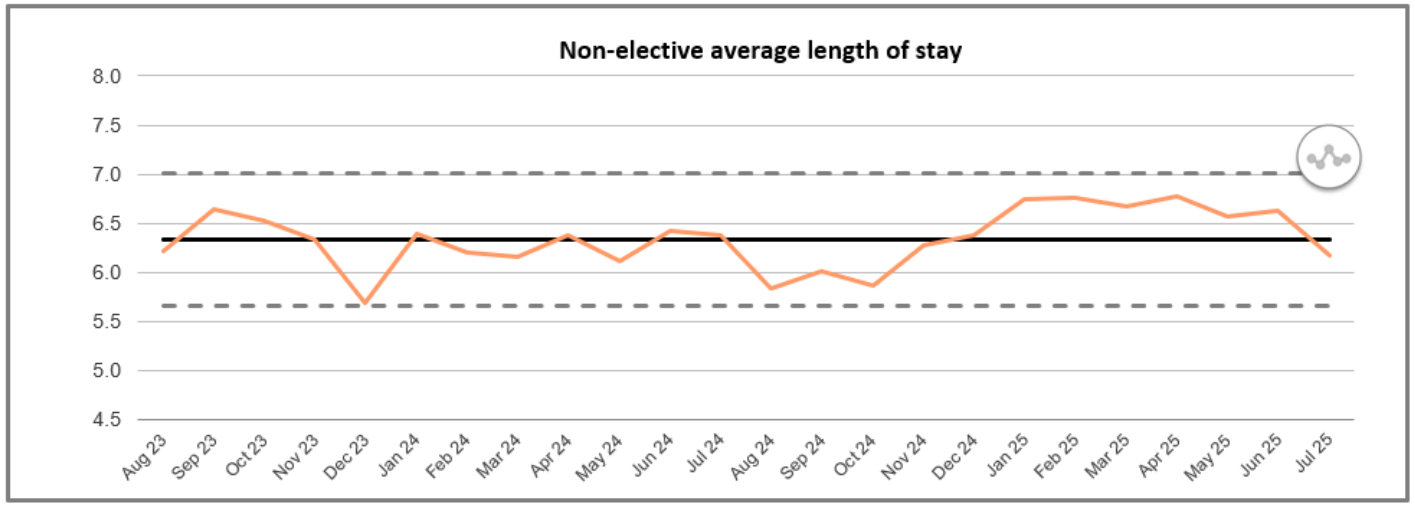
Learning from a recent inquest has been presented Trust wide. This focused is on raising awareness of contacting families following a fall. To further strengthen the message there have been changes to the LOOK/FEEL/MOVE post fall training, in the Incident reporting, debrief toolkit, and in Clinical Practice Educator training on the wards.

2025/26 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Non-elective average length of stay

Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
5.8	6.0	5.9	6.3	6.4	6.7	6.8	6.7	6.8	6.6	6.6	6.2



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 improved and reduced to 6.2 days in July, now tracking 0.2 days lower than the baseline period in July 2024. 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 key performance indicator of 33% discharges before midday.

Risks

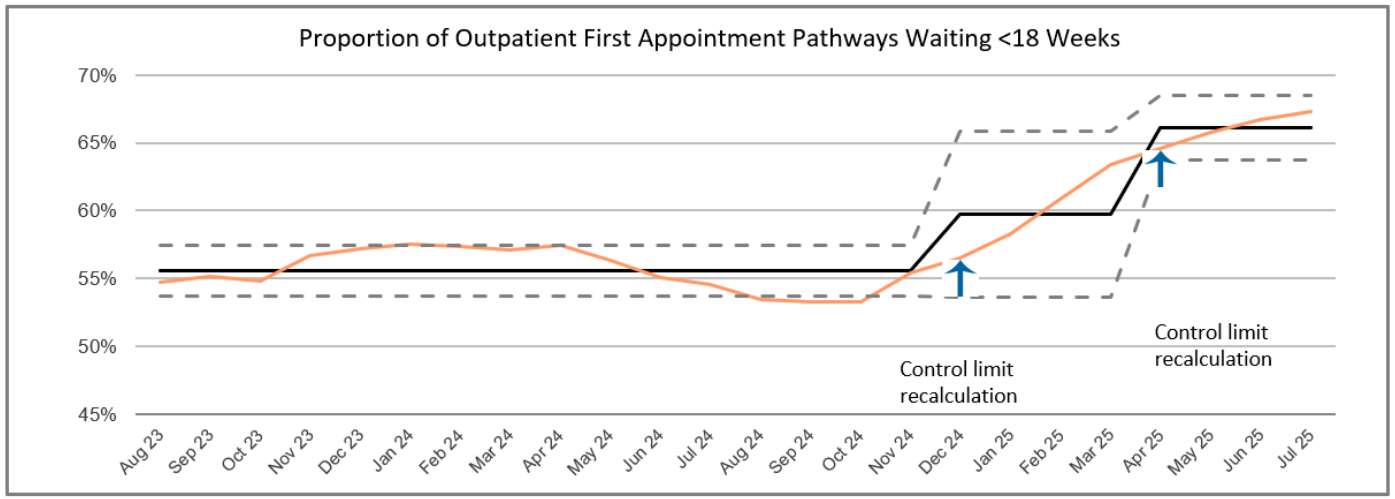
There is a risk that high hospital occupancy leads to poor patient flow through the hospital which impacts on the safe delivery of care. High occupancy resulting in delays to offloading ambulances (risk 731) , overcrowding in ED / ED majors (690) and the use of temporary escalation spaces to deliver 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

Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
53%	53%	53%	55%	57%	58%	61%	63%	65%	66%	67%	67%



Special cause - improving

Performance

The performance has improved to reach the 67% interim milestone target set by the workstream in April 2025. The Trust is now exceeding the 5% increase on the November baseline (55%) as well as the milestone.

16 of the 27 specialties are exceeding the national target of 72%. The workstream have set the next milestone target to align with the national 72% for the trust.

From July, the composition of the working group has been expanded to include specialties that were previously out of scope.

To further enhance performance and meet the new stretch target, a digital solution will be implemented in July to support duplication within straight-to-test pathways. Additionally, the clinic room sub-group will explore opportunities to increase new slot capacity through regional benchmarking.

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 72% 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

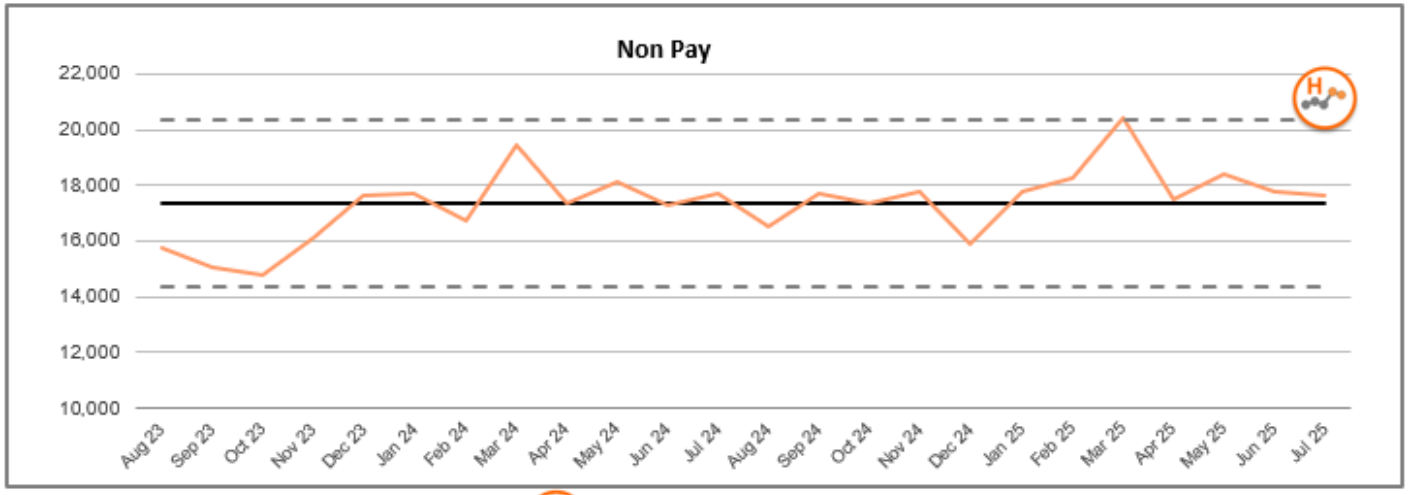
- Administrative capacity to build and support new pathways may result in delays to implementation or pausing of this sub workstream.
- Capacity Constraints: If there is insufficient capacity to handle the increased demand for early appointments, it could delay the overall process and hinder the achievement 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.
- Impact of onoging resident doctor industrial action and reduction in Outpatient and Elective capacity.

2025/26 Breakthrough Objectives

Non-Pay run rate stabilisation and reduction

Great Western Hospitals NHS Foundation Trust

Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
16549	17727	17381	17799	15918	17764	18289	20422	17485	18390	17782	17611



Special cause - concern

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 M04 the Trust has delivered £4.3m of actual savings, leading to an under delivery of £6.4m. 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

M04 costs were £0.2m lower than M03 due to non-recurrent prior year benefits transacted in-month totalling £0.6m), offset by higher drug, outsourcing and education & training 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. Posters have been positioned in ward/clinical stock areas showing top 10 items purchased. More information will be added over the coming weeks and months to heighten awareness. 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:

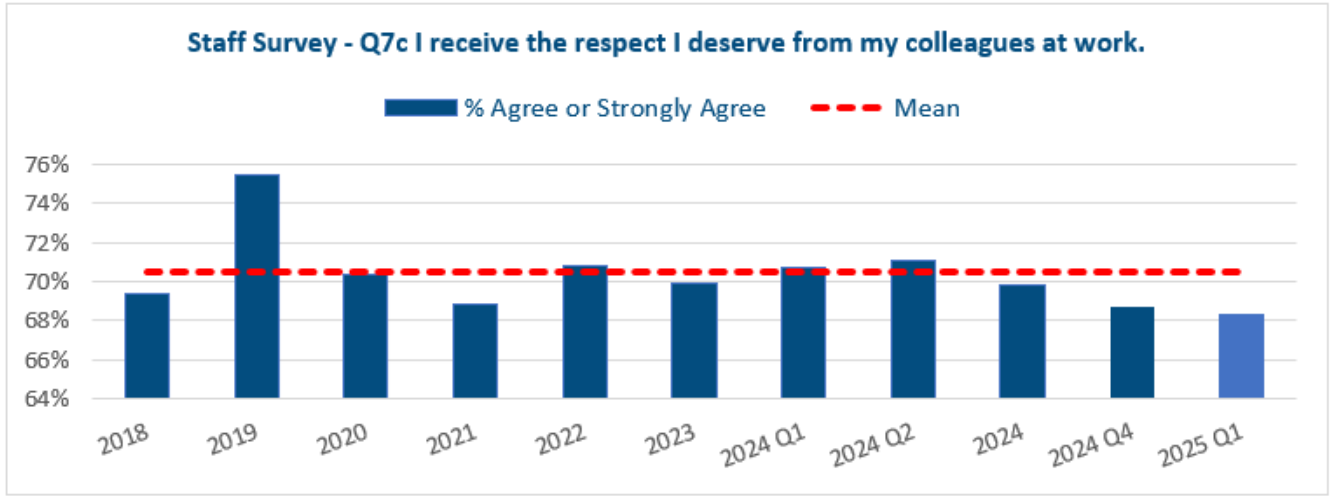
a) Necessary resource commitment (time and staff) from affected departments (specialties, Procurement, Finance)
b) External factors such as inflation pushing costs further beyond the funding envelope
c) Lead times and/or group held contracts preventing quick release of costs
d) System limitations in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

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%	68.30%



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

Leadership Conference & Clever Together
Work continues on embedding values and behaviours, with a finalised framework and launch plan in preparation for October 2025. This follows engagement at the Leadership Conference and through Clever Together, ensuring the approach reflects staff input and supports a respectful workplace culture.

Healthcare Support Worker (HCSW) Engagement
The first HCSW Forum was held on 18th July, with monthly meetings now scheduled to strengthen the HCSW voice and involvement in respect-related initiatives. An A3 is being developed to understand root causes of issues, and a joint Ward Manager/HCSW away day is planned for August to build collaboration and address challenges.

Never OK Campaign
The Task & Finish Group met on 29th July to review information from 226 staff who engaged with Wiltshire Police during the relaunch, and to agree draft terms of reference. Further campaign promotion was held in the atrium on 30 July to raise awareness and encourage reporting of unacceptable behaviours.

Risks

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

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Apr-25	May-25	Jun-25	Jul-25	Trend
Concerns and Complaints	No. of concerns received	SPC		357	317	346	431	
IP&C	C.Diff	4.50 (Int)		5	9	6	5	
	MSSA	1.92 (Int)		2	4	1	5	
	E.coli	7.50 (Int)		10	9	9	6	
FFT	Inpatients Positive Responses	90.2% (Int)		88.8%	89.3%	92.8%	88.4%	
	Daycases Positive Responses	95.0% (Int)		94.9%	92.0%	94.1%	93.1%	

Performance & Counter Measure

In July, the number of concerns received by the PALS service rose to 431, the highest volume seen to date. The rise in concerns reflects persistent themes around patients requesting updates or information, about referrals or outcomes. The PALS team continues to provide thematic information and highlight actions needed, supporting services to respond more effectively.

We have seen a drop in overall Family and Friends Test (FFT) response rates for both inpatients and day cases this month. This is in part due to unprocessed cards by our current supplier, impacting reported scores. An urgent procurement process is required to provide a sustainable solution.

C. diff numbers fell for the second month running but remain above threshold. Methicillin-Sensitive Staphylococcus Aureus (MSSA) numbers have increased in month to five (one in June). The suspected source of infection is different in each case, although a peripheral line has been confirmed as present in all cases and confirmed as the source in one case. In response a review of peripheral line care and development of more robust guidelines is being completed.

Risks

Procurement of a new Friends and Family Test supplier has been delayed leading to a risk that we will have no FFT collection and reporting from October. The risk has been escalated.

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	Apr-25	May-25	Jun-25	Jul-25
Harm	Patient safety incident investigation	SPC		1	3	2	5
	No. of Falls in month	SPC		104	104	71	87
	No. falls with moderate harm or above	SPC		0	1	0	4
	Medication incidents with moderate harm	SPC		3	1	1	8
	Pressure Ulcer (Hospital Acquired)	SPC	L	6	10	18	5
	No. of complaints received	SPC		44	71	67	81
	Number of reopened complaints	SPC		3	5	6	6
IP&C	MRSA	0 (Int)	?	0	0	0	0
	Klebsiella	2.17 (Int)	?	2	1	3	1
	Pseudomonas	1.75 (Int)	?	2	1	1	3

Performance & Counter Measure

There were five Patient Safety Incident Investigations (PSII) reported in the month of July. There are 27 PSII's in progress with 17 overdue against Trust internally set timelines. Five are being managed by external investigators, two of which are due to be presented for discussion at the next review meeting. Work continues to support investigators with guidance tailored to the investigation they are undertaking.

The number of falls in month is 87 an increase from 71 in June. There are four falls, all in different wards, that have resulted in the patient experiencing moderate harm or above in month. Each fall will be reviewed as part of the fall's improvement review process.

Hospital-acquired pressure ulcers decreased in month to five. The lowest point reach in the last 12 months.

There were eight medication incidents recorded as moderate harm or above. All are under review and the level of harm is therefore subject to change.

We have seen some improvement in response rates; however, the number of complaints open in July has risen from 67 to 81. The number of reopened complaints remains the same as last month at six, which is broadly in line with the trend seen across Banes, Swindon, Wiltshire as a whole.

There have been no Methicillin-resistant Staphylococcus aureus (MRSA) cases so far in 2025/6.

There has been a decrease in Klebsiella and this remains under trajectory. There has been an increase in Pseudomonas in month. In two of the cases the primary source of bacteremia has been identified as an upper urinary tract, both patients presented with a urinary catheter.

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. Patients are currently directed from our website to contact the PALS team with any additional needs or challenges as an interim measure.

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Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Apr-25	May-25	Jun-25	Jul-25
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)	P	100.6%	100.3%	99.2%	95.9%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	P	107.6%	109.1%	102.8%	113.0%
FFT	Overall response rate (%)	30.3% (Int)	?	39.1%	25.5%	44.6%	28.2%
	Positive response (%)	90.0% (Int)	?	90.6%	82.8%	93.7%	87.7%
	ED & UTC Response Rate	18.2% (Int)	?	20.5%	21.3%	19.5%	19.3%
	ED & UTC Positive Responses	79.4% (Int)	?	79.9%	77.4%	80.1%	75.6%
	Inpatients Response Rate	26.9% (Int)	?	32.0%	26.9%	34.4%	26.7%
	Daycases Response Rate	27.1% (Int)	?	31.6%	31.2%	33.4%	26.7%
	Outpatients Positive Responses	97.0% (Int)	?	97.5%	71.4%	98.6%	98.9%
	Maternity Response Rate	46.3% (Int)	?	100.0%	100.0%	43.5%	27.1%
	Maternity Positive Responses	91.8% (Int)	?	95.8%	93.6%	94.0%	94.2%

Performance & Counter Measures

Safe Staffing fill rates has remained above the National target and are within safe parameters.
We have seen an overall drop in FFT response rate. The main area of decline is maternity services. Although the maternity SMS function has now been reinstated, embedding the use of Badgernet is continuing and is likely to be impacting results. In addition, failure of our current supplier to process cards has impacted our results.
Overall positive responses for the trust have dropped slightly with declines in ED/UTC and maternity impacting this.

Concerns remain around FFT provision from October due to delayed procurement process.

Improvement Actions:

- FFT facilitator supporting clinical teams to review data & themes
- Improving Together team now using FFT feedback proactively in all training sessions and as part of driver setting
- A new survey has been launched specifically aimed at carers of patient with a dementia diagnosis. The survey is being completed on inpatient wards and results will feed into the dementia strategy and carers committees to inform where improvements in practice are required.
- The Emergency department have commenced a patient experience A3 improvement project with the aim of improving communication. Staff are currently reviewing the barriers to communication and suggesting ideas that could be contributing so that actions can be identified.
- Our Health Care Support Workers and Clinical Practice Educators have focussed their recent training and education on improvements around personal care and hygiene and includes training related to patients' personal assessments.

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Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-25	May-25	Jun-25	Jul-25	Trend
RTT	No. of >=18 weeks waiters		H	21678	22320	23234	24024	
	No. of >=52 weeks waiters		H	816	764	679	707	
DM01	No. of patients on DM01 waitlist			8092	8087	8273	One month behind	
	DM01 performance %	99% (Nat)	F	84.8%	85.0%	84.3%	One month behind	
	DM01 6 week wait breaches		H	1230	1214	1298	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	?	70.9%	69.7%	78.2%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	93.2%	90.3%	87.4%	One month behind	
	% Cancer 2 week wait	93% (Nat)		47.3%	53.2%	50.9%	One month behind	

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

Performance & Counter Measure

Diagnostics

July's validated DM01 performance showed a increase in performance from 84.3% in June to 86.4%. This is due to recovery from the issues with MRI and CT having unexpected down time and sickness in NOUS reducing activity in May. The number of patients on the waiting list has increased by 8 to 8,281. There are now 1,293 patients waiting over 6 weeks vs 1298 in June.

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 2,969 on the waiting list and 630 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

69.0% of the 62-day breaches were with the Plastics, Colorectal & Urology pathways.

31D performance fell short in June due to capacity in the Skin pathways, accounting for 13 of the 30 pathway breaches: Outpatient capacity in Plastics (2) and Derm(11) were the main contributors. 7 Breast pathways and 5 Colorectal pathways breached due to Elective Capacity.

Cancer waiting times for first appointment remain below standard. Skin is the largest contributors with 46.7% of all breaches. Outpatient capacity was the main reason for breaches, being responsible for 76.1% of breaches.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-25	May-25	Jun-25	Jul-25	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	69.6%	70.3%	69.0%	68.9%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	9.0%	8.5%	5.6%	5.6%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	47.6%	47.9%	49.2%	50.8%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	17.8%	17.4%	10.8%	11.1%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	91.9%	92.3%	89.1%	87.6%	
	Emergency Care - AED - Median Stay	240 (Int)	H	306	295	280	240	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		2575.72	2715.92	1150.56	1422.47	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		816	804	429	502	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		42.9%	43.6%	21.9%	23.6%	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4-hour performance (type 1 and 3) remained consistent at from 68.9 (down 0.1%). This is 9.1% below the 25/26 national target. The reduction in overall performance relates to type 3 performance consistently below 90% over last few months (previously sustained at 95% or above) and Type 1 consistent at around 45%.

Total % over 12 hours (Type 1) remained reduced although up 0.3% from last month at 11.1%. This is still over target but reflects ongoing improved onward flow during July. Any prolonged length of stay in ED leads to overcrowding and subsequent delays in ambulance offload.

Ambulance handover delays over 15 minutes increased from 1151 hours to 1422 hours (phase 1 breakthrough objective = 2100 hours) - this is a direct result of onward flow creating capacity within the ED. Whilst up from last month, ED still had periods of handovers less than 15 minutes with several days best performing Trust in region.

Number of ambulance handovers over 60 minutes remains improved at 23.6%.

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 – 323 up to 27/7 (projected 371 for month) down on previous months around 200 patients. Patients continue to move through THP to facilitate offloads in July, as formal ED cubicle known to be shortly available.
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.

Risks

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-25	May-25	Jun-25	Jul-25
RTT	No. of >=78 weeks waiters	SPC	L	3	5	2	2
Cancer	% 28 day faster diagnosis	75% (Nat)		80%	77%	79%	One month behind
	No. of referrals received	SPC	H	1957	2022	2082	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.1%	0.1%	0.1%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5552	5509	5708	5851
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	83.1%	87.4%	88.7%	87.8%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		54.7%	59.2%	61.8%	60.7%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		51.5%	58.3%	49.3%	57.1%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	203	201	213	208
	Emergency Care - UTC - Median Stay	240 (Int)	P	155	150	171	158

Performance & Counter Measure

ED, CEU & UTC

Patient attendances continue to be higher than those seen since May 2024 – 11,580.

ED – 4705, CEU – 820, UTC – 6055

Triage performance for ED for 15-minute standard 61%. Triage within 30 minutes is 79% (meantime 19 minutes) - 1% decrease.

Triage in CEU is 63% for 15-minute assessment and 87% within 30 minutes – meantime 15 minutes. This is the best performance since the creation of CEU in November 2024

For Type 3 (UTC only) triage performance within 15 minutes has improved 8% from 49% to 57%. Triage within 30 minutes is 79% (meantime 20 minutes) - improved.

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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Apr-25	May-25	Jun-25	Jul-25
ED	Total Number of Ambulance Handovers	SPC		1902	1845	1959	2129
	Number of Ambulance Handover Over 15 Minute Waits	SPC		1648	1516	1413	1475
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	L	86.6%	82.2%	72.1%	69.3%
	Number of Ambulance Handover 30 Minute Waits	SPC		1251	1103	837	875
	Percentage of Ambulance Handover Over 30 Minutes	SPC	L	65.8%	59.8%	42.7%	41.1%
	Average hours lost to ambulance handover delays per day	SPC		86	88	38	46

Performance & Counter Measure

ED, CEU & UTC

Number of ambulance conveyances increased in July to 2129, an increase of 170 on June. This is the highest number of conveyances since data records from June 2024. in Despite this, onward flow is again reflected in average daily hours lost which was 46, whilst up slightly from June, down by 40 hours on previous months.

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	Apr-25	May-25	Jun-25	Jul-25
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		685	678	502	506
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		307	309	289	278
	Elective Patients Average Length of Stay (Days)	SPC	H	3.6	3.4	3.0	3.9
	Non-Elective Patients Average Length of Stay (Days)	SPC		6.8	6.6	6.6	6.2
	GWH Discharges by Noon (%)	SPC		16.5%	13.0%	16.7%	16.3%
	Number of Stranded Patients (over 14 days)	SPC		131	151	125	110
	Number of Super Stranded Patients (over 21 days)	SPC		72	92	75	61
	Adult general and acute type 1 bed occupancy	SPC		97.6%	97.3%	94.3%	98.6%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	H	18.3%	19.0%	19.3%	19.9%
	Proportion of patients discharged from hospital to their usual place of residence	SPC	H	95.88%	95.90%	96.33%	95.90%
	The Number of Patients in Temporary Escalation Spaces within ED	SPC		4	3	1	1
	Total adult general and acute Temporary Escalation Space beds occupied	SPC		23	19	7	3
	Total paediatric general and acute Temporary Escalation Space beds occupied	SPC		0	0	0	0
	Total Temporary Escalation Space beds occupied	SPC		23	22	7	3

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. Offloading onto hospital trolleys and one directional flow approach started in July.
- 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 August to expedite discharge as part of seasonal planning / bank Holiday preparation.

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	Apr-25	May-25	Jun-25	Jul-25
Use of Resources	Capital Expenditure (£'000)	SPC		1170	934	1087	901
	Pay (£'000)	SPC		27255	27304	27182	27046
	Non Pay (£'000)	SPC		17485	18390	17782	17611

Performance & Counter Measure

Capital spend at M04 is £4.1m against a plan of £6.5m, giving an underspend against plan of £2.4m. The underspend drivers are equipment replacement (£0.3m), EPR (£1.0m) with the remainder due to divisional related CDEL schemes.

M04 pay costs are £0.1m lower than M03 due to reduced medical agency and nursing bank spend as a result of tighter grip and control and lower escalation costs.

Non-Pay is £0.2m lower than M03 due to non-recurrent prior year benefits transacted in-month totalling £0.6m), offset by higher drug, outsourcing and education & training spend.

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 £6.4m shortfall on the Trust's efficiency savings programme at M04 is the key driver behind the £7.6m 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	Apr-25	May-25	Jun-25	Jul-25
Workforce	% of leavers within 1st year of employment	14.8% (Int)		10.3%	11.7%	11.6%	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 June to 11.6%, below the Trust KPI of 14.8%.
- The response rate for the Q2 Pulse Survey was 20.9%, an increase on the Q1 Pulse Survey (19.2%).

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

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend Vs Last Month	Trend Vs Jul-24
		Vacancy																	
	W	Vacancy Rate	%	7.00%	3.44%	3.82%	3.53%	3.31%	3.53%	3.44%	3.34%	3.06%	2.98%	4.28%	4.26%	4.18%	4.25%	↑	↑
	W	Vacancy Rate	WTE	-	186.71	207.11	191.29	179.89	192.27	187.54	182.32	167.40	162.89	215.93	215.09	210.64	214.60		
	W	All Nursing Vacancy	%	7.00%	0.96%	1.30%	0.64%	0.72%	1.49%	1.99%	1.78%	1.24%	1.01%	0.15%	0.06%	0.05%	-0.05%	↓	↓
	W	All Nursing Vacancy (Reg & Unreg)	WTE	-	25.61	34.47	17.00	19.26	39.90	53.22	47.73	33.37	27.15	3.52	1.47	1.23	-1.17		
	W	All Registered Nursing Vacancy	WTE	-	5.24	0.02	-27.25	-36.48	-28.09	-24.47	-24.01	-10.00	-8.16	-10.86	-7.52	-9.24	-10.35		
	W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	-11.35	-23.55	-47.80	-49.08	-41.52	-42.81	-41.32	-37.51	-33.85	-41.18	-38.96	-38.48	-40.30		
	W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	20.37	34.45	44.25	55.74	67.99	77.69	71.74	43.37	35.31	14.38	8.99	10.47	9.18		
	W	Medical Vacancy	%	7.00%	7.82%	10.39%	8.99%	7.84%	6.37%	7.36%	8.01%	8.92%	8.25%	8.31%	8.05%	8.10%	8.00%	↓	↑
	W	Medical Vacancy	WTE	-	58.44	77.65	67.20	58.64	47.53	54.93	60.01	66.79	61.77	61.95	59.95	60.35	59.64		
	W	STT/AHP Vacancy	%	7.00%	3.00%	2.30%	3.92%	4.31%	3.71%	2.28%	2.21%	1.67%	1.91%	8.27%	7.73%	7.09%	7.39%	↑	↑
	W	STT/AHP Vacancy	WTE	-	25.62	19.64	33.48	37.01	31.82	19.62	19.03	14.42	16.50	66.18	61.87	56.78	59.15		
	W	SMA Vacancy	%	7.00%	6.57%	6.44%	6.30%	5.55%	6.24%	5.10%	4.74%	4.51%	4.91%	7.55%	8.22%	8.26%	8.69%	↑	↑
	W	SMA Vacancy	WTE	-	77.04	75.35	73.61	64.98	73.02	59.76	55.55	52.82	57.47	84.28	91.80	92.28	96.98		
	W	Recruitment Time to Hire - AFC	Days	46.00	40.40	43.80	44.10	42.80	41.40	39.50	42.19	44.30	33.60	34.80	36.40	39.70	37.70	↓	↓
	W	Recruitment Time to Hire - Bank	Days	46.00	22.90	-	30.30	26.70	42.90	37.50	42.90	42.70	38.30	40.00	18.00	40.20	61.10	↑	↑
	W	Recruitment Time to Hire - Medical	Days	46.00	44.20	57.40	37.25	38.40	44.50	36.80	45.02	41.00	36.50	38.00	37.40	40.20	49.00	↑	↑
		Workforce Utilisation																	
	W	Establishment WTE	WTE	-	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	5,043.74	5,043.74		
	W	Substantive WTE	WTE	-	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	4,833.10	4,829.14		
	W	Additional Substantive WTE	WTE	-	9.23	6.30	7.64	9.62	13.99	11.26	12.96	13.66	16.45	11.97	11.84	9.79	9.54		
	W	Bank WTE	WTE	-	264.51	269.93	268.71	270.61	289.89	270.37	325.49	305.77	413.99	311.69	306.31	270.91	287.37		
	W	Agency WTE	WTE	-	25.00	25.62	13.89	23.84	25.72	38.68	39.05	31.77	64.42	48.54	54.27	45.68	44.12		
	W	Budgeted vs Worked WTE Variance	WTE	-	112.04	94.74	98.95	124.18	137.33	132.77	195.18	183.80	331.97	156.27	157.33	115.74	126.43		
	W	Actual Worked vs Budgeted %	%	-	102.06%	101.75%	101.82%	102.28%	102.52%	102.43%	103.58%	103.36%	106.07%	103.10%	103.12%	102.29%	102.51%		
	W	Total Workforce Cost £	£	-	£25.57M	£25.87M	£25.27M	£36.50M	£26.75M	£28.12M	£27.24M	£27.93M	£28.58M	£26.55M	£26.60M	£26.34M	£25.70M		
	W	Agency Spend as % of Total Spend	%	4.50%	1.94%	1.58%	1.01%	1.23%	1.64%	1.60%	2.52%	1.97%	2.14%	2.26%	2.40%	2.75%	1.82%	↓	↓
	W	Agency Spend £	£	-	£0.50M	£0.41M	£0.26M	£0.45M	£0.44M	£0.45M	£0.69M	£0.55M	£0.61M	£0.60M	£0.64M	£0.72M	£0.47M		
	W	Agency Target £	£		£0.49M	£0.47M	£0.46M	£0.44M	£0.42M	£0.41M	£0.39M	£0.37M	£0.36M	£0.20M	£0.19M	£0.18M	£0.17M		
	W	Agency Spend vs Target £	£ Diff	£0.00M	£0.01M	-£0.06M	-£0.20M	£0.01M	£0.01M	£0.04M	£0.30M	£0.18M	£0.25M	£0.40M	£0.45M	£0.55M	£0.30M	↓	↑
	W	Bank Spend £	£	-	£2.32M	£2.04M	£1.88M	£2.29M	£2.15M	£2.21M	£1.71M	£2.66M	£2.70M	£2.21M	£2.18M	£2.05M	£1.92M		
	W	Bank Target £	£		£1.96M	£1.88M	£1.81M	£1.73M	£1.65M	£1.57M	£1.50M	£1.42M	£1.34M	£2.90M	£2.56M	£2.22M	£1.88M		
	W	Bank Spend vs Target £	£ Diff	£0.00M	£0.36M	£0.15M	£0.07M	£0.56M	£0.50M	£0.64M	£0.22M	£1.24M	£1.36M	-£0.69M	-£0.38M	-£0.17M	£0.05M	↑	↓
	W	Registered Nursing Bank Fill	%	45.00%	85.23%	82.25%	85.50%	83.28%	84.19%	77.28%	83.99%	84.92%	85.52%	84.22%	90.84%	91.21%	84.35%	↓	↓
	W	Unregistered Nursing Bank Fill	%	70.00%	79.50%	77.63%	78.67%	71.95%	71.89%	65.05%	70.73%	74.37%	76.95%	76.35%	87.65%	85.20%	88.84%	↑	↑

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend Vs Last Month	Trend Vs Jul-24
		Retention																	
	W	All Turnover %	%	13.00%	10.47%	10.91%	10.70%	11.08%	11.14%	11.24%	11.08%	11.01%	11.26%	11.31%	11.16%	10.85%	-	↓	↑
	W	Voluntary Turnover %	%	11.00%	7.90%	8.66%	8.50%	8.80%	8.75%	8.78%	8.62%	8.48%	8.55%	8.41%	8.29%	8.13%	-	↓	↑
	W	Number of Leavers	Headcount	-	46	63	55	54	41	45	35	30	70	38	32	42	-		
	W	Number of RN Leavers	Headcount	-	14	14	8	13	13	14	9	8	12	8	8	11	-		
	W	Registered Nursing Vol Turnover	%	-	7.36%	7.70%	7.30%	7.39%	7.32%	7.47%	7.25%	7.28%	6.96%	6.51%	6.16%	6.01%	-		
	W	Number of Unreg Nursing Leavers	Headcount	-	6	10	13	12	8	12	1	5	9	6	10	9	-		
	W	Unregistered Nursing Vol Turnover	%	-	10.69%	11.10%	10.34%	10.87%	10.98%	10.97%	10.27%	9.77%	10.06%	9.45%	9.81%	9.21%	-		
	W	Leavers within 1st Year - Rolling 12 Month	%	-	9.57%	11.00%	10.62%	11.04%	9.68%	9.90%	9.02%	10.37%	10.94%	10.30%	11.68%	11.62%	-		
	W	Number of starters	Headcount	-	46	52	85	57	47	43	61	55	55	40	25	48	-		
		Absence																	
	D	Sickness Absence % Rolling 12 Month	%	3.50%	4.57%	4.57%	4.53%	4.57%	4.59%	4.59%	4.61%	4.65%	4.68%	4.68%	4.68%	4.65%	-	↓	↑
	D	Sickness Absence %	%	3.50%	5.19%	4.55%	4.26%	4.87%	4.88%	4.94%	5.14%	4.92%	4.49%	4.13%	4.11%	4.22%	-	↑	↓
	W	Long Term Sickness %	%	2.00%	2.50%	2.57%	2.12%	2.29%	2.26%	2.33%	2.12%	2.49%	2.22%	2.12%	2.09%	2.24%	-	↑	↓
	W	Short Term Sickness %	%	1.50%	2.69%	1.98%	2.14%	2.58%	2.62%	2.60%	3.02%	2.42%	2.26%	2.01%	2.02%	1.98%	-	↓	↓
	W	Sickness Absence Cost £	£	-	£850.4k	£755.3k	£727.5k	£873.5k	£860.3k	£866.9k	£897.5k	£773.1k	£815.5k	£681.0k	£702.2k	£685.5k	-		
	W	WTE Days Lost	WTE	-	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	6,159.6	6,117.3	-		
		Learning & Development																	
	W	Mandatory Training Compliance %	%	85.00%	92.42%	89.84%	89.85%	90.58%	89.79%	90.06%	90.27%	90.03%	90.03%	90.46%	90.94%	91.66%	91.60%	↓	↓
	W	Role Essential MT %	%	85.00%	94.14%	89.00%	89.52%	90.57%	88.86%	89.37%	89.79%	89.70%	89.86%	90.57%	90.95%	91.77%	91.95%	↑	↓
	W	CQC Safe MT %	%	85.00%	90.71%	90.88%	90.25%	90.58%	90.97%	90.95%	90.89%	90.45%	90.24%	90.33%	90.92%	91.52%	91.15%	↓	↑
	W	Bank-Only Mandatory Training Compliance %	%	85.00%	-	86.96%	82.88%	82.42%	84.73%	85.86%	83.96%	81.72%	80.81%	65.69%	64.67%	64.11%	73.77%	↑	↓
	W	Appraisal Compliance %	%	85.00%	84.88%	84.67%	84.09%	84.90%	84.29%	83.46%	84.51%	84.35%	84.40%	83.88%	81.56%	80.36%	80.08%	↓	↓
	W	Non Medical Appraisal Compliance %	%	85.00%	84.95%	84.71%	84.37%	84.94%	84.60%	83.81%	84.63%	84.44%	84.24%	84.15%	82.14%	81.04%	80.45%	↓	↓
	W	Medical Appraisal Compliance %	%	85.00%	84.40%	84.38%	82.07%	84.58%	82.09%	80.94%	83.68%	83.68%	85.48%	82.08%	77.82%	76.02%	77.75%	↑	↓

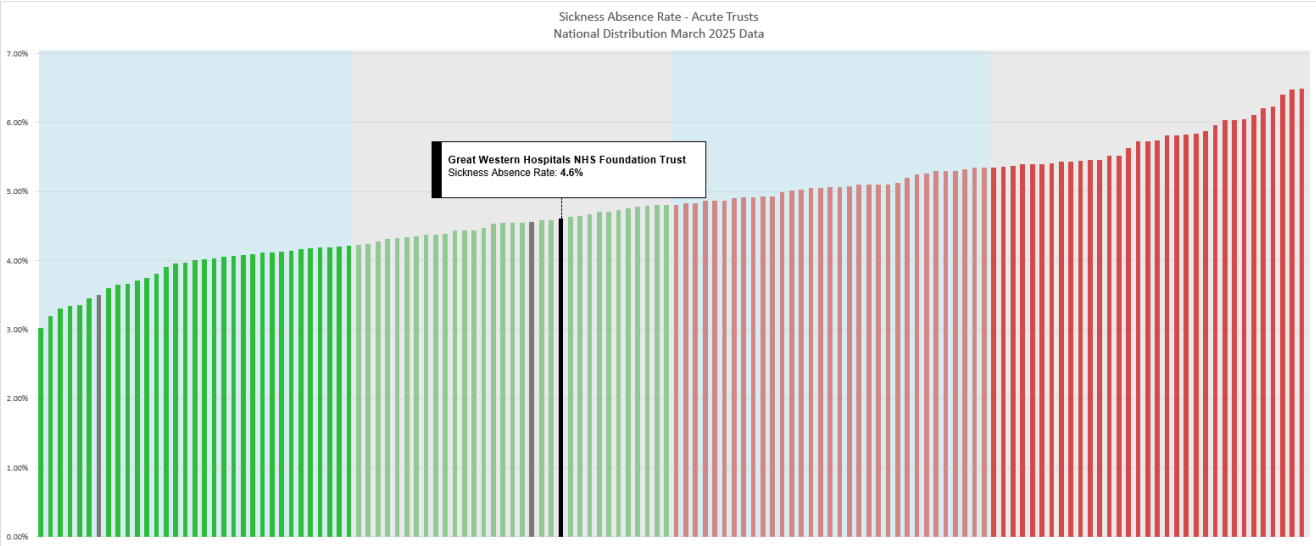
Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend Vs	
																		Last Month	Jul-24
		Demographics																	
	W	Staff in Leadership Roles % (B8a+)	%	-	4.29%	4.25%	4.21%	4.28%	4.30%	4.26%	4.29%	4.25%	4.27%	4.30%	4.36%	4.30%	4.20%		
	W	Staff in Leadership Roles WTE (B8a+)	WTE	-	273.00	273.00	271.00	276.00	277.00	275.00	278.00	276.00	277.00	255.00	259.00	256.00	252.00		
	W	% of Leadership Roles who are Female (B8a+)	%	-	70.33%	70.70%	70.11%	70.29%	70.40%	70.18%	70.50%	69.93%	69.68%	68.24%	68.34%	67.58%	67.86%		
	W	% of Leadership Roles who from BME (B8a+)	%	-	6.59%	6.23%	6.27%	6.16%	6.50%	6.55%	6.47%	6.52%	6.50%	5.88%	6.18%	5.47%	5.56%		
	W	Staff in Leadership Roles % (B8c+)	%	-	0.96%	0.93%	0.93%	0.90%	0.93%	0.93%	0.94%	0.94%	0.92%	1.01%	1.03%	1.01%	1.00%		
	W	Staff in Leadership Roles WTE (B8c+)	WTE	-	61.00	60.00	60.00	58.00	60.00	60.00	61.00	61.00	60.00	60.00	61.00	60.00	60.00		
	W	% of Leadership Roles who are Female (B8c+)	%	-	57.38%	58.33%	56.67%	56.90%	55.00%	55.00%	55.74%	54.10%	53.33%	53.33%	52.46%	51.67%	53.33%		
	W	% of Leadership Roles who from BME (B8c+)	%	-	3.28%	3.33%	3.33%	3.45%	5.00%	5.00%	4.92%	4.92%	6.67%	5.00%	4.92%	5.00%	5.00%		
	W	% of Leadership Roles who are disabled (B8c+)	%	-	1.64%	1.67%	1.67%	3.45%	3.33%	3.33%	3.28%	3.28%	3.33%	3.33%	3.28%	3.33%	3.33%		
	W	Male % of Workforce	%	-	18.56%	18.48%	18.32%	18.40%	18.46%	18.51%	18.58%	18.61%	18.67%	19.33%	19.44%	19.51%	19.67%		
	W	Female % of Workforce	%	-	81.44%	81.52%	81.68%	81.60%	81.54%	81.49%	81.42%	81.39%	81.33%	80.67%	80.56%	80.49%	80.33%		
	W	BME % of Workforce	%	-	27.31%	27.53%	27.99%	28.30%	28.40%	28.46%	28.67%	29.29%	29.43%	30.08%	30.30%	30.65%	30.66%		
	W	White % of Workforce	%	-	64.84%	65.00%	64.54%	64.41%	64.30%	64.17%	63.94%	63.48%	63.22%	62.05%	61.76%	61.35%	61.27%		
	W	ER Cases Closed	Number	-	59	48	43	56	47	56	53	31	38	52	43	48	40		

Our People



Performance & Counter Measure

The Trust Sickness Absence Working Group continues to drive improvements, with strong countermeasures and shared learning shaping practice across the organisation:

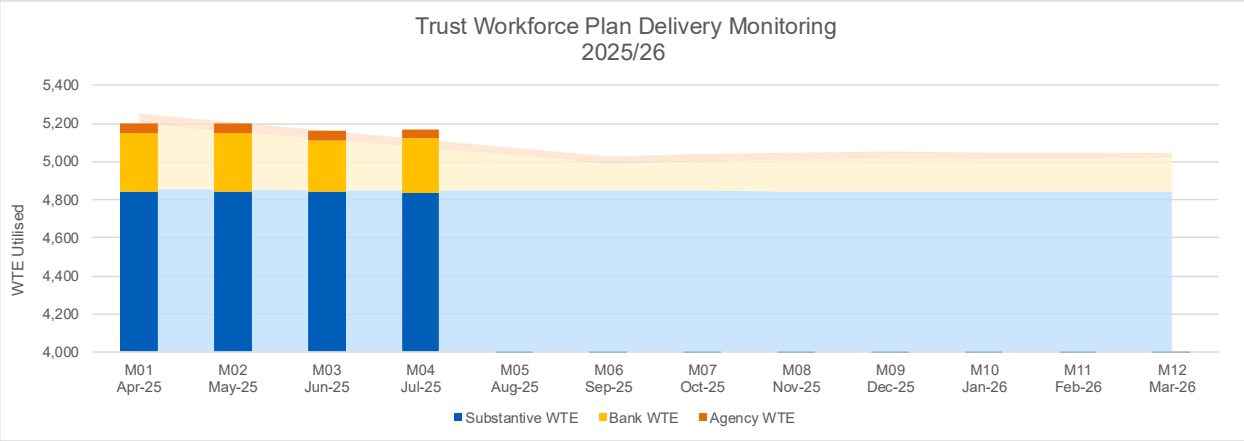
- **Health Passport rollout** – The editable Health Passport, supporting staff with disabilities, long-term conditions, mental health issues, or learning disabilities/difficulties, is underway. A Trust-wide communications plan is being developed during August ahead of the formal launch.
- **Targeted health & wellbeing support** – Following feedback from the Trust Absence Lead at the monthly senior nursing meeting, a tailored support package is being developed for three high-pressure teams identified by the Chief Nurse.
- **Group-wide long-term conditions policy** – Work has begun to create a new policy for supporting staff with long-term conditions, drawing on regional best practice. Collaboration across the Group's Care Organisations is commencing in August.

Strong results are already being seen in some areas. Surgery & Planned Care recorded a reduction in absence from 4.1% to 3.9% in June. Measures behind this improvement — including mandated phone calls when staff report absence (with an early focus on return-to-work), consistent completion of return-to-work meetings, and a two-week pause on bank shifts post-absence to aid recovery — have had a significant positive impact on a former hotspot area and are being shared for wider adoption.

By contrast, Corporate Services saw a spike in absence during June, rising from an average of 3.4% to 4.2%, driven in part by long-term sickness cases. This area remains a focus for targeted support as Trust-wide initiatives are embedded. Analysis is also underway to review if there is any impact from vacancy control measures and Corporate redesign work, triangulating vacancy levels against sickness absence and turnover rates.

Our People

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**	**5,159**	5,170	0	0	0	0	0	0	0	0
	Variance	-53	-7	-5	50	-	-	-	-	-	-	-	-
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**	**4,843**	**4,839**	0	0	0	0	0	0	0	0
	of which Overtime	**12**	**12**	**10**	**10**	0	0	0	0	0	0	0	0
	Variance	-13	-11	-8	-11	-	-	-	-	-	-	-	-
Bank	Plan	347	306	265	224	*183*	*142*	157	165	174	176	178	180
	Actual	**312**	**306**	271	287	0	0	0	0	0	0	0	0
	Variance	-36	0	5	63	-	-	-	-	-	-	-	-
Agency	Plan	52	50	48	46	*43*	*41*	39	37	35	33	30	28
	Actual	**49**	54	**46**	**44**	0	0	0	0	0	0	0	0
	Variance	-4	4	-2	-2	-	-	-	-	-	-	-	-

Performance & Counter Measure

- In July, we utilised 5,170 WTE against a planned 5,120 WTE, resulting in an adverse variance of +50 WTE compared to plan and a month-on-month increase of 11 WTE from June. This rise contrasts with the reduction achieved in the previous month.
- The above-plan position was driven entirely by higher temporary staffing usage in M4. The largest contributor was Support to Clinical staff, where bank usage exceeded plan by +26 WTE. Medical & Dental also added pressure, with bank usage +12 WTE above plan and agency usage +6 WTE higher than expected. While Registered Nursing temporary usage remained favourable to plan (–33 WTE), the savings here were offset by the overuse in other groups.
- From July to August, to remain on plan we will need to reduce Bank usage by 104 WTE (from 287 WTE in July down to the August plan of 183 WTE) and Agency usage by 1 WTE (from 44 WTE in July to the August plan of 43 WTE). Achieving this reduction will require targeted actions to significantly scale back Bank shifts across all staff groups, with particular focus on those areas showing the largest variance to plan. Agency usage is already close to plan, but close monitoring will be required to prevent any increase while Bank reductions are implemented.

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.

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

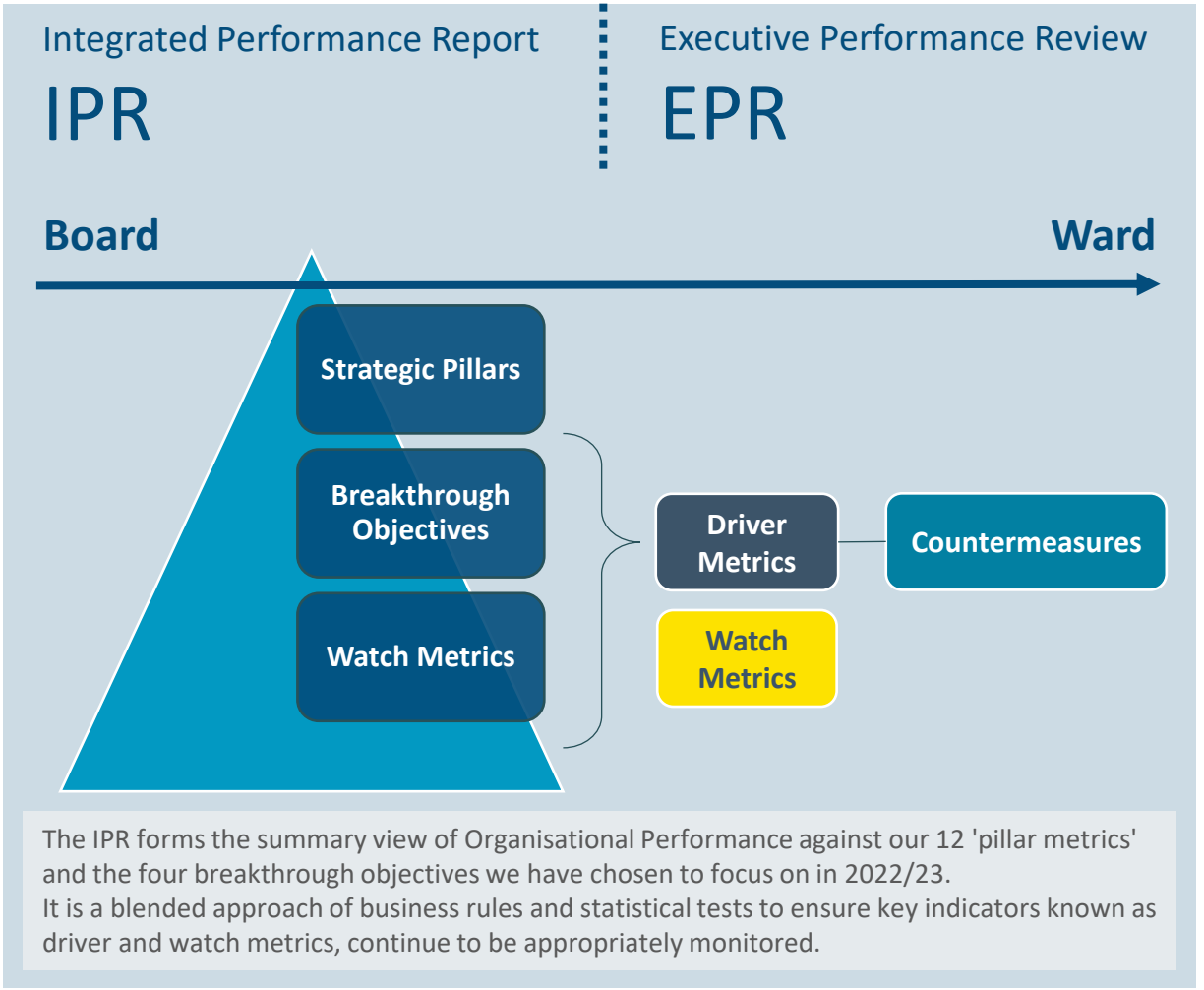
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

- 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

1 Our four strategic pillars

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

- 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

Continuous Improvement on Drivers

Performance Management on Driver & Watch Metrics

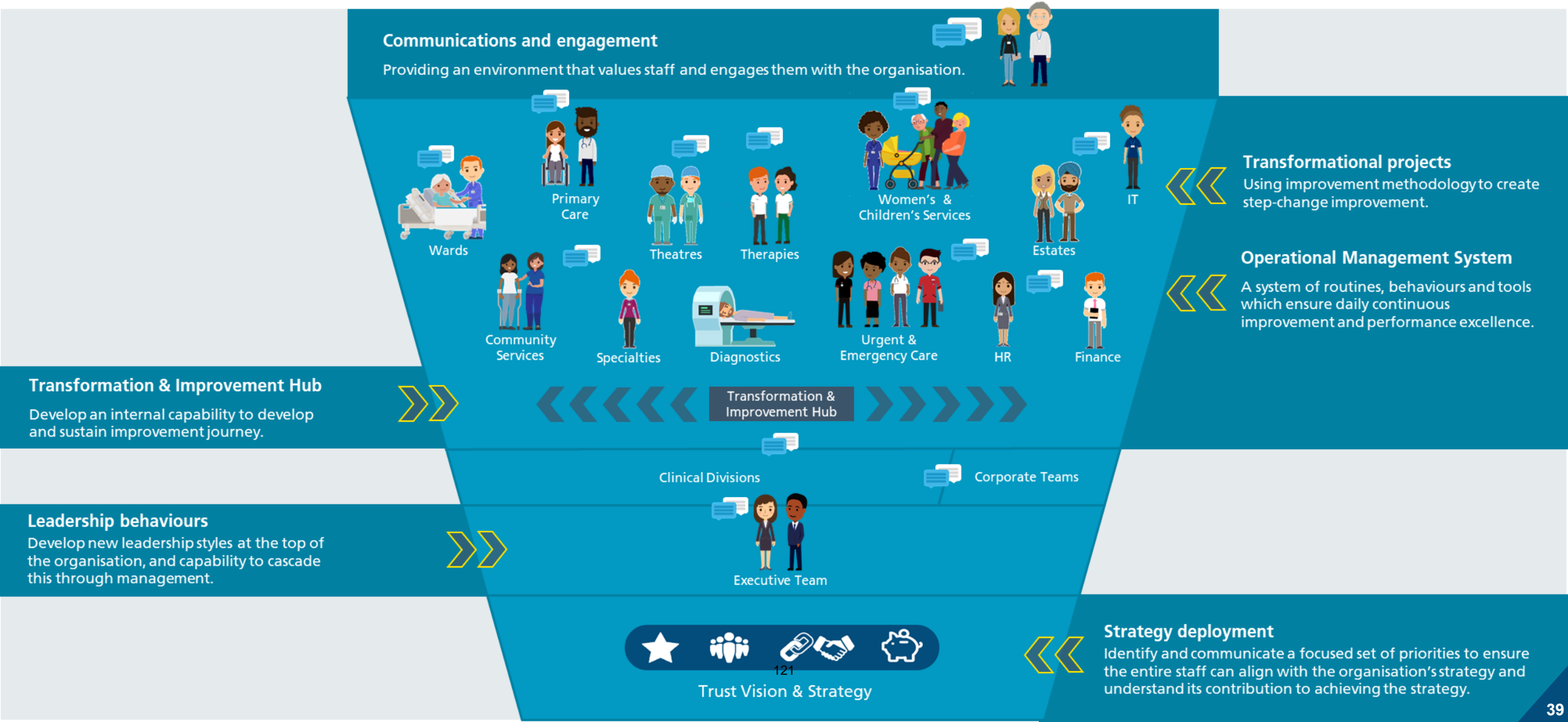
Level	Daily	Weekly	Monthly
Exec			Exec Performance Meeting
Division		Divisional Weekly Driver	Divisional Performance Meeting
Speciality		Speciality Weekly Driver	Speciality Performance Meeting
Frontline	Improvement Huddles		Frontline Performance Meeting

Information Flow

Information Flow

Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

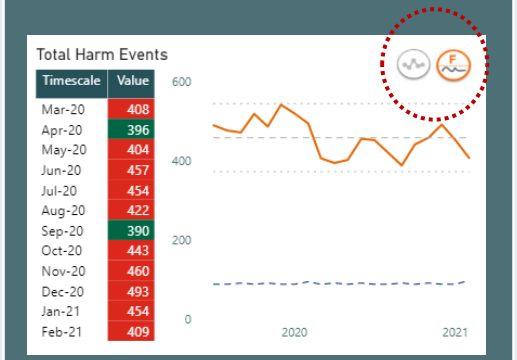
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

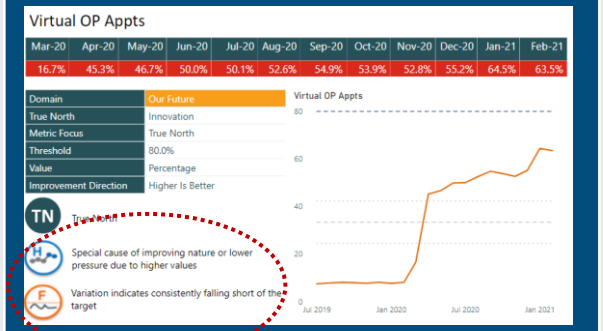
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Board Committee Assurance Report

Committee	**Charitable Funds Committee**
Meeting Date	13 August 2025
Committee Chair	Julian Duxfield, Non-Executive Director

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Financial reporting	Partial	
2. Charity Funds Rationalisation	N/A	Yes
3. Fundraising update	Partial	
4. Cases of need	Good	
5. Medicine Division update	N/A	
6. Fundraising Report, Quarter 1	Partial	
7. GWH Arts Programme - development update	N/A	
8. Committee Effectiveness Review 2024	N/A	
9. External review action plan	Partial	

POINTS OF ESCALATION	A paper will be presented to the Trust Board meeting in September to outline and secure approval for recommendations to substantially reduce the number of charitable funds across the Trust which will help move from a restrictive model of fund management to a more strategic and flexible approach to deliver the best for the hospital and its patients.
KEY AREAS TO NOTE	The total value of the Trust's overall charitable funds on 30th June 2025 were £900k of which £646k is restricted and £254k is unrestricted. Prior to the meeting the general fund's uncommitted balance currently stood at £71k, above our agreed minimum threshold of £57,000. There was extensive discussion about the final proposed structure of the post-rationalisation funds. It was agreed that a model based on the Trust's divisional structure would secure the best balance between: motivating donors; securing flexibility of use of funds and reassuring staff that funds would be targeted at areas that donors cared about. Each division will have an unrestricted fund and at least one restricted fund. It was agreed that dialogue would be needed with divisions to ensure the approach works for each division and is standardised where possible to reduce additional workload for the divisions. The committee discussed the two proposed cases of need, continuing to build funds allocated for the Clix prescription lockers and to 'pump prime' collateral for a new chemotherapy appeal campaign. It was agreed to focus on diverting available funds into the prescription lockers to ensure these are implemented as soon as possible and for a soft launch of the appeal so that the fundraising team can start the private phase, any financial investment will be discussed at the November if still required. A summary of the thinking that has been done to date to develop a coherent arts strategy and programme for the benefit of GWH patients was shared. It was

	agreed that this should continue to be developed with the arts programme being within the charity team. The annual committee effectiveness review raised no substantive issues except for the need to add an Executive Board member to the committee membership to secure quoracy.
BOARD ASSURANCE FRAMEWORK & RISKS	It was agreed that the financial reporting summary should be clear about the cash position of the general fund as well as accrual of the legacy income expected. Once this amendment is made the assurance level can be increased back to 'good'. Discussions around fundraising focussed on the overall 'return on investment' (RoI) of the Trust's work to secure charitable donations, a relatively crude but useful measure. This dipped in 2024/25 to an overall return of 2.16 against a longer-term average of close to 3. Staffing issues account for much of this dip and it was agreed that at the next meeting we would review the broader fundraising strategy and an achievable RoI for the medium-term. As previously, the external review action plan was assessed at 'partial' pending approval of the funds rationalisation project.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	The sterling work of the current team - most notably Cat Weaver, Associate Director of Charitable Funds - to keep things going in the face of significant team absences and the loss of experienced team members was acknowledged.
REFERRALS TO OTHER BOARD COMMITTEES	N/A

Key to committee assurance ratings
Ratings focus on overall assurance over effectiveness of controls'.
Controls : The measures in place to control risks and reduce the impact or likelihood of them occurring.

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

Report Title	**Learning from Deaths Annual Report 2024/25**				
Meeting	**Board of Directors**				
Date	**11/09/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Dr Stephen Haig, Interim Chief Medical Office				
Report Author	Dr Laurie Powell, Trust Mortality Lead				
Appendices	Learning from Deaths Annual Report 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:

Actions ongoing, improvements have been made but not yet completed.

Report

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

Annual 2024/2025 Report Highlights:

- The most recent Trust Level SHMI for the period January 2024 to December 2024 is 1.06 "as expected".
- The trust has given notice to withdraw from the Telstra contract at the end of September 2025
- There were unexpected periods where deaths were lower than average compared with previous year. The winter period reported higher proportion of deaths, predominantly with respiratory conditions.
- ED attendances and admissions overall were higher compared to previous year.

- General Medicine, Geriatric Medicine and Accident & Emergency accounted for 69% deaths overall.
- There were 602 completed SJR's; representing 485 patient deaths being reviewed (34% of inpatient deaths).
- There is good evidence of internal mortality monitoring via the mortality dashboard, and review of external data (SHMI, national audits), both of which are reviewed weekly (or as available) by the Trust Mortality Team.
- Triangulation of data sources via the monthly LfD sub-group meetings ensures that quantitative data is used in tandem with qualitative data.
- Improved engagement with the quarterly LfD meetings ensures that learning is widely shared between departments, and key topics are explored.
- Work continues to improve current processes and support provided to departments in relation to internal mortality reviews to inform improvement plans.

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:	
Accountable Lead Signature	
Date	**31/07/2025**

Learning from Deaths

Annual Report

2024-2025

Project Lead name and job title:	**Dr Laurie Powell** **Trust Mortality Lead**
Contact Details:	laurie.powell1@nhs.net
Specialty / Department:	Mortality
Division:	Corporate
Executive Lead	Dr Steve Haig, Chief Medical Officer
Draft Report Prepared by:	Dr Laurie Powell
Report Finalised by:	Dr Laurie Powell
Report Completion Date:	July 2025

Background / Rationale

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

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

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

Strategic Driver: Learning from Deaths National Guidance[1]

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

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

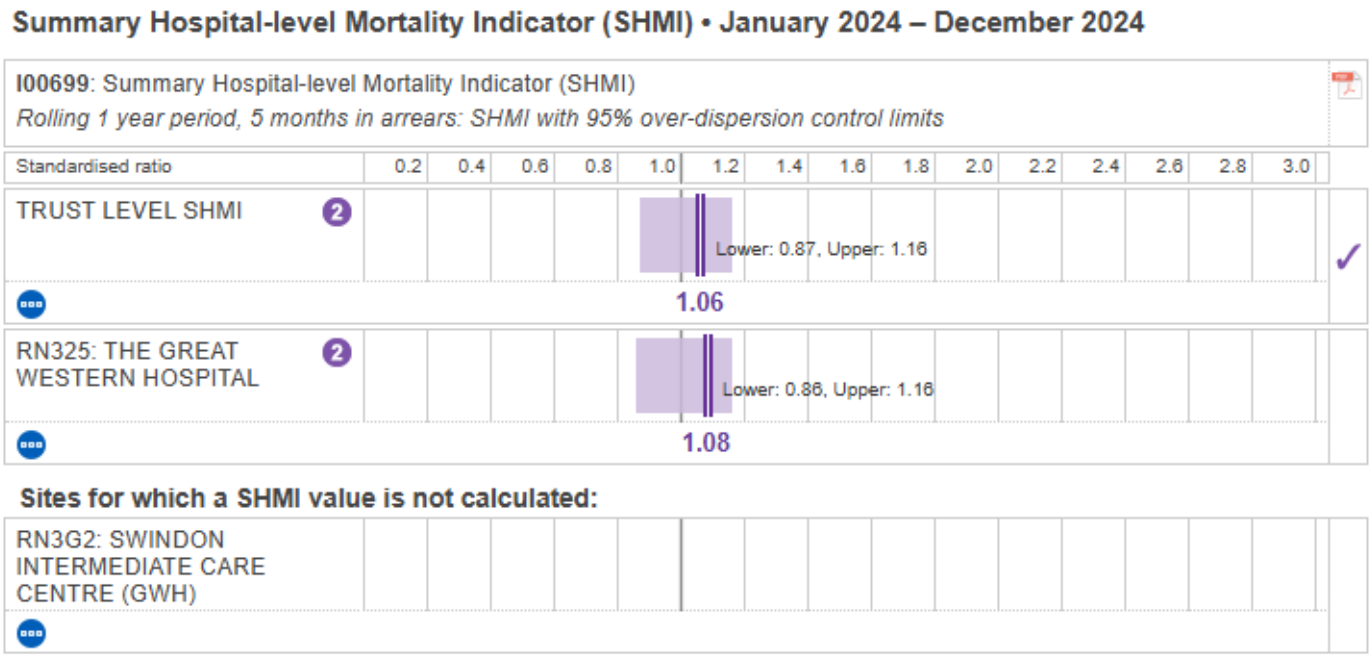
Data Period: Deaths during 1st April 2024 – 31st March 2025

SHMI

(Standardised Hospital Mortality Index)

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

As this report is being submitted for the committee- and sub-committee meetings following the year-end in April (i.e. for July meetings), we are able to include the latest SHMI publication which covers the year from January 2024 to December 2025. The next publication is due to be released on 14th August 2025 and will cover the period April 2024 to March 2025. There is always a five-month lag applied to SHMI data due to the process of "cleansing" the data by NHSE. The most recent Trust Level SHMI for the period January 2024 to December 2024 is 1.06 ("as expected", increase seen from previous publication covering October 2023 to September 2024, which was 1.04). It should be noted that NHSE have stopped reporting unit-level SHMI for SWICC, instead now being presented as "Trust Level" which for this data period includes SWICC and The Great Western Hospital.



Telstra Health

HSMR (Hospital Standardised Mortality Ratio) is another ratio of observed to expected deaths in hospital, adjusted for case-mix factors, and is the ratio reported and analysed by Telstra Health.

Reports from Telstra Health were inconsistent during the year referred to by this report, primarily due to the increased level of hospital spells which were regularly uncoded for primary diagnosis, which was a recurring challenge throughout the reporting period.

Reports were also unavailable due to issues with the data integrity related to the Hospital Episode Statistics (HES) data received from NHS England, meaning that Telstra have not been able to issue reports. This meant the Learning from Deaths team, were unable to review or report on appropriate mortality indicators relating to HSMR, CUSUM alerts and weekday/weekend data.

Due to the inconsistency of the HSMR reports and the effect of the number of residual codes applied from GWH (i.e. coding of symptoms and signs rather than a primary diagnosis coding) means that the Learning from Deaths team have used other data to direct their work and learning.

It should be noted that the trust has given notice to withdraw from the Telstra contract at the end of the current tenure, which is the end of September 2025. This is following numerous discussions with the BSW mortality

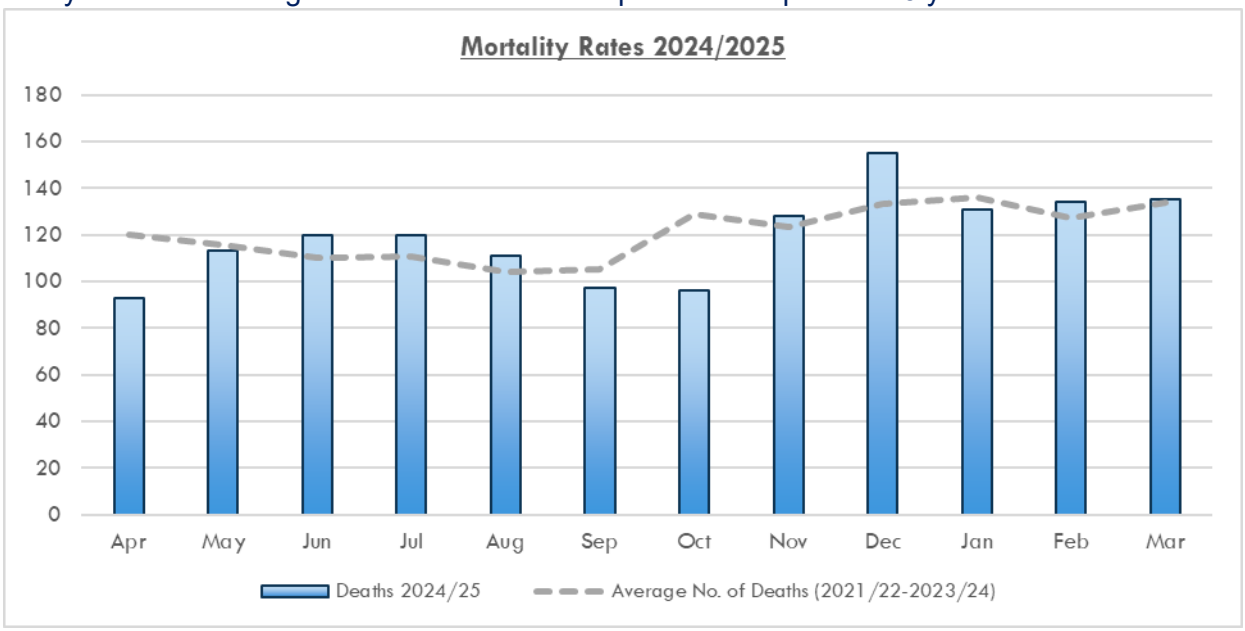
leads and procurement teams, discussion with the trust board and support from the Chief Medical Office. Considerable work has been undertaken to ensure appropriate data is available from other sources to provide assurance around mortality trends.

Mortality Data

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

The number of deaths recorded during 2024/2025 was 1433 which was 59 more deaths than the previous year. This represents an average 119 deaths per month, which is an increase from 115 deaths per month in 2023/24.

Internal data showed unusually lower levels in the number of deaths; April and October 2024 reported significantly less than average number of deaths compared to the previous 3 years.



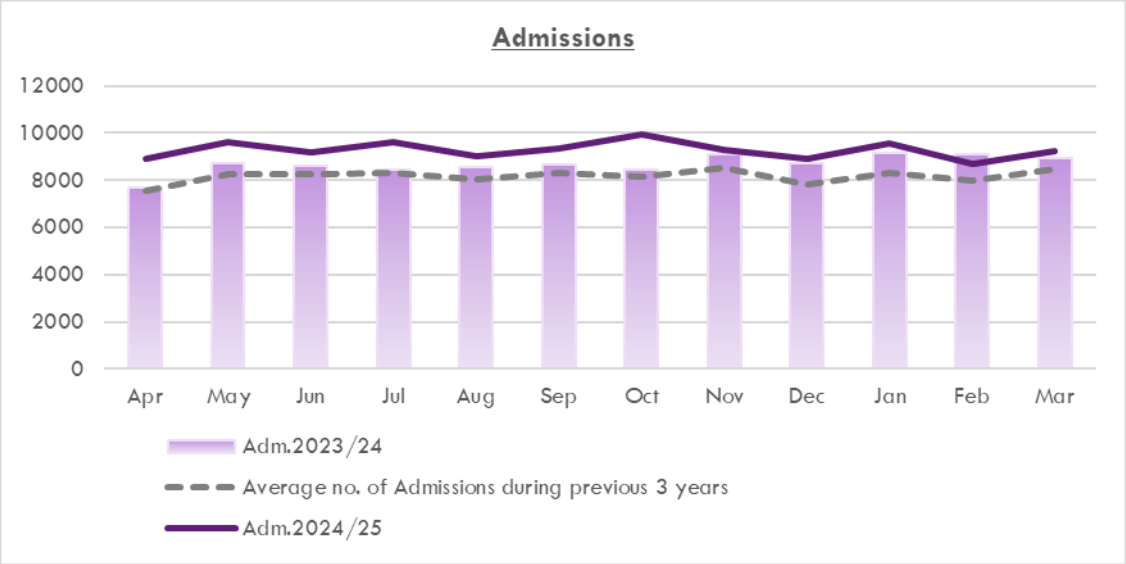
There was an unexpected rise in the number of deaths in November 2024; a review of internal data concluded there were no isolated areas of unusually high deaths, and there was no correlation in the data between deaths and the critical incident that was declared in November 2024.

A weekly review of Trustwide data was implemented to closely monitor the mortality rates throughout the winter period and data was shared with divisional leads to support early identification and timely response to unexpected activity; where areas of concern were identified, correlating data was reviewed accordingly.

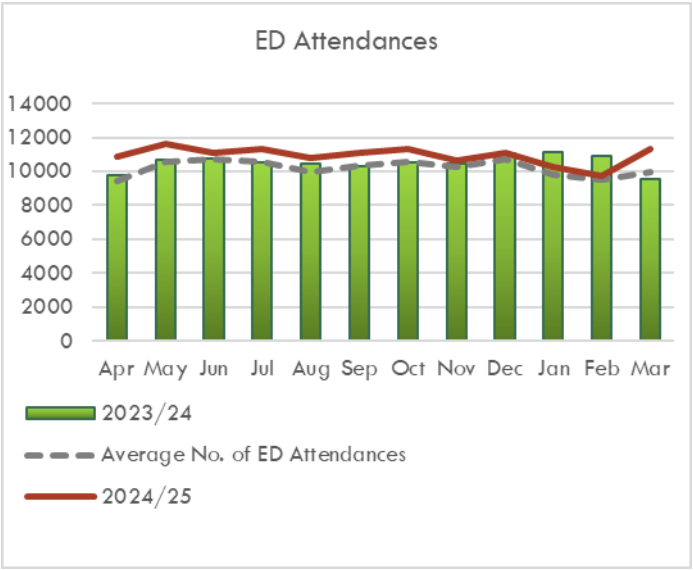
Admissions data identified exceptionally high number of admissions during October 2024 (9923 compared to 9272 average), off which, 106 deaths were reported. A third of these deaths occurred in November, notable in the first 10 days. Although admission activity returned to average levels in November, this meant the overall mortality rate for this month rose to 1.4% of total inpatients/admissions.

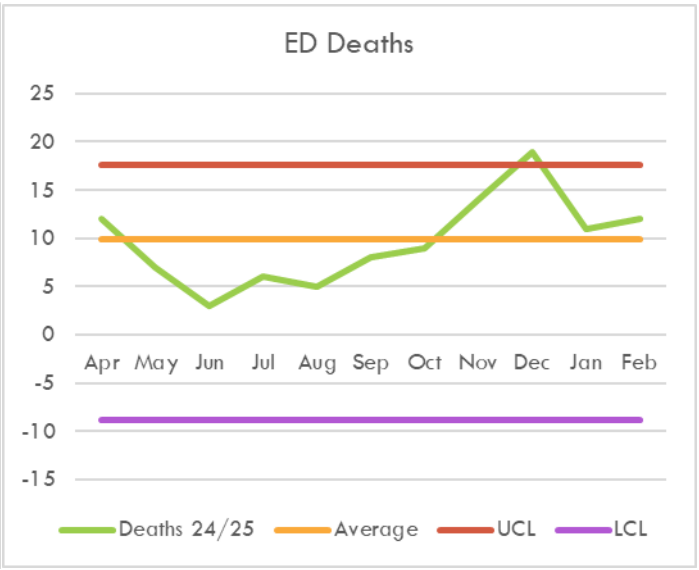
The number of deaths in December 2024 was reported to be significantly higher than average; cause of death data was reviewed which identified a combination of diagnoses and causes of death expected for this time of year particularly for Respiratory related infections, including Influenza, COPD and Pneumonia. A high proportion of 'Community Acquired Pneumonia' also contributed to this mortality group.

On review of the overall admissions data, this showed activity to be higher than 2023/2024; the proportion of deaths has ranged between 1.0% to 1.7% throughout the year. Reassuringly the mortality rate has remained at 1.3% of overall admissions.



Internal monitoring of data in relation to attendances to the Emergency Department (ED) was reported to be a total of 131129, of which, the proportion of deaths within ED was 0.1%. This represents an average of 10 deaths per month which is the same as previous year.





Deaths by Speciality

General Medicine, Geriatric Medicine and Accident & Emergency continue to have the greatest number of deaths, accounting for 69% of deaths during the year:

Speciality at time of death	Number of deaths recorded
GENERAL MEDICINE	459 (↓77)
GERIATRIC MEDICINE	419 (↑108)
Accident & Emergency	116 (↓7)

Structured Judgement Reviews

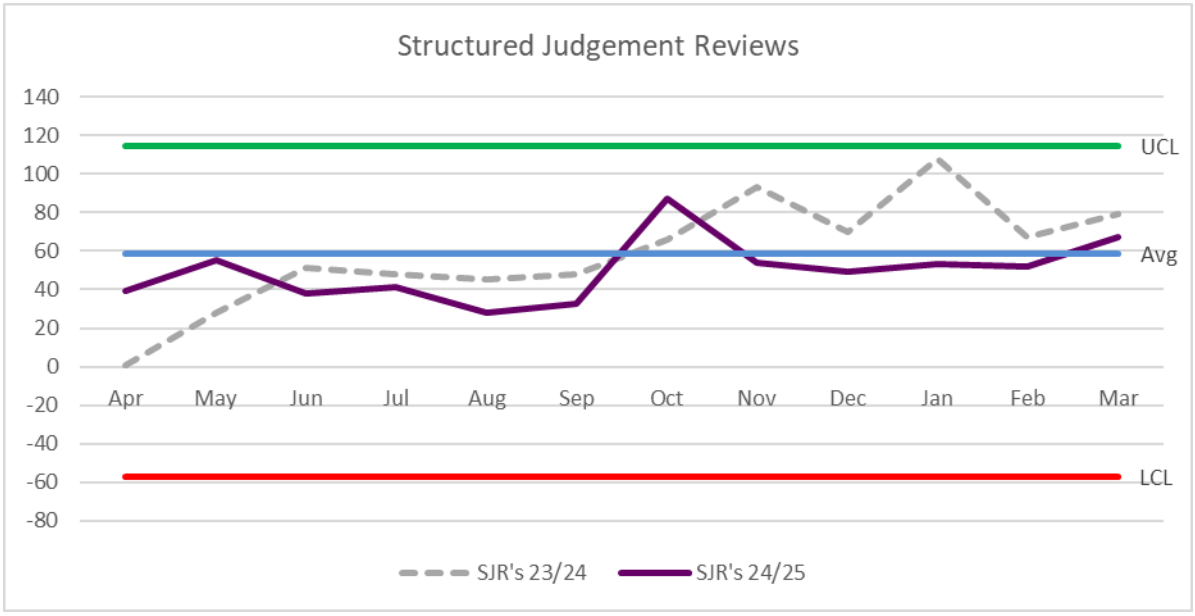
In line with national requirements (National Guidance on Learning from Deaths), it is recommended that all in-patient deaths are reviewed to identify whether further analysis of the patient's care is required in order to identify any problems in care, or examples of excellent care, and emerging themes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

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

For the period this report relates to, patient deaths were reviewed using the Structured Judgement Review (SJR) tool. This is a systematic exercise using nationally accepted methodology to review individual case records in order to identify any problems in care or examples of excellent care. This allows opportunities to draw learning or conclusions that may inform further actions needed to improve care within a setting or for a particular group of patients.

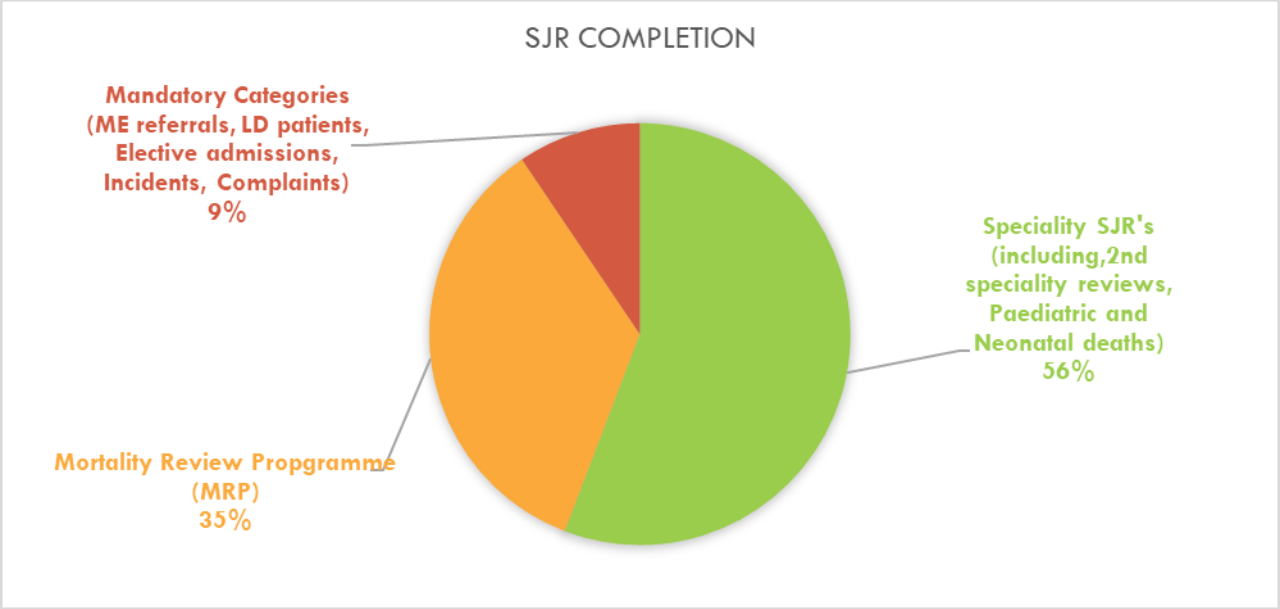
The procedure for the period that this report relates to (April 2024-March 2025) varied, and includes the following:

- April 2024 – September 2024: SJR is requested by the Clinical Audit, Effectiveness and Mortality Team for the specialties to complete and return to the team within a specified timescale. SJRs can be used within departments for learning and presentation at departmental Mortality and Morbidity meetings.
- September 2024 – March 2025: Mandatory category reviews were requested solely via the Mortality Review Programme to ensure timely completion. This was in addition to standard SJRs (e.g. for departmental interest/QI work) which could be done by departments as time allowed, however it would still be expected that they would be submitted to the CAEMT for collation.



During 2024/2025, 602 SJR's were undertaken; this represents 485 patients and overall 34% of inpatient deaths. It should be noted that some deaths undergo more than one review.

The Mortality Review Programme (MRP) encourages clinicians who wish to take part in completing SJRs (and who may not have a high number of deaths within their own department) to sign up for a specified time period and complete SJRs not completed by the specialty teams. During 2024/2025, the MRP contributed to 35% of overall SJR's.



Themes arising from Structured Judgement Reviews (SJRs).

SJR's during this reporting period identified overall Good and/or Excellent care delivered with evidence of timely investigations, resuscitation, IV fluids, Senior reviews and good involvement of specialist teams. Care delivered in ED was also scored Good and/or Excellent with prompt assessments, thorough clerking and prompt investigations and treatment.

Documentation remains the biggest opportunity for improvement. This includes completion of sepsis proformas, management plans and decision making, completion of Respect forms.

Additional opportunities for improvements were identified in relation to systems and process where there were notable delays with radiology requests (timely requests for scans or scans undertaken), requesting CT's and completing neurological examinations in the first 24hrs of admission. There were also identified long waits for assessments after transfer to another speciality and prolonged admissions particularly in elderly patients.

Thematic Trustwide Mortality Reviews

Reviewing internal data has provided the opportunity to undertake thematic Trustwide Mortality reviews.

During the year 2024/2025, the LfD team led 3 themed mortality reviews looking into alerts raised by various means. These include the following:

Inpatient Falls (June 2024), which was derived from the triangulation of mortality, clinical audit and incident data. This work led to a multidisciplinary in-person meeting to review a sample of casenotes of patients who had fallen during an inpatient admission at the Trust, which allowed the collaboration/facilitation of discussions, key learning, and the identification of improvements.

Highlighted themes from the review included the need for a standardised approach across the trust particularly in clinical documentation (completion of Falls proforma), clinical care which included varied levels of understanding of prescribed care requirements i.e. line of sight/1hourly/2hourly observations. The report and action plan were completed in collaboration with the Falls team who were able to include further recommendations into their workplan priorities.

A further thematic mortality review was undertaken to review the care of patients with a hip fracture (October 2024). This piece of work supported the Trauma & Orthopaedic Department which was in response to an outlying mortality alert received in May 2024 for patients who had died following admission to the Trust with fractured neck of femur (identified by the National Hip Fracture Database).

The review demonstrated good local practice, including compliance with NICE Guidelines NG124 for Hip Fracture. Amongst some of the local improvements recommended by the British Orthopaedic Association (BOA) there were additional recommendations around the monitoring of local hip fracture data so that adverse trajectories in data points can be quickly identified and responded to in a timelier way.

The report was finalised in collaboration with the Hip Fracture Lead who was able to present and share the findings and begin actions for implementation within the service. Deaths returned to expected levels and will continue to be monitored by the division with support from the LfD team. A British Orthopaedic Association review is also planned for September 2025.

A Pneumonia review (December 2024) was undertaken in response to recurrent SHMI notifications of more than expected deaths from pneumonia within the Trust (though still within expected levels) and in conjunction with the high proportion of deaths during this period. The review was limited to 10 patient notes and looked to understand whether care for patients with hospital-acquired pneumonia met national standards. This was shared with the pneumonia lead and will be reviewed alongside a correlating National Confidential Enquiries into Patient Outcomes and Deaths (NCEPOD) audit and local audit to inform work plans.

Trust Mortality Meetings and Reporting

The structure of work undertaken by the Trust Mortality Team has continued to change during 2024 to 2025, and the team is pleased to report that for the first time since the current lead took tenure, the Quality and Safety committee rated the assurance level provided by the team as “Good”, which is a significant improvement from “Limited” when she started in the role.

The main changes made during 2024/2025 include:

- The weekly meetings between the LfD core team (comprising of the LfD lead and CAEMT manager with oversight from the Deputy Chief Medical Officer) continue, and allow for review of, and discussion around, trust mortality data, concerns raised following SJRs, or incidents reported, alerts raised by any means.
- Establishment of the “Learning from Deaths Sub-Group”, comprised of the core LfD team, the Medical Examiner, the Clinical Coding manager, the head of PALS, the legal team and the Investigation Lead from the patient safety team. The group meets monthly, with a brief presentation from each member regarding themes emerging from their area relating to patients who have died in the Trust. This allows for triangulation of data from multiple sources, which is reviewed alongside national mortality data e.g. SHMI, alerts etc.
- Establishment of the quarterly “Learning from Deaths” meetings, which has demonstrated significant improvement in engagement and attendance from clinical leads. We also now have regular governor representation. This meeting has more of a focus on qualitative learning occurring within the trust, with an opportunity for departments to share their learning. The LfD team share any important trust-wide learning and any updates to the LfD process.
- The establishment of a route for medical examiners to refer concerns to the patient safety team in order that they can be assessed and managed appropriately.

- Update of the Learning from Deaths policy, setting out expectations for departments and divisions with regards to their responsibilities in learning from deaths.

In the year April 2024-March 2025 the LfD team chaired 4 Trust Learning from Deaths Meetings, 7 LfD sub-group meetings and had weekly LfD team meetings (unless core members were on leave).

Minutes for the Trust Mortality meetings are shared with the Patient Quality Subgroup Committee for noting.

Quarterly reports are prepared for, and presented to, the Patient Quality Sub-committee and the Quality and Safety Committee, reporting on SHMI, SJRs, trust mortality and trust activity (admissions).

Key Assurances

There is good evidence of internal mortality monitoring via the mortality dashboard, and review of external data (SHMI, national audits), both of which are reviewed weekly (or as available) by the Trust Mortality Team. Reports have been inconsistently available from Telstra Health, though when available were used alongside internal data and SHMI.

Triangulation of data sources via the monthly LfD sub-group meetings ensures that quantitative data is used in tandem with qualitative data (e.g. complaints, SJR outcomes, patient safety investigation outcomes, medical examiner themes and information from the coroner via the legal team) to ensure a comprehensive view of mortality within the Trust is taken and priorities for learning identified accordingly.

Improved engagement with the quarterly LfD meetings ensures that learning is widely shared between departments, and key topics are explored.

Participation in the Mortality Review Programme has improved this year following a presentation to, and discussion with, the Chief Medical Officer and Associate Medical Directors who have agreed to ensure all departments contribute to the programme. This ensures that we can complete mandatory category SJRs within a timely manner, ensuring any concerns identified are managed early and within appropriate timescales for duty of candour.

Key Areas for development

The LfD team have been working on a new process by which SJRs will be requested only if another review is ***not*** being undertaken, e.g. PSIRF, complaint investigation, coroner referral. This is to ensure that work reviewing patient notes (which can take some hours for patients with long stays) is not duplicated by two reviewers working independently. It is felt that this time would be better spent participating in themed reviews or other learning from deaths activity. The team are looking at how work occurring as part of other processes that contributes to “learning from deaths” can be captured and used for data analysis.

The LfD team intend to finalise an “offer letter” which can be sent out in response to alerts or concerns raised around mortality data. This enables the team to be consistent in their approach to supporting the Trust in responding to concerns and sets expectations of what can be expected by departments and divisions in monitoring their own mortality data.

It was agreed that the Mortality Review Programme would continue with AMDs providing names of allocated reviewers within their divisions, and ensuring training is undertaken to fulfil requirements.

Having given notice for termination of the Telstra contract, discussions will be held to ensure that the Trust can uphold its obligations in meeting the Quality Schedule requirements, and to be confident that it has oversight of mortality across the trust – this is likely to involve the digital information team and will likely be part of a BSW-wide programme of work which may offer opportunities for shared processes and benchmarking, looking at PowerBI capabilities to support this.

Whilst there remains a delay in scanning and coding, it is acknowledged that there was a risk of unidentified themes in uncoded notes, and work is being undertaken with the digital team to further quantify this risk and its impact on mortality data.

Further encouragement for departments to be able to capture learning from deaths activity that is relevant to their specialty and meets requirements from the trust LfD team. It is acknowledged that learning from deaths in ED would be different to learning from deaths in oncology, and processes should allow for the differences and encourage engagement by being relevant. It is hoped that further work in this area will be shared at the quarterly learning from deaths meetings.

Actions and Improvements

The summary below outlines the actions and improvements made between April 2024 and March 2025:

- Further consolidation of mortality meeting process:
    - Weekly meetings of LfD Team to review data, themes, identify and manage concerns to discuss at the monthly LfD sub-group meetings, and to collate learning to share at quarterly Trust-wide Learning from Deaths meetings (previously Trust Mortality Meetings)
- Engagement in System Mortality Group meetings with BSW – these meetings commenced in January 2024 and enable collaborative work between mortality teams at RUH, SFT and GWH, supported by the ICB Chief Medical Officer and other staff.
- Further strengthening of the internal mortality database and ability to send out regular updates to divisional managers with details of deaths occuring within divisions and departments, and SJRs undertaken in comparison to those requested.
- Launch of the SJR training module.
- Agreement with AMDs and CMO that divisions will nominate SJR reviewers to participate in the Mortality Review Programme to ensure timely completion of mandatory-category SJRs, and to support indpendent review of deaths by clinicians not directly involved in caring for the deceased patient.
- Launch of themed mortality reviews, with two taking place in person, with a multi-disciplinary team reviewing clinical notes. Reports were written for all 3 reviews, and shared with relevant teams.
- Ability to supply a rapid response to ICB concern regarding spike in deaths seen at GWH in November 2024, with review of patient notes, analysis of SJR outcomes during that time and clarification that there were no concerning circumstances relating to the deaths observed during the period referred to.
- Final draft of Learning from Deaths policy ratified by Quality and Safety committee setting out expectations of departments and divisions, as well as those of the Learning from Deaths team.
- Improvement in engagement of trust-wide Learning from Deaths meetings, demonstrating an improvement in attendance, engagement in discussion during the meeting, sharing of learning and good feedback. We have also recently managed to secure governor representation at these meetings.
- Improved rating from Quality and Safety Committee from “partial” assurance to “good assurance” with positive feedback from the committee about improvements made.

Actions and Improvements still in progress

- Further establishment of the appropriate identification of cases for SJR, and pathway for reviews occurring through other routes (e.g. PSIRF, coroner, M&M meetings, PALS) to ensure capture and ability to analyse data and identify themes.
- Grand Round – Learning from Deaths Event (April 2024) to raise awareness
- Development of “offer” available to departments and divisions for support with looking into mortality queries and concerns
- Further development of the quarterly learning from deaths meeting to ensure the focus is on sharing learning and demonstrating improvement in practice as a result of learning from deaths.
- Working alongside patient safety team to support PSIRF priorities
- Clarification of divisional oversight of audits with integral mortality indicator.
- Identification of further themes for multi-disciplinary reviews
- Further collaboration with respiratory team regarding pneumonia deaths
- Collaboration with sepsis lead regarding sepsis deaths

Summary of Assurance

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

Summary of Risk

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

Executive Sign-Off

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

References

1. NHS England » Learning from deaths in the NHS

Report Title	**Freedom to Speak Up Annual Report 2024-25**				
Meeting	**Trust Board**				
Date	**11/09/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Luisa Goddard, Chief Nurse				
Report Author	Sonia Maciver, Lead Freedom to Speak Up Guardian				
Appendices	Nil				

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 rating has been rated Good. Over the course of this financial year, the Trust has strengthened the Freedom to Speak Up (FTSU) service by increasing the Lead Guardian role from two to four days per week (effective from 3rd March 2025). In addition, several new volunteer Guardians were recruited during 2024/25, with further expansion planned in the year ahead.

The newly appointed Lead Guardian has also identified opportunities to improve both processes and historical data. Work is already underway to address these areas, alongside planned benchmarking activities to support the continued development of the service and raise awareness further.

Report

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

In 2024/25, the Trust received 58 Freedom to Speak Up (FTSU) concerns, with a notable increase in reporting during the second half of the year. Key themes included inappropriate behaviours, bullying and harassment, and concerns around policies and processes.

Key achievements:

- Appointment of a new Lead Guardian (March 2025)
- Expansion of the Ambassadors network to 10 members
- Progress on mandatory FTSU training compliance
- Strengthened communication and engagement plan

Priorities for 2025/26:

- Development of KPIs and action plans
- Introduction of FTSU Champions and Ambassadors
- Integration with Trust initiatives (e.g. Expected Behaviours rollout)
- Enhanced collaboration with staff networks and EDI programme
- Improved monitoring for detriment and follow-up processes

This programme of work will continue to support a culture of openness, inclusivity, and psychological safety, ensuring staff feel confident to raise concerns and that learning from these concerns drives improvement in patient and staff experience.

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)	332 - Risk that staff feel unable to speak up and therefore the opportunity for learning and improvement is missed.	6
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement		
Next Steps		

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

Explanation of above analysis:

The paper acknowledges the different needs of people with protected characteristics and suggests mitigations to support them use the Freedom To Speak Up service.

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to:
Note the update regarding the FTSU service and the actions taken to support improvement.

Accountable Lead Signature	Luisa Goddard.
Date	4 September 2025

1. Introduction

This report outlines the progress and impact of the Freedom to Speak Up service across the Trust during 2024/25. The Trust remains committed to fostering a culture of openness, psychological safety, and inclusivity, enabling staff to raise concerns confidently. The Trust has established mechanisms for staff to raise concerns or issues, particularly relating to quality of care, patient safety, and bullying or harassment.

The FTSU service is supported by a network of Guardians, Line Managers, Chaplaincy, Staff Networks, Professional Nurse and Midwifery Advocates, and People Operations.

2. Service Overview

The FTSU Guardians (Ambassadors/Champions) operate independently and impartially, providing support and guidance to staff. They are aligned with the National Guardian's Office (NGO) principles and contribute to both local and national networks.

We are committed to listen to our staff, learn lessons and improve patient care by using the eight principles set out by the National Guardian's Office:

1. Value speaking up
2. Role-model speaking up and set a healthy Freedom to Speak up culture
3. Make sure workers know how to speak up and feel safe and are encouraged to do so.
4. When someone speaks up, they are thanked, listened to and their concerns are followed up.
5. Use speaking up as an opportunity to learn and improve
6. Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements
7. Identify and tackle barriers to speaking up
8. Continually improve our speaking up culture

The service reports quarterly to the NGO and internally to the Trust Board, Quality and Safety Sub-Committee, and Trust Management Committee.

3. Service Development & Training

The speaking up culture continued to be developed during 24/25, through key workstreams that are monitored through a close working relationship between the accountable Executive Director Lead, Non-Executive Director and Lead Guardian. There are regular Lead Guardian meetings, FTSU guardians catch up meetings and Guardians case review meetings to ensure resolutions and improvements are being sustained.

Key developments in 2024/25:

- Recruitment of additional Guardians (January 2025)
- Appointment of Lead Guardian (March 2025)

- Communication plan in place with an overarching plan for the year. Quarterly detailed plans are still in development.
- Engagement with Senior Leadership Team, Divisional Leaders, and staff
- Attendance at key meetings (Patient Quality Sub-Committee, Patient Safety Learning Group, Speak Up/Clever Together)
- Identification and implementation of process improvements

3.1 Training:

To help facilitate good conversations and support staff to speak up, the FTSU training has been made mandatory for all three modules. The training includes “Speak Up”, “Listen Up” and “Follow Up” modules. Compliance data shows steady improvement across divisions.

Trust compliance of FTSU mandatory training as of 31st March 2025 is provided in tables one and two below. Table three shows the compliance data for both modules.

Table one – Freedom to Speak Up compliance data for ‘Speak Up’.
Live data to date as of 31st March 2025

Freedom to Speak Up - All Workers – Speak Up 3 Years	
Community Services Division	100.00%
Corporate Services Division	88.51%
Family and Specialist Services Division	86.52%
Medicine Division	82.36%
Surgery and Planned Care Division	83.31%

Table two – Freedom to Seak Up compliance data for ‘Listen Up’.
Live data to date as of 31st March 2025

Freedom to Speak Up - Managers – Listen Up 3 Years	
Corporate Services Division	79.10%
Family and Specialist Services Division	78.13%
Medicine Division	79.07%
Surgery and Planned Care Division	89.66%

Table three – ‘Speak Up’ and ‘Listen Up’ compliance data September to 31st March 2025.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Speak Up All workers	52.86%	60.14%	70.40%	74.53%	76.86%	79.84%	84.73%
Listen Up Managers	36.91%	41.84%	57.69%	62.12%	67.95%	70.00%	80.30%

4. Case summaries for 24/25

In addition to providing the FTSU service, it is essential that there is a robust system for the collection of mandated data and that the data is reviewed and analysed to support the development of the service. Each concern is reviewed and allocated against a theme, in some cases there is more than one theme threaded through a concern.

Anonymised data is shared with the National Guardian's Office quarterly as follows:

- The number of cases received.
- The number of cases raised anonymously.
- The number of cases with an element of:
    - patient safety/quality concern
    - worker safety or wellbeing
    - bullying or harassment
    - other inappropriate attitudes or behaviours
    - where people indicate that they are suffering disadvantageous and/or detrimental treatment as a result of speaking up
- Concerns brought by professional/worker groups
- Concerns where there was a response to the feedback question: 'Would you recommend staff to use the FTSU service' (and the answer)

There have been a total of 58 concerns received by the Freedom to Speak Up Guardians in 2024-25, and we have noted an increase in the number of concerns raised during the second half of the financial year.

Quarterly breakdown:

- Q1: 10 cases
- Q2: 6 cases
- Q3: 25 cases
- Q4: 17 cases

Themes:

- Inappropriate Attitudes & Behaviours: 20
- Bullying & Harassment: 18
- Policies & Processes: 9
- Quality & Safety: 3
- Detriment: 1
- Worker Wellbeing: 1
- Unknown/Other: 6

Number of cases, per quarter, in 24/25:

	Q1	Q2	Q3	Q4
Policies Procedures & Processes	2	1	4	2
Inappropriate Attitudes & Behaviours	3	1	14	2
Quality & Safety			1	2
Patient Experience				
Bullying and Harassment	3	2	4	9
Detriment as a result of Speaking Up	1			
Worker Wellbeing		1		
None of the above		1	1	
Unknown	1		1	2
Total for 2024/2025 (as of 24/03/25)				**58**

5. Looking forward to 2025/2026:

The new Lead Guardian has completed the NGO's FTSU Guardian training and has started managing cases. Once fully embedded in the role, the Lead will work to increase the number of Guardians and expand the service further to be supported by Champions. Champions will not take cases to manage but will support though promotion of the service and engagement rather than case management.

The following is a list of ongoing and planned actions that will be focused for the next six months:

- Induction and Engagement: Continue raising FTSU at induction and other education programmes, engaging with all staff and attend key meetings to maintain FTSU visibility and alignment with Trust initiatives, supported by refreshed promotional materials and a trusted escalation pathway.
- Service Review and Improvement: Conduct benchmarking across BSW and the wider region, with ongoing review and enhancement of FTSU processes and delivery.
- Expansion of the Service: Grow the Guardian network and introduce FTSU Champions and Ambassadors across the Trust.
- Action Plans and KPIs: Develop action plans and KPIs following the Trust-level self-assessment to guide and monitor service delivery.
- 10-Year NHS Plan: Embed revised models, reporting structures, and learning / improvements from concerns raised.
- Equality, Diversity & Inclusion: Collaborate with staff networks (BAME, LGBTQ+, Disability, Carers) and the EDI Lead to build awareness and trust in FTSU. Continue to develop strategies to support staff with protected characteristics to speak up with adjustments in place if required.
- Cultural Change: Support the rollout of Expected Behaviours to promote inclusivity, psychological safety, and confidence.

6. Conclusion

The 2024/25 reporting period has seen progress in strengthening the Freedom to Speak Up service across the Trust. With increased visibility, expanded Guardian capacity, and improved training compliance, the foundations for a more open and psychologically safe culture are being established. The rise in concerns raised, particularly in the latter half of the year, seem to reflect an early indication of growing staff confidence in the service. This will continue to be monitored in 2025/26 to ensure sustainability. Looking ahead, the Trust remains committed to embedding speaking up into everyday practice, enhancing collaboration with staff networks, and ensuring that learning from concerns continues to drive improvements in both patient care and staff experience.

Report Title	**Improving Together Year 3 Review**				
Meeting	**Trust Board**				
Date	**11/09/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Emily Beardshall, Interim Chief Officer – Improvement & Partnership				
Report Author	Emily Beardshall, Interim Chief Officer – Improvement & Partnership				
Appendices	Improving Together Year 3 Review including Appendix 1 – Training Roll-out Appendix 2 – Divisional Level Benefits Appendix 3 – Year ahead training plan				

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:

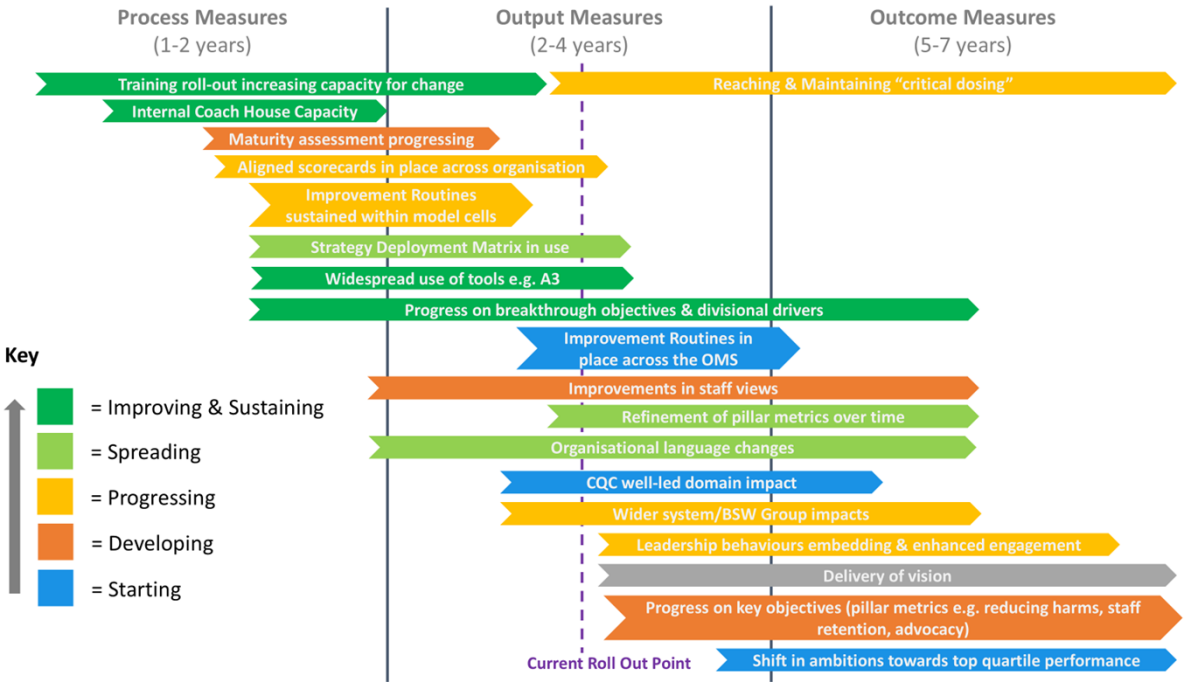
This paper has an assurance rating of good given the significant progress made on the roll-out of Improving Together during year 3. Overall the outcome framework is on track and the report provides assurance of the benefits being seen and the next steps needed to keep the deployment on track. Sustainability of improvement routines remains challenged and further progress on this would be needed to give a substantial rating at the year 4 review.

Report

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

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

It reviews the benefits framework for the roll out of the Improving Together approach; the paper lays out expected improvements in: process measures, output measures and outcome measures. This is based on the framework used for the year 1 review in June 2023. Progress across the Operational Management System (OMS) is detailed alongside assessment of the benefits seen, reflections and learning from year 3 of the implementation of Improving Together. The summary of the assessment is shown below.



Overall the paper concludes that

1. Assessment against the evaluation model shows that implementation of Improving Together is making good progress and we are learning from what is working well and refining where needed. Adaption has worked well during year 3 to increase the focus of improvement work and to deliver benefits more consistently than in year 2.

2. However, the sustainability of frontline routines remains challenging and it is a good time to review how we best support frontline teams focusing on approaches that are feasible given resource constraints.

The outcome of the review has informed the following priorities for year 4.

Priorities for year 4 deployment are suggested as

1. **Strengthening Cross-Organisational Collaboration (Group Working & BSW Integration)**
   - As Improving Together becomes embedded across the BSW Hospitals Group next year will focus on deepening collaboration through a shared Strategic Planning Framework (SPF) and aligned routines.

2. **Accelerating frontline ownership & sustainability:**
   - Embedding performance review meetings across all levels
   - Increasing focus on improvement tools and support with overcoming barriers, continuing to widen re-engagement activities
   - Simplifying huddle processes, focusing on building improvement into existing operational routines, and sustaining fast track rollout across teams

3. **Elevate staff and patient/public voice.** We will scale initiatives that:
   - Amplify staff feedback into huddle themes and A3s
   - Embed patient voice in Rapid Improvement Events and quality improvements
   - Increase use of the Improvement App and visibility of success stories

4. **Support priority transformation programmes**
   - The launch of a cross-site Shared EPR (Electronic Patient Record) presents a vital opportunity to unify improvement culture, processes, and metrics.
   - Ensure that digital transformation translates to tangible improvements in patient safety, experience, and clinical staff productivity.
   - Embedding the NHS 10-year plan priorities through continuous quality improvement supporting population health management and left shift in care pathways

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)	Improving Together is a key part of mitigation to BAFS1 – Outstanding Patient Care	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Improving Together Steering Group July 25 & TMC August 25	
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:

Explanation of above analysis: The subject of this paper is the roll out of an operational management system that places quality improvement at the heart of the work of the Trust. As such it has no directly positive or negative impact on protected groups, but there is an opportunity through the recommendation to increase patient and public voice to consider traditionally under-represented groups

Recommendation / Action Required

The Board/Committee/Group is requested to:

Trust Board are asked

- to receive the reflections and learning to support the refinement of our practice

- to discuss the suggested priorities for year 4 and consider the role of Board members in moving these forwards. This may include reflecting on further learning, resources or support Executives and Non-Executives may need to undertake these roles.

Accountable Lead Signature	
Date	**01/09/2025**

NHS
Great Western Hospitals
NHS Foundation Trust

Improving Together Year 3 Review

Trust Board 11th September 25

Improving
together

Year 3 Review

Great Western Hospitals NHS Foundation Trust

Purpose

May 2025 marked the end of the third year of deployment of the Improving Together approach to continuous quality improvement across the organisation.

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

It reviews the benefits framework for the roll out of the Improving Together approach building on the model used in the first two years that shows the expected improvements in: process measures, output measures and outcome measures.

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

The Operational Management System

Refresh of the OMS for 2025/26

- Improving Together is our Trust-wide approach to change, innovation and continuous improvement which introduces a consistent methodology across the organisation so that 'improving' becomes something we all do in the same way. Improving Together is not a project but is a way of creating a culture of continuous improvement, developing and empowering our workforce so all staff feel able to contribute to making improvements as part of their day job, every day.
- This is not a 'bolt on' to existing work but provides the operating system for our organisation, through a structure of processes and routines that link 'board to ward' (the Operational Management System, or OMS). We have been using this approach since 2022 to deliver our vision and the 4 pillars we want to be known for. It has become the golden thread that runs through all that we do to make Great Western Hospitals a safer place to receive care and a better place to work.
- Key to the Improving Together approach is that by aligning around a smaller number of priorities and enabling teams through standard systems and tools, improvement is delivered in the processes and outcomes of the organisation. Improving Together relies on a set of behaviours that encourages coaching to enable front line teams, who can best see what needs to change, to find and deliver the improvements required. Importantly it also emphasises that by focussing on a smaller number of priorities, leaders are more respectful of individuals' and teams' time, and can have higher expectations of the delivery of improvement.
- This approach aligns extremely well with the direction of NHS IMPACT the national policy for improvement across the NHS which drives NHS organisations to have five major components of an improvement approach.
- The table below outlines the way in which Improving Together allows us to map our overall strategic intent to specific measurables (pillar metrics) which will help us understand if we are 'winning or losing'; this is known as our Strategic Planning Framework and has recently been updated to align with our refreshed strategy. The pillar metrics are then cascaded through the organisation through the operational management system, based around a set of improvement routines (including huddles, scorecard agreements and performance reviews) and lean tools and techniques.

NHS Impact (2023) The 5 key elements of an improvement programme

The Operational Management System

Refresh of the OMS for 2025/26

Great Western Hospitals NHS Foundation Trust

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

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

12 Month Breakthrough Objectives

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

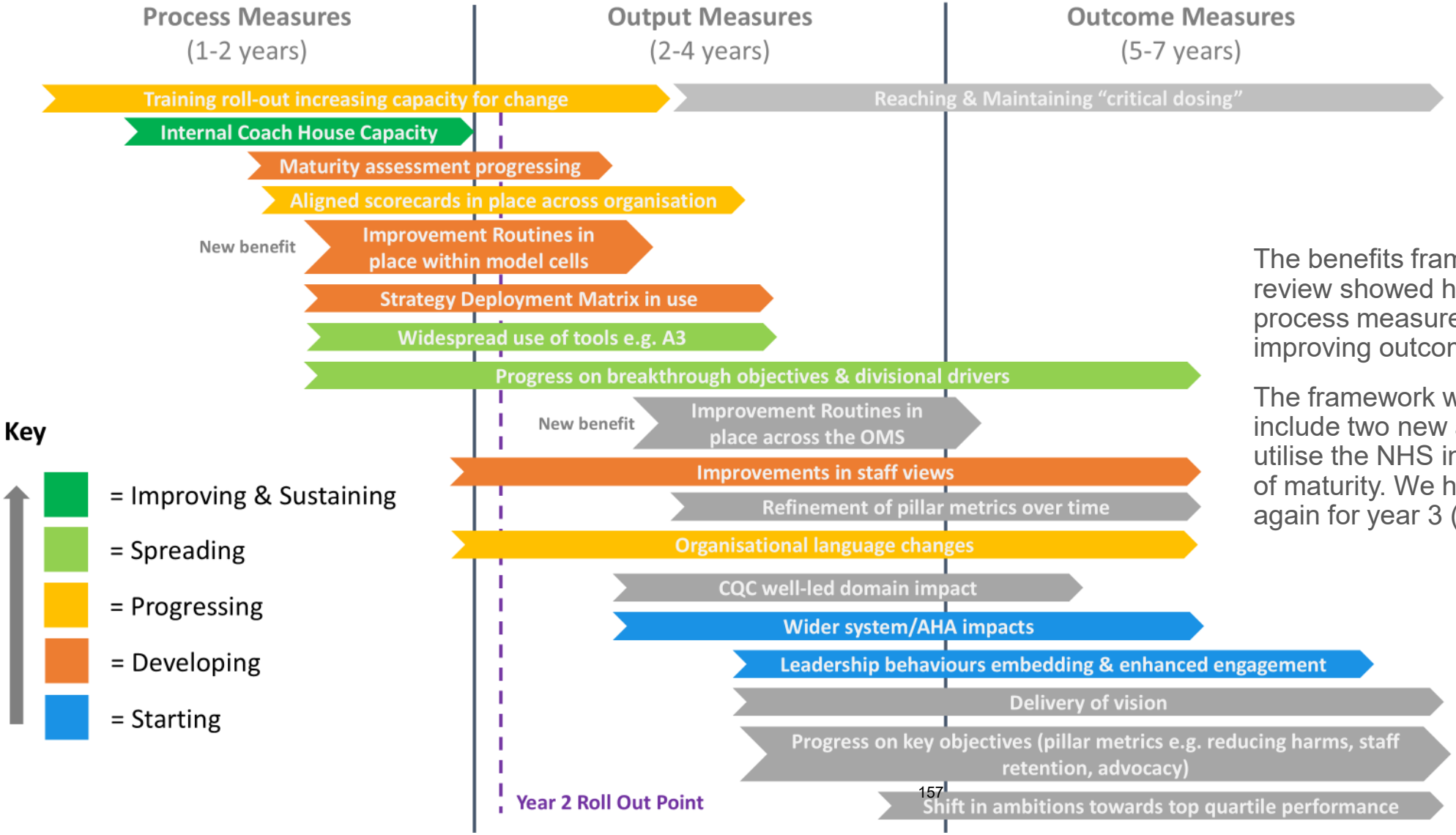
Operational in nature and where we will focus our improvement

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

Year 2 review

Great Western Hospitals NHS Foundation Trust

The Framework – from year 1



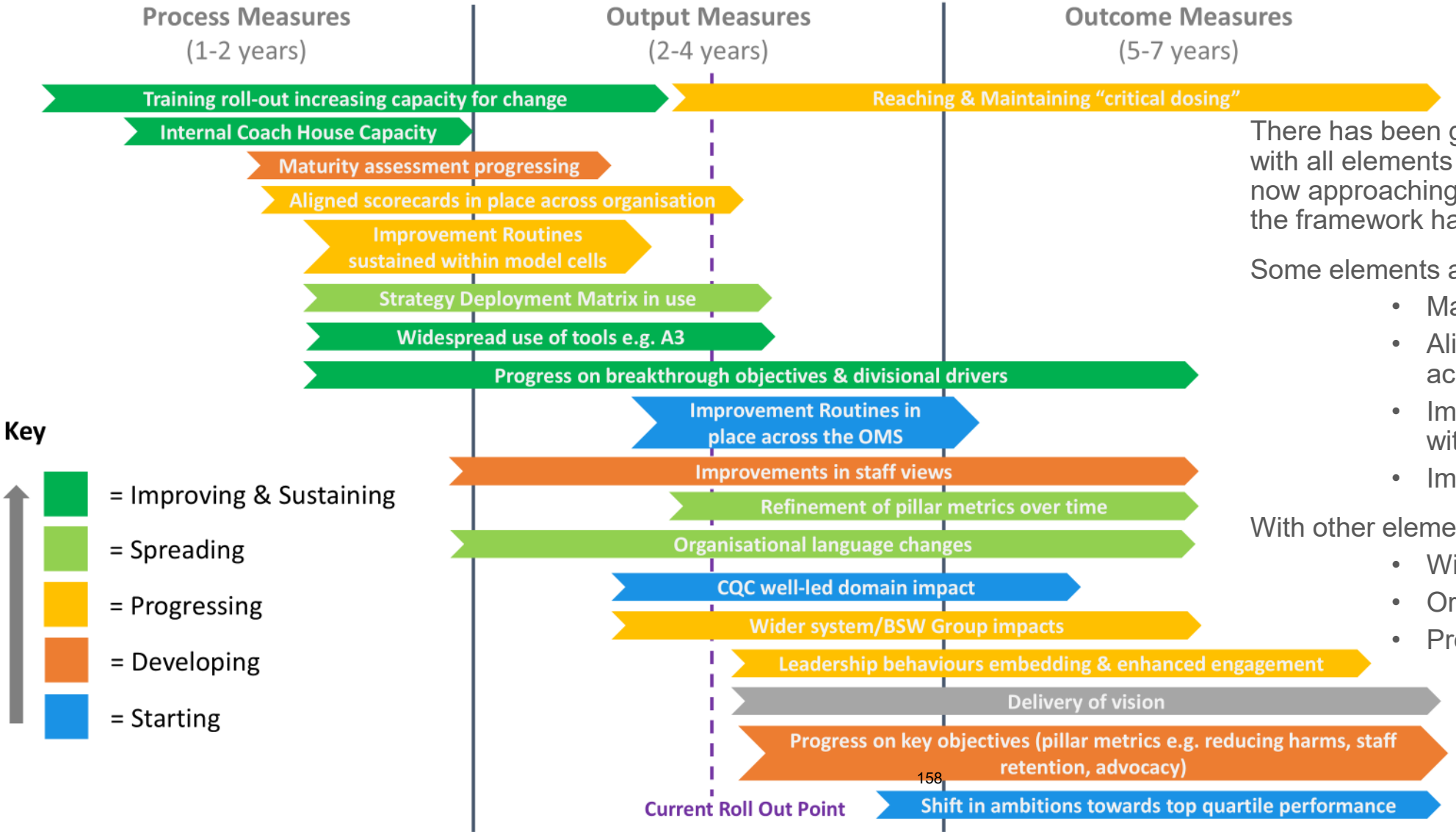
The benefits framework from the June 2023 review showed how we expected to move from process measures, towards outputs and then improving outcomes.

The framework was updated in year 2 to include two new anticipated benefits and to utilise the NHS impact criteria for assessment of maturity. We have used this framework again for year 3 (next page).

Year 3 review

Updated for June 2025

Great Western Hospitals NHS Foundation Trust



There has been good progress on early benefits with all elements showing improvement. We are now approaching the point where all elements of the framework have, as a minimum started.

Some elements are behind expected progress

- Maturity assessment progress
- Aligned scorecards in place across the organisation
- Improvement routines sustained within model cells
- Improvement in staff views

With other elements progressing faster

- Wider system/group impacts
- Organisational language changes
- Progress on key objectives

Year 3 Priorities

NHS
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NHS Foundation Trust

Maturity & Sustainability

During the year 2 review three priorities were set for year 3

Focus on sustainability: The third year of Improving Together implementation has been a successful period where practices and knowledge have become more embedded, however, sustainability challenges remain. We have focused on the interface between the frontline, specialty, division and executive layers. Involvement of divisional teams in frontline training has supported alignment. We have acted on feedback from staff and have significantly simplified trainings to reduce the time commitment and focus on essentials.

We have also supported re-engagement activities with teams to support relaunches of improvement routines and focus on delivery. Moving forwards an A3 on sustainability is in place with clear plans to develop review meeting practice following feedback from teams.

Increasing the patient/public voice: we have redesigned training material to focus our “why” on improving patient experience. We have built more patient feedback into priority setting with teams and highlighted taking a patient perspective during use of improvement tools such as Go & See and Rapid Improvement Events.

Improving Together is linking closely with our patient safety teams on supporting improvements arising from PSIRF and ward accreditation work.

Increasing work at Group level: across the BSW Hospitals Group we have worked together to align training and bring our teams more closely together to share knowledge and work jointly on shared problems. We have developed a Group Strategic Planning Framework which will evolve as a Group Strategy is launched during 2025/26. We have started to implement a Group Engine Room to plan together and share priorities and resources more directly.

Our **Improving Together Week** in November 24 got the organisation talking about improvements through activities and Tea Trolley rounds (we made 750 hot drinks!)

Training Roll-Out

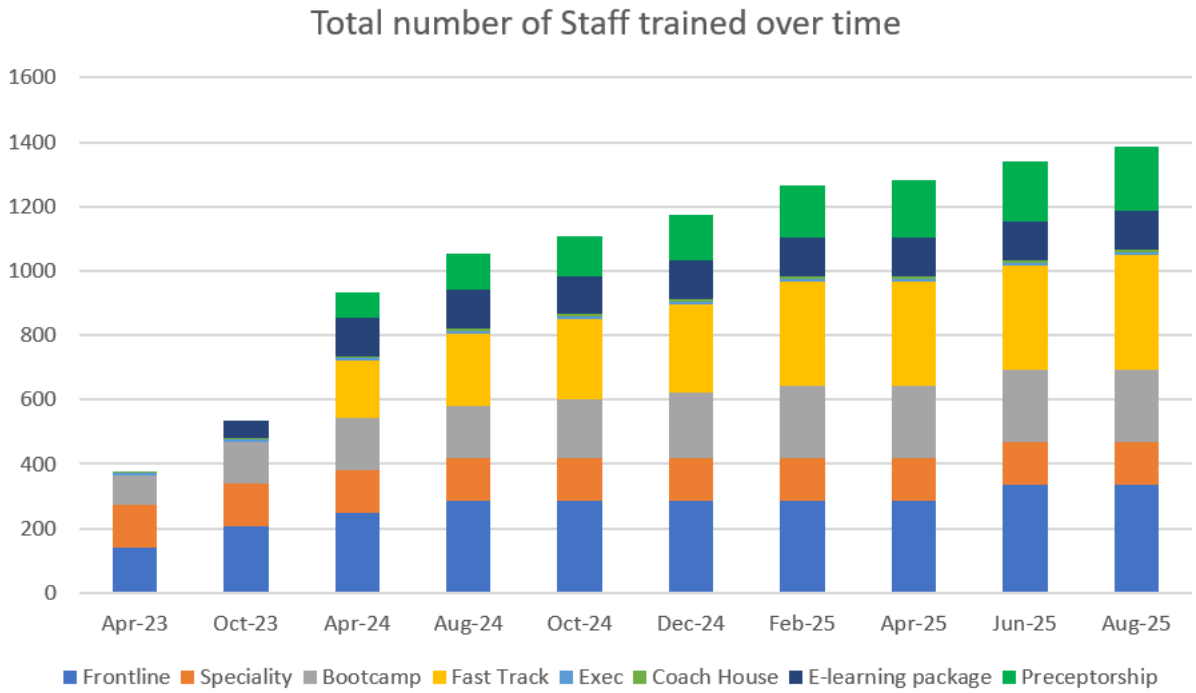
Great Western Hospitals NHS Foundation Trust

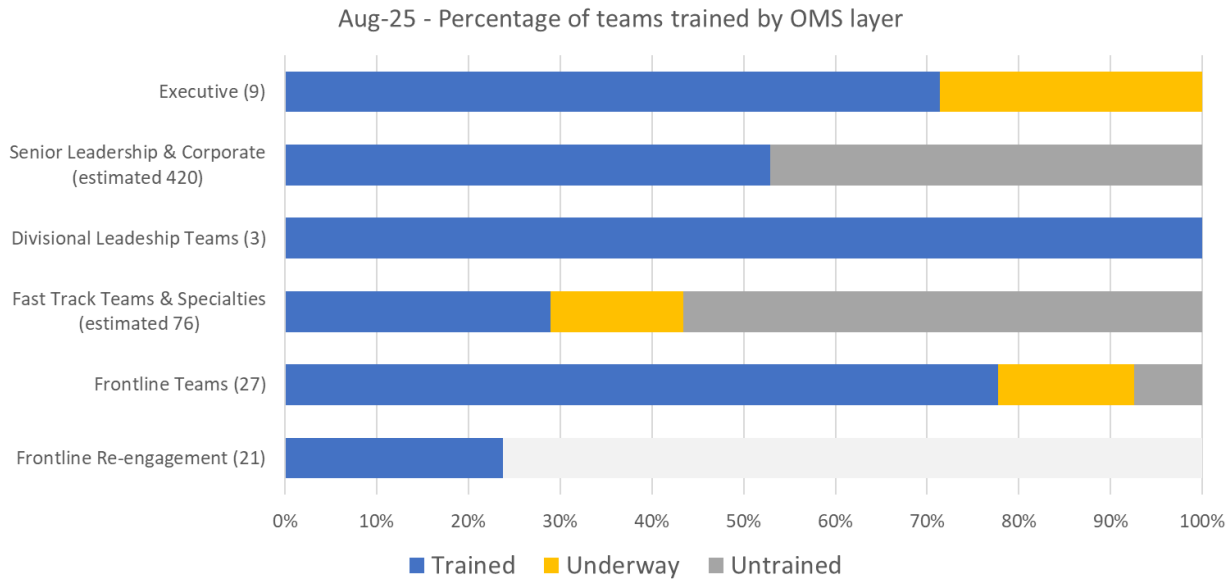
As part of the focus on sustainability we have reviewed our approach to training and the training offer has been refreshed and updated. We have continued with three core modes of training: Fast Track, Frontline and Boot Camp whilst introducing increased content in Corporate Induction and supporting other training delivery across the organisation. This includes aligning with the ward accreditation programme and preceptorship training.

- **Fast Track** training has been continued alongside other modes
  - Self-selecting – tend to be smaller frontline teams and corporate teams
  - Tailored to meet the needs of teams
  - Delivered at a time and pace that works for the team
- **Frontline** training has continued we are now delivering Cohort 7 which is expected to be the penultimate cohort
  - We have updated our training formats to support the operational context reducing from five to three modules. Content has been simplified to be directed at what the teams need at the start of their journey
  - Increased involvement from divisional and specialty teams has made a big difference
  - There is increased focus on working sessions delivered at durations and times that suit the teams with the Coach House supporting direct delivery of improvement
- **Bootcamp** training has continued in a reduced format, We have trialled the first bootcamp delivered at Group level for new senior leaders across the BSW Hospital Group
- **Re-engagement:** There has been increased focus on re-engaging frontline teams from earlier cohorts to support them in increasing their sustainability of approach and maximise benefits, this support has been ward based and at the pace of the team

Training Roll-Out

Training KPI progress





- Training roll-out is expected to take 5-7 years
- There has been a loss of some trained staff in-year as 7 community teams had received training (3 frontline teams and 4 fast track teams)
- Training is progressing at a good rate, with steady progress on frontline cohort and fast track training. Approximately 28% of staff have now received targeted Improving Together training this is an increase from 18% at the year 2 review
- Improving Together material is present in all “in house” leadership development training including junior doctor QI training and New Consultant programme
- Teams who have received frontline and fast track training are shown in appendix 1

Sustainability – frontline teams

Maturity & Sustainability

The graph shows the outcome of the 6-monthly sustainability audit with frontline teams. It shows that around 50% of teams struggle to maintain the routines and practices that are introduced through training.

Improvement tools and techniques, including A3 structured problem solving, are sustained within teams

Overall we have found improvement huddles are not well sustained in frontline areas, reasons given include: operational pressures & staff fatigue, routines not embedded within normal flow & huddles feel repetitive, lack of accountability for team's chosen drivers, over-reliance on senior nursing team members to sustain practice. Many areas are keen to re-engage and are being supported;

Family & Specialist Services

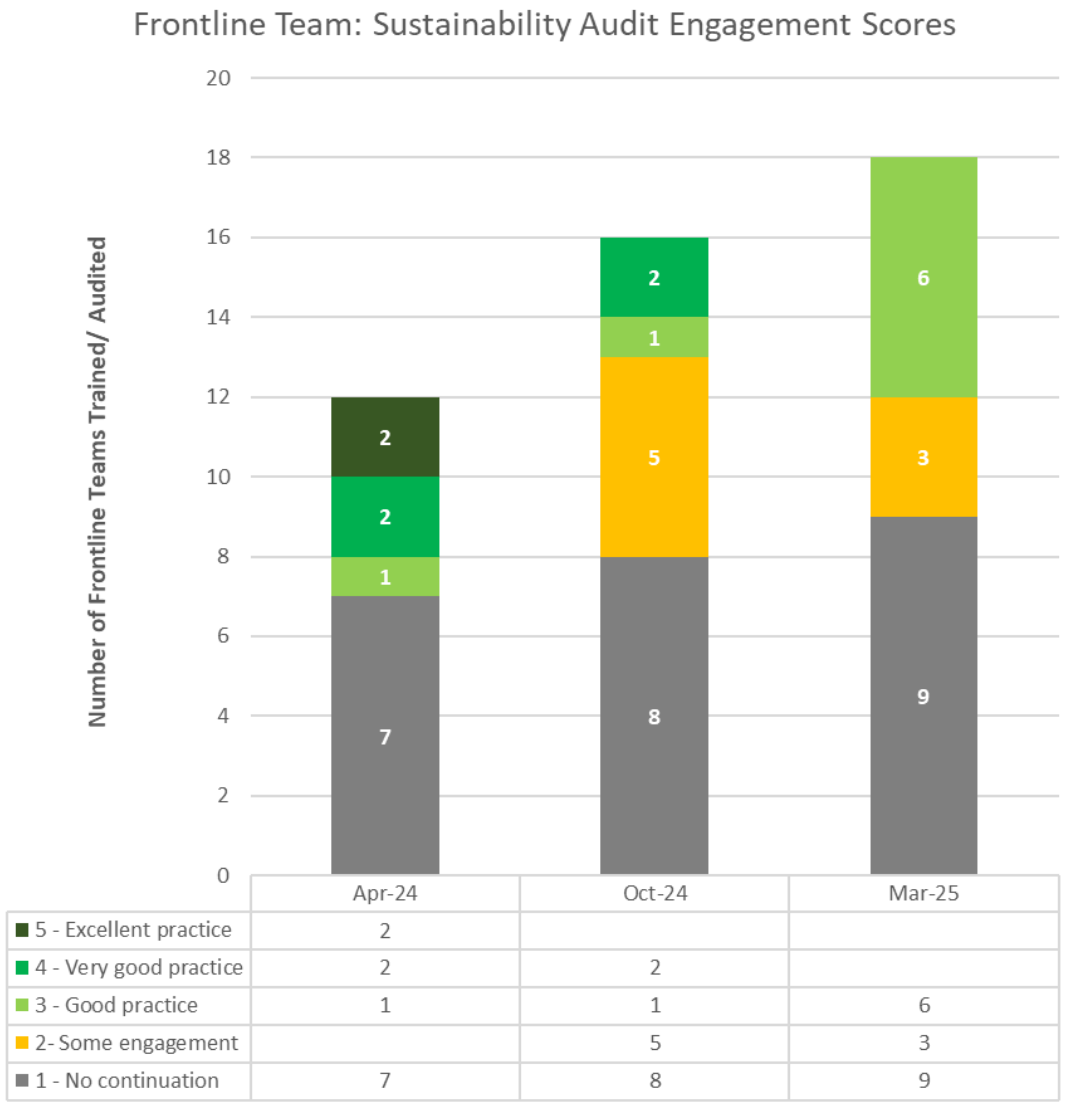
- **Children's Unit** – Enthusiastic to restart improvement huddles, have been actioning some of the improvement tickets
- **Delivery** – Boards displaying current project that is underway in the department. Improvement huddles started in April specifically around this topic.
- **Beech** – New ward manager in post who is keen to restart huddles.

Medicine

- **MAU** – Keen to restart improvement huddles.
- **ED** – Keen to restart improvement huddles. Improvement activities are ongoing
- **Neurology** - Monthly improvement huddles underway using the boards in ED

Surgery and Planned Care

- **Meldon** – Monthly data provided on the Performance Board.
- **SAU** – Boards displaying themes from re-engagement from tea trolley.
- **Aldbourne** – Not currently huddling but still making improvements on driver areas



Figures exclude 3 community teams who transferred to HCRG

Sustainability – fast track teams

Great Western Hospitals NHS Foundation Trust

Maturity & Sustainability

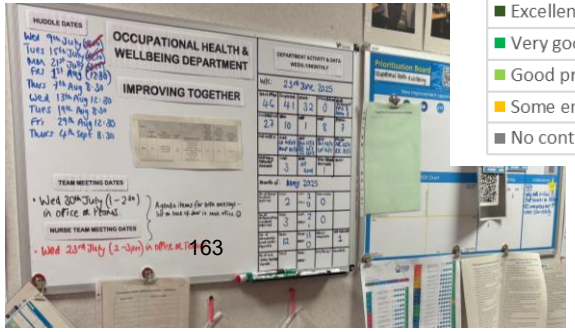
The number of teams receiving fast track training and using prioritisation boards has continued to increase. The graph shows the outcome of the 6-monthly sustainability audit with frontline teams. It shows a continued theme that teams receiving fast-track training remain more engaged with improvement huddles over time with 63% of teams continuing an improvement routine. Where routines have stopped feedback from teams is that departmental structures have made it difficult to continue routines and workload pressures often prevent improvement work.

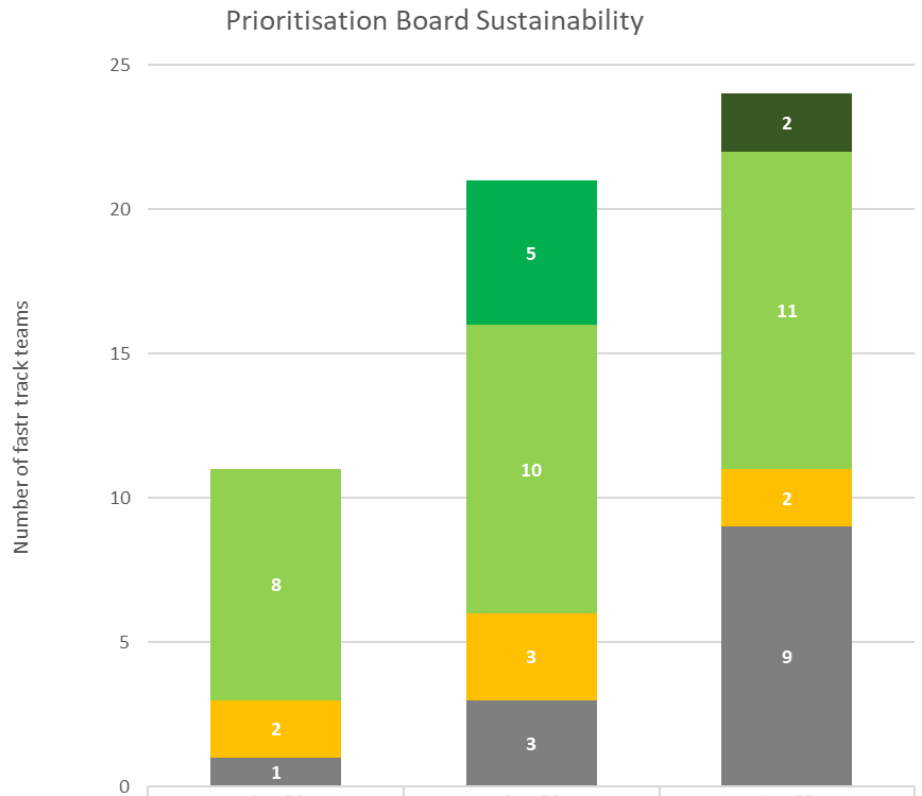
There have been many successes with fast-track teams

- Virtual boards are working well
- Positive feedback from teams that huddles provide focus and keep accountability
- These teams select the frequency of improvement huddles and monthly is emerging as a common frequency
- Practice is developing and changing including wider stakeholder engagement, developing feedback mechanisms

Improvements have included:

- Bringing a remote team together
- Improving paperwork efficiency for caseload monitoring
- Learning from incidents and creating a champions network
- Improving staff morale in conjunction with the TED tool
- Improvements to Trust processes to reduce errors
- Alignment between teams across GWH, RUH and SFT





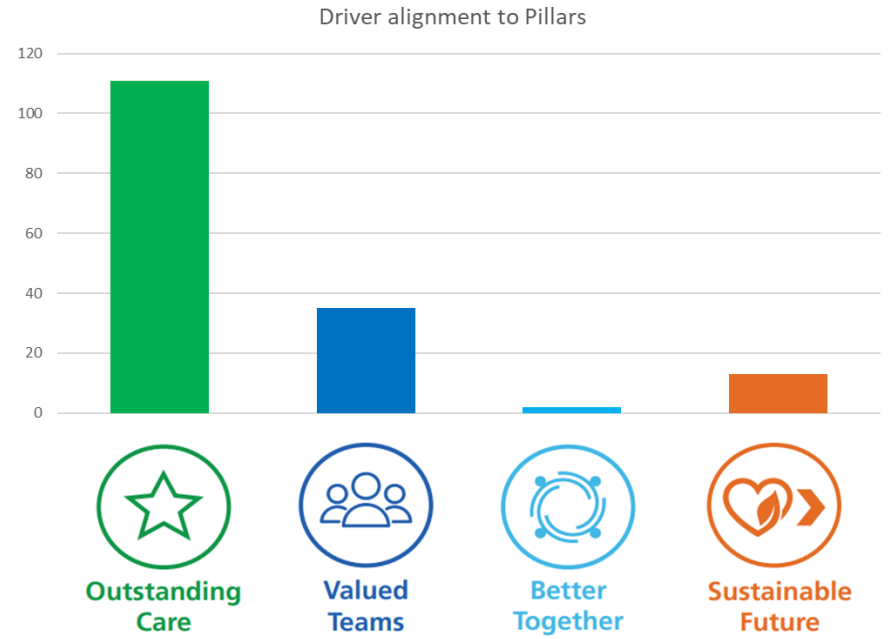
	Apr-24	Sep-24	Apr-25
Excellent practice			2
Very good practice		5	
Good practice	8	10	11
Some engagement	2	3	2
No continuation	1	3	9

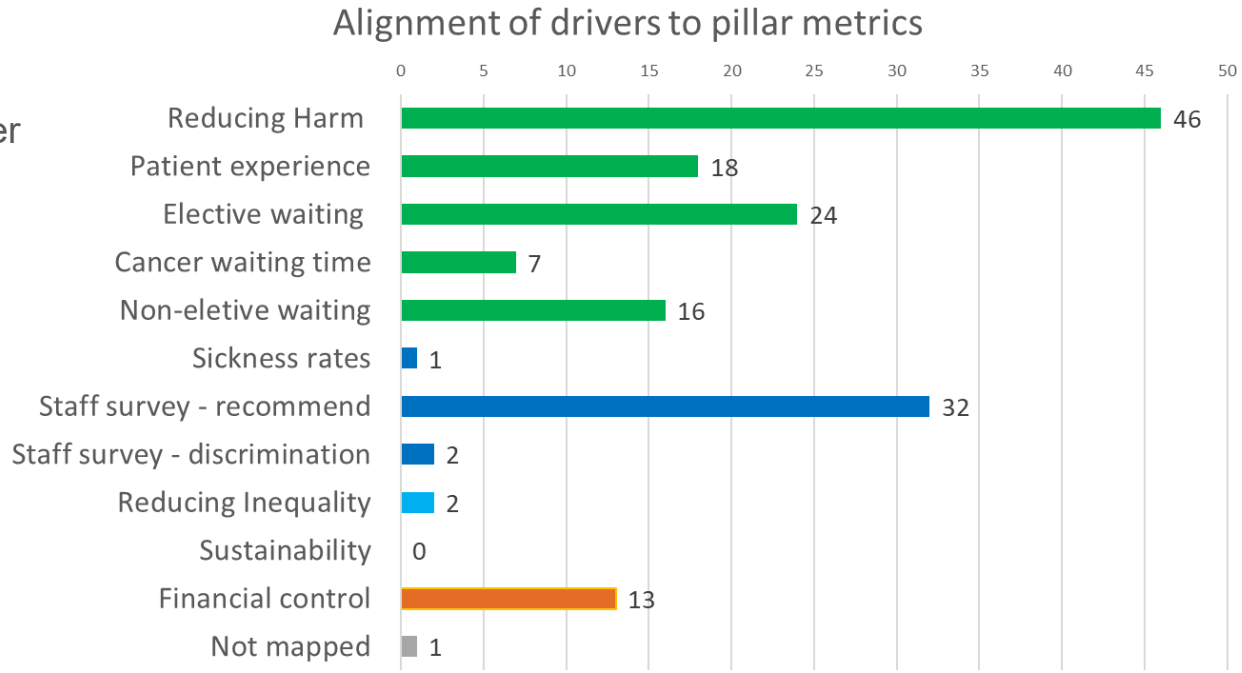
Figures exclude 4 community teams who transferred to HCRG

Strategic Alignment

Metric Alignment

- The six monthly audit also looks at driver metrics across the organisation (last completed in March 25)
- Gives an assessment of which driver and breakthrough objectives have improvement energies aligned across our Trust
- Where drivers are not readily available original drivers that were set during training are used. Given the sustainability audit results a significant proportion of driver metrics across the organisation are dormant. There has also been a trend towards recommending that teams work with a smaller number of priorities/drivers
- Overall the audit looks at the alignment of 162 drivers set at team, speciality and divisional level.
- 100% of drivers could be mapped to a strategic pillar with the majority mapping to outstanding care. Very few metrics align to the Better Together (1.2%) and Sustainable Future (8.0%).
- When drivers are mapped to individual pillar metrics it is clear that reducing harm and improving waiting times and access are priorities for teams alongside working on increasing staff morale and respect.
- There is much lower alignment of team priorities to areas such as reducing discrimination and working with partners to reduce health inequalities. When this is reviewed teams say that they find it harder to understand how they can directly influence these areas.

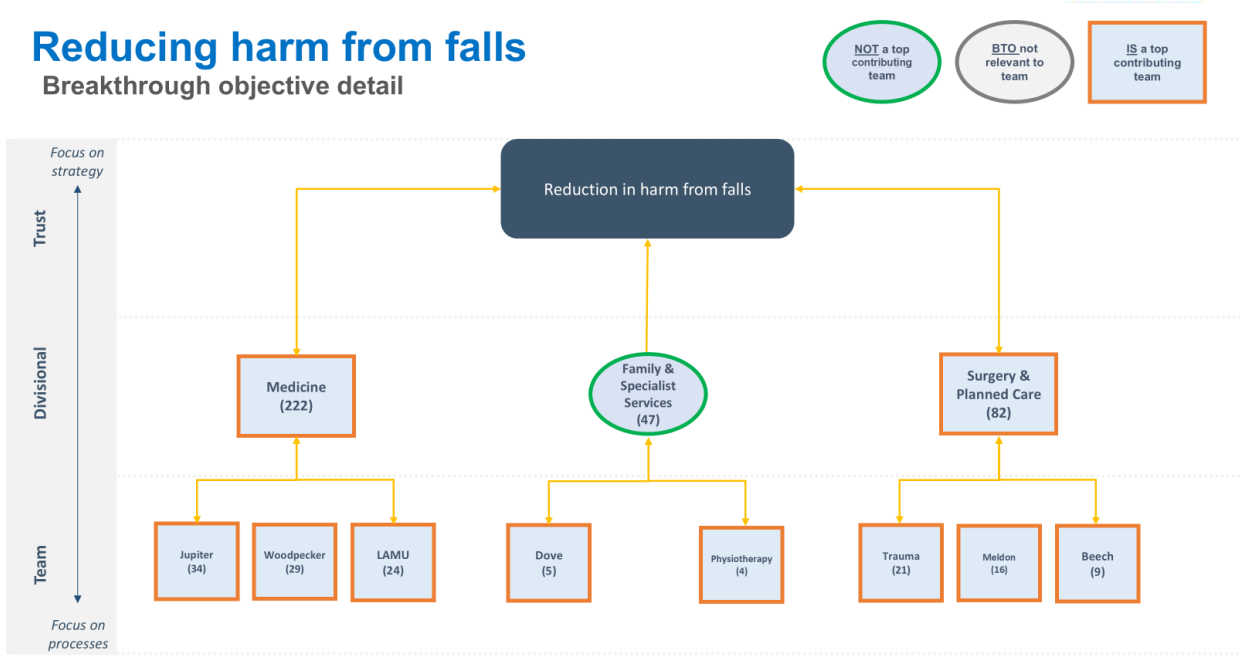




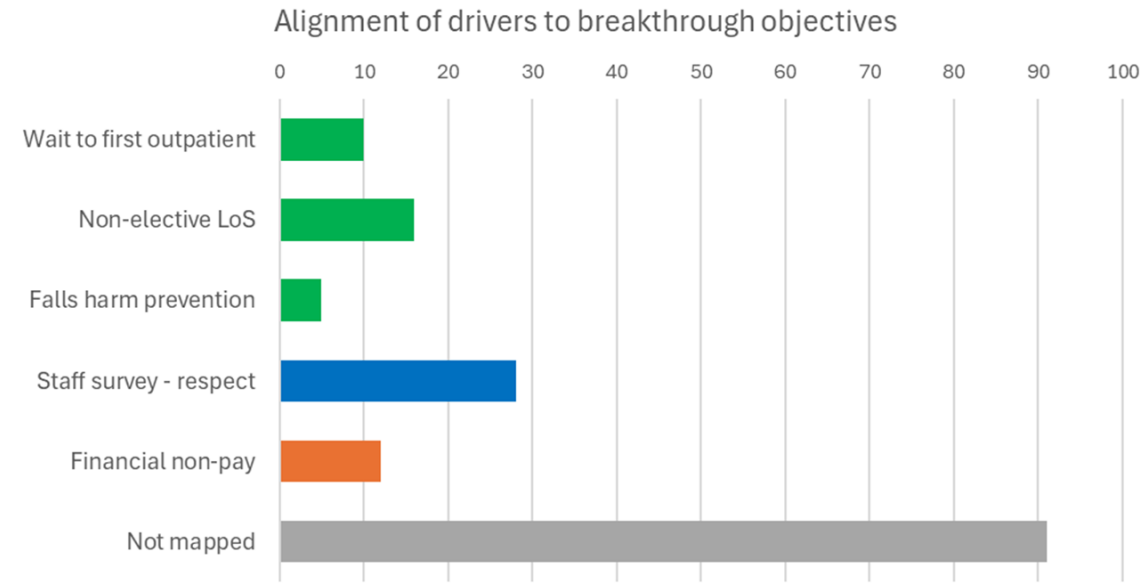
Strategic Alignment

Breakthrough objective alignment

- There has been increased focus on the strategic alignment between our 2025/26 breakthrough objectives and drivers across the organisation.
- 70 of the driver metrics across the organisation directly support the delivery of a breakthrough objective.
- The Coach House have provided support to each of the breakthrough objective groups to increase understanding of top contributing areas and to co-ordinate action across those working on similar problems supporting 4 key roles
  - Creating alignment & dialogue across the organisation
  - Understanding the position through go & see
  - Acting as a point of escalation for unresolved issues
  - Sharing celebrations



Metric – Number of falls incidents resulting in harm (Low – Death) reported on Datix between April 2024 – March 2025



Corporate Projects

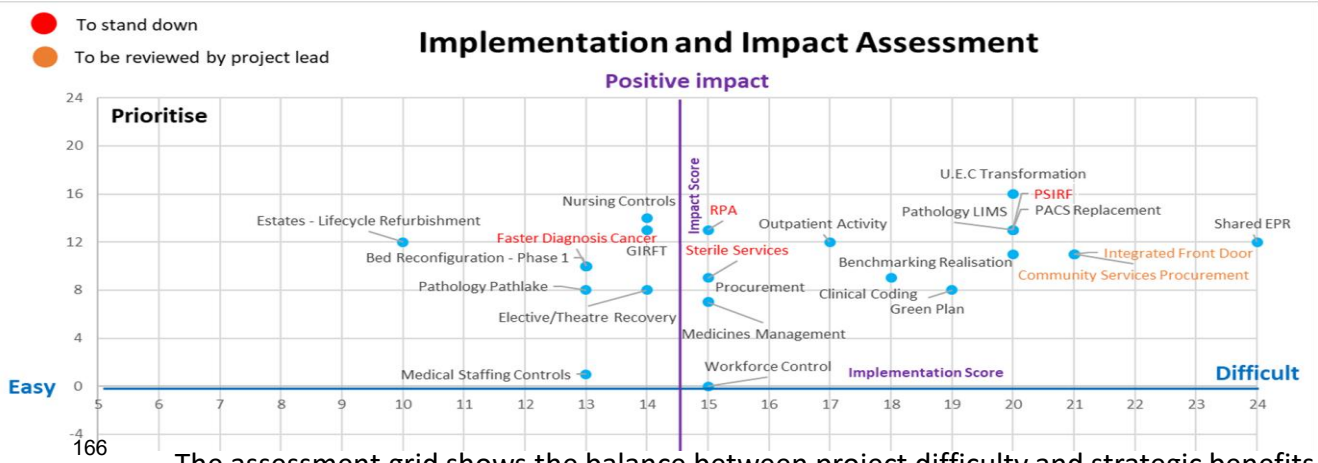
Prioritisation & Resourcing

Great Western Hospitals NHS Foundation Trust

During 2024–25, the Trust's corporate project management approach matured significantly, supported by the Improving Together framework and strengthened governance via Trust Resource Reallocation & Investment Group (TRIGG) and Trust Management Committee (TMC). The corporate portfolio continued to be coordinated via the Strategy Deployment Matrix (SDM), with a review and reset completed in July 2024 that segmented all live projects into four categorisations. The SDM now explicitly incorporates Financial Recovery Sub-Committee led workstreams, supporting alignment with strategic transformation priorities such as EPR implementation, Community Services Integration, and outcomes-based delivery. Bi-monthly project reviews at TRRIG informed actionable updates at TMC, with assurance provided that governance and controls were embedded across the programme.

Key achievements included the standardisation of programme exit criteria, enabling the controlled transition of select projects out of central oversight and into operational ownership, improving agility and reducing scrutiny burden. Steps were taken to better manage resources by creating a "wait list" for projects that had low activity or were not using many resources, helping us focus on the highest impact work. We also improved how we link corporate projects to key organisational risks. Several projects - including pathology LIMS and benchmarking were flagged as higher risk, and actions were taken to address those issues.

Trust Projects and Change Initiatives	Category	Executive sponsor	Operational Lead	Project Lead	Constraints to delivery	Benefits Delivery BRAG	Milestone Progress BRAG	Benefits Delivery BRAG	Milestone Progress BRAG
Integrated Front Door Risk Register ID 679 Risk Rating 3 End Date: 01/10/2024	Mission Critical	Simon Wade	Julian Auckland-Lewis	Katherine Brown	- None reported	G	G	G	G
Sterile services Risk Register ID 565 Risk Rating 12	Mission Critical	Simon Wade	Julian Auckland-Lewis	Katherine Brown	- Key constraints are: - - Capital funding. - - Cost: utilities / infrastructure required for green field site. - - Unnecessary involvement of NHSE / DHSC slowing procurement process down.	Currently paused and will be reviewed on a 6 monthly basis as dependent on capital funds			
Shared EPR Risk Register ID 628 Risk rating 9	Mission Critical	Roger Steadman	Jon Burwell	Kelly Kleiff	- Future state review (FSR) workshops are needing to be planned and scheduled without all programme resource in place. SME networks have not been established between central and local resources. Risk to appropriate representation at the 500+ FSR workshops to be held over a 5 month period starting in November.	G	A	G	G
Pathology LIMS Risk Register ID 729 Risk Rating 20	Mission Critical	Jon Burwell (Interim)	Graeme Getty	Karen Fido	- Analyser workstream at risk of falling behind schedule due to lack of engagement from 3rd Party suppliers - New Infection Control system being procured.	A	A	A	A
RPA	Mission Critical	Felicity Taylor-Drew	Peter Coutts	Rob McKinley		Review ongoing whether to stand down or re-scope. Helen Mee and Jon Burwell			
GIRFT Supports several risks but not directly to a risk	Important	Steve Haig *(original lead recorded as C Thompson)*	None	Gary Crisp	- Potential lack of progress against recommendations made in historical GIRFT reports, deep dives and system visits. - T&I capacity (Q3&4 2024/25)	A	G	A	G
Green Plan Risk Register ID 1005 Risk Rating 8	Important	Simon Wade	Rupert Turk	Caroline Railston-Brown	- Lack of funding	R	R	R	R
Faster Diagnosis Cancer Risk Register ID 448 Risk Rating 20	Important	Felicity Taylor - Drewe	Steve Hambley			Outstanding TMC action on whether benefits have been realised or whether stand down request based on resources – **to be discussed at TRIGG**			
Pathology Pathlake End date Early 2025	Important	Felicity Taylor - Drewe	Trace Farrow	Graeme Getty	- Delay to S4 combined LIMS project	G	G	G	G



The assessment grid shows the balance between project difficulty and strategic benefits, supporting informed decision-making

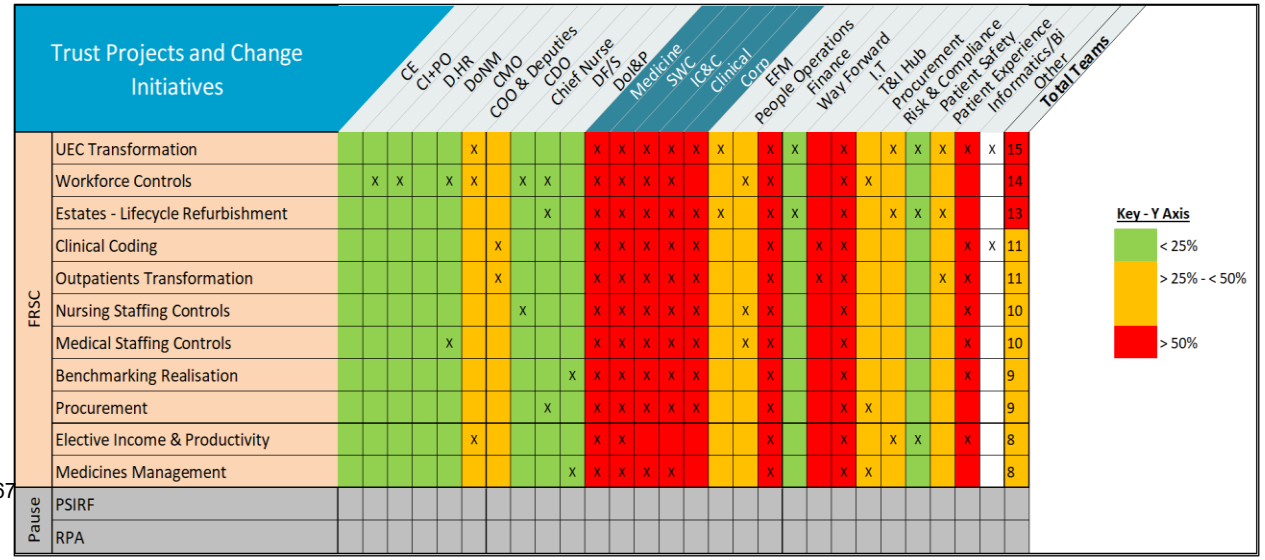
Corporate Projects

Strategy Deployment Matrix

Great Western Hospitals NHS Foundation Trust

During Q1 of 2025/26, the corporate projects routine continued to improve in visibility, assurance, and alignment to Trust priorities, with delivery fully embedded in TRRIG reviews and TMC reporting cycles. There has been increased focus on benefits realisation with the Integrated Front Door project leading the way on this. The Strategy Deployment Matrix (SDM) was comprehensively reviewed in July, resulting in reclassification of projects into revised implementation and impact groupings. The SDM now reflects greater integration of operational risks and quality priorities, and updates from Financial Recovery (FRSC) workstreams remain embedded.

Highlight reports will be streamlined to focus assurance and reduce administrative burden, particularly for lower-risk or inactive items. Two projects - Shared EPR and Urgent & Emergency Care transformation were classified as requiring the most intense resourcing and remain under close review due to their impact on cross-Trust capacity. Transformation capacity and resource bottlenecks will continue to be monitored.



Board & Governance

Strengthened commitment

In 2025/26, the Trust has further strengthened its commitment to effective leadership, a positive workplace culture, and robust governance:

Leadership Capability: Enhanced induction and ongoing professional development for new executive and non-executive directors, supported by tailored leadership forums and mentoring programmes.

Positive Culture: Progress towards a more inclusive and improvement-focused environment, as evidenced by higher staff engagement, increased engagement in the NHS Staff Survey and active promotion of organisational values. As we move forward into launching “our behaviours” Improving Together will be at the heart of the work with our behaviours being crucial to the delivery of the Operational Management System.

Increased Strategic Alignment: The Board focuses on aligning or improvement intent with increasingly strong links to the Trust’s vision and strategic objectives; we are working to simplify reporting to committees on key improvement drivers and risk-based escalations.

Governance and Accountability: There has been a focus on committee and Executive Review level accountability to increase alignment and create readiness for BSW Hospitals Group changes. Moving into year 4, increased focus is needed on the alignment and accountability through the specialty and frontline levels and within the Corporate division.

Continuous Improvement: Learning from both successes and setbacks are actively captured and shared, driving organisation-wide improvement and innovation. The Executive Review Meetings and Improving Together Steering Group are the focus of this work.

Improving Together across the Group

Great Western Hospitals NHS Foundation Trust

Delivery at Group Level

Improving Together is a common approach across BSW Hospitals Group which has given us a great opportunity to collaborate across providers. During the last year we have developed a Group Strategic Planning Framework and implemented a Group Engine Room which is supporting the delivery of the five key shifts we want to be known for. Moving forwards we will develop a Group strategy which will support further progress on the Group SPF and we will share skills and resources between teams.

The Coach House teams are increasingly working together to share learning, support delivery and deliver common approach and materials. We have started to deliver training and coaching together.

As we move into year 4 of deployment there will be increased emphasis on delivery through group and a shift to more risk-based escalation. Creating strategic alignment and managing resource across the Group.

Group Strategic Planning Framework

Vision: Working together, learning together, improving together to provide excellent care for our population

Vision metrics

- Developing an engaged workforce
- Making our teams diverse and inclusive
- Making our services safer
- Improving timely access to our services
- Improving the experience of those who use our services
- Improving our financial sustainability
- Improving health equity

Strategic Initiatives 3-5 years
Group focus

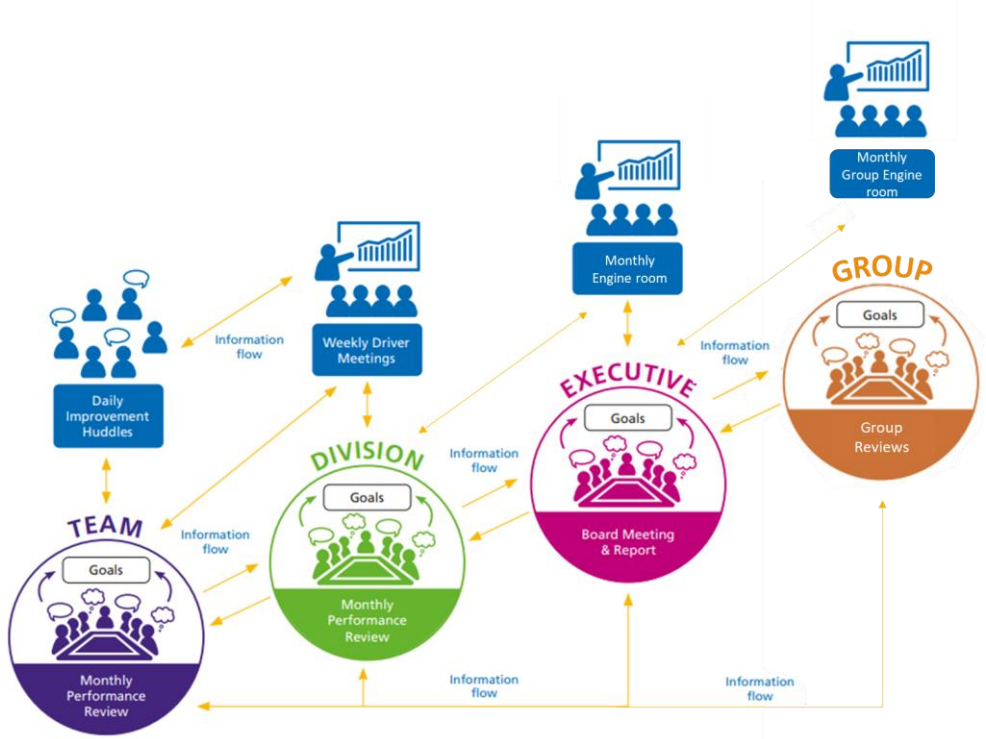
- Transforming model of care/ left shift
- Increasing sustainability
- Becoming an effective group
- Delivering digital maturity
- Taking our people with us

Corporate Projects

Breakthrough Objectives 12-18 months
Trust focus

- Reducing waits for our patients
- Increasing value/productivity
- Reducing avoidable harm
- Improving staff satisfaction

BSW HOSPITALS GROUP



Benefits Realisation

Improving
together

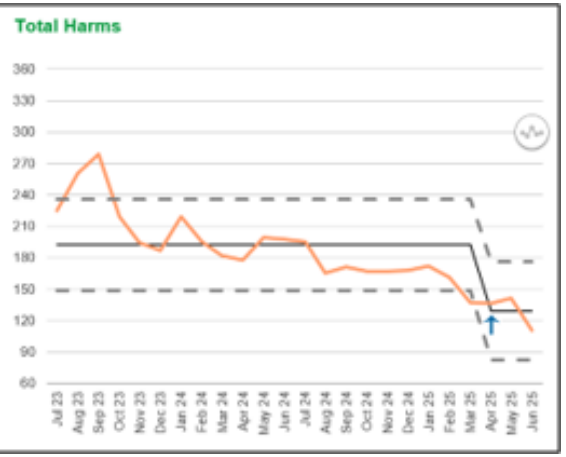
Pillar Metrics

2024/25 Progress

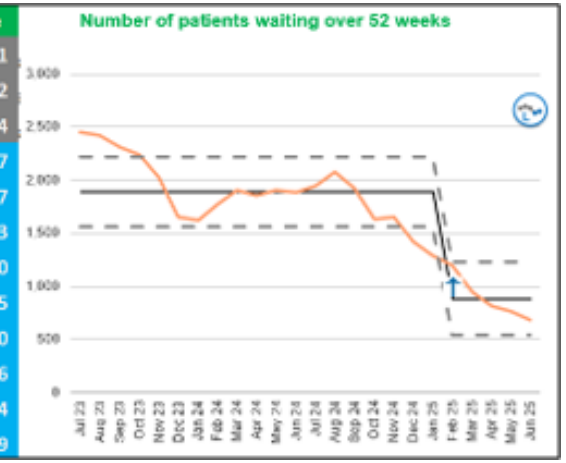
Our pillar metrics show how well we are delivering on our strategic pillars over the lifetime of our strategy. Ongoing measurement against our 12 pillar metrics have shown

- a 64% reduction in total avoidable harms across the Trust in the past three years, from 308 recorded in January 2022, to 111 in June 2025.
- A 65% reduction in the number of patients waiting over 52 weeks for treatment between July 2024 and June 2025.
- A reduction in the voluntary turnover rate of staff from 11% in March 23 to a sustained position of 8.5% over the last year
- Improvement in positive responses in the Friends and Family test score which reached 90% in April 2024, an increase from 87% in January 2021 and above the Trust's internal target of 85%.
- Approximately 30% reduction in our direct carbon footprint in line with our improvement plan.
- We remain focused on creating improvement in other pillar metrics including
  - Reducing the length people wait in our Emergency Department
  - Improving our timely response to patient complaints
  - Reducing the disparity between white and BAME staff experiencing discrimination at work from colleagues
  - Increasing the number of staff who would recommend GWH as a place to work
  - Living within our financial resources

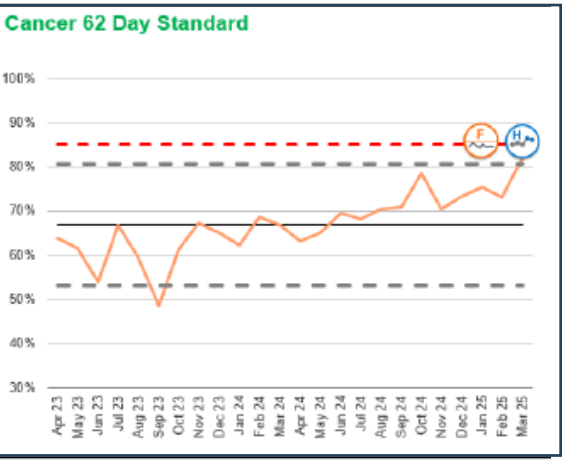
Timescale	Value
Jul 24	195
Aug 24	165
Sep 24	171
Oct 24	167
Nov 24	167
Dec 24	168
Jan 25	172
Feb 25	161
Mar 25	137
Apr 25	136
May 25	141
Jun 25	111



Timescale	Value
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
Jun 25	679



Timescale	Value
Apr 24	63.1%
May 24	65.1%
Jun 24	69.4%
Jul 24	68.1%
Aug 24	70.3%
Sep 24	70.8%
Oct 24	78.5%
Nov 24	70.4%
Dec 24	73.4%
Jan 25	75.3%
Feb 25	73.1%
Mar 25	82.1%



Breakthrough Objective Refresh

2024/25 Progress

Great Western Hospitals NHS Foundation Trust

- Breakthrough objectives refreshed for 2024/25, aim is for rapid improvement (of around 20-30%) over a 12-18 month period
- A breakthrough objective is derived from our understanding of where the biggest opportunity exists for improvement in our pillar metrics
- A breakthrough objective should be operational in nature and can be supported by frontline continuous improvement and corporate project resource
- Breakthrough objectives have been refreshed for 25/26 following the launch of our updated strategy

Breakthrough Objectives

		Aim	Progress
BTO	Ambulance Handover delays	Reduce total number of minutes waiting for patient handover	No significant change
BTO	Reducing Harm from falls	Reduction in number of falls by 10% (<90 falls per month)	Improvement in SPC run chart
BTO	Staff Survey = receive respect	Achieve 75% in staff survey	No significant change
BTO	Financial Recovery	Reducing run-rate to plan	Early signs of improvement

13/01/25	20/01/25	27/01/25	03/02/25	10/02/25	17/02/25	24/02/25	03/03/25	10/03/25	17/03/25	24/03/25	31/03/25
911	963	1028	999	704	739	587	960	657	652	412	942

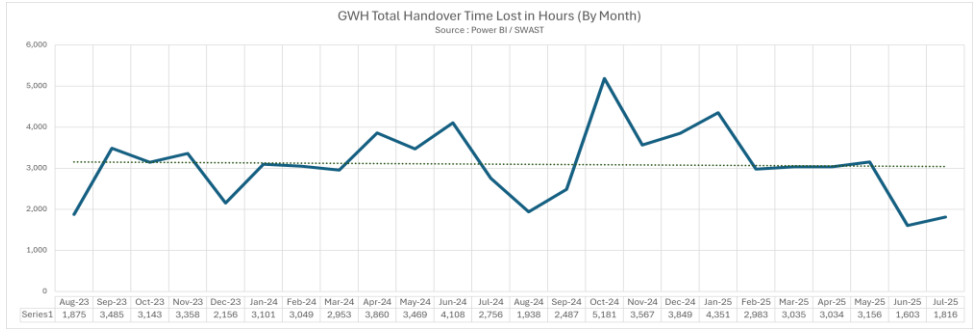
Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
97	83	101	83	112	117	117	105	84	104	104	71

2019	2020	2021	2022	2023	2024
75.44%	70.37%	68.85%	70.80%	69.96%	69.80%

Expenditure	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total expenditure (excl. passthrough items)	39,339	40,664	38,705	39,705	39,538	39,904	48,729	40,649	40,834	42,865	42,370	65,856
Medicine	12,248	12,820	12,457	12,931	11,862	12,206	16,193	13,250	12,909	13,581	13,246	14,812
SWC	10,484	10,848	10,666	10,633	10,818	10,628	15,049	10,865	11,573	11,003	11,344	11,984
ICC	5,397	5,420	5,057	5,578	5,685	5,620	7,188	5,962	6,181	5,634	5,310	5,723
Corp	7,947	8,022	8,014	8,169	8,348	7,971	8,915	8,008	8,262	8,313	9,080	9,183

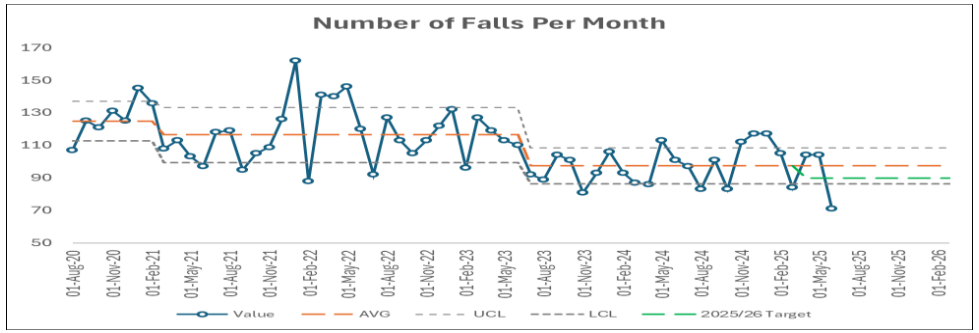
2024/25 Breakthrough Objectives

BTO Ambulance Handover delays



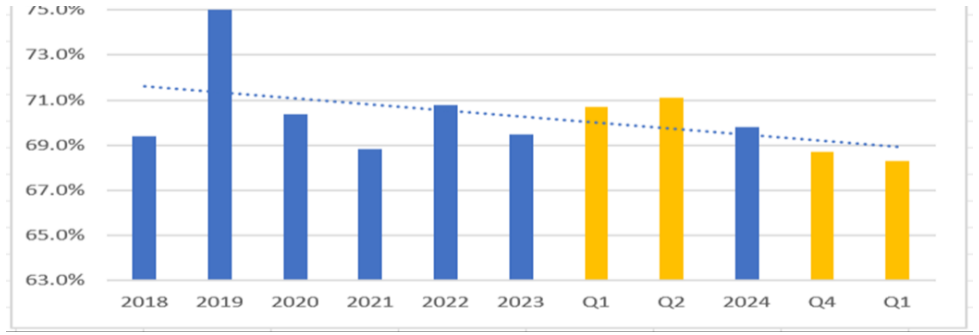
Ambulance handovers stopped being a breakthrough objective in March 2025. This has remained a key metric in UEC recovery and progress has been made during Quarter 1 of 2025/26.

BTO Reducing Harm from falls



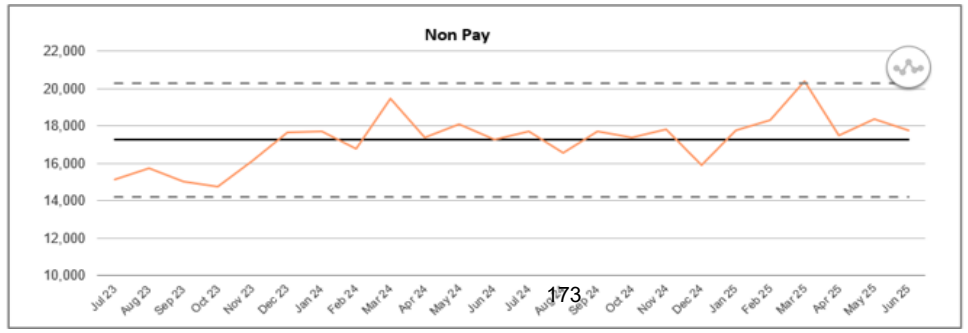
Significant improvement made over time, this metric has been a breakthrough objective for 14 months. Our improvement against the 2022/23 trend suggests we could have prevented an additional 456 patient falls costing the NHS circa £1.1m and significantly reducing harm.

BTO Staff Survey = receive respect



There has been no significant change to this metric although areas rating the question below average have changed. There is intensive work ongoing through divisions to support areas where scores are lower and learn from areas where scores are higher.

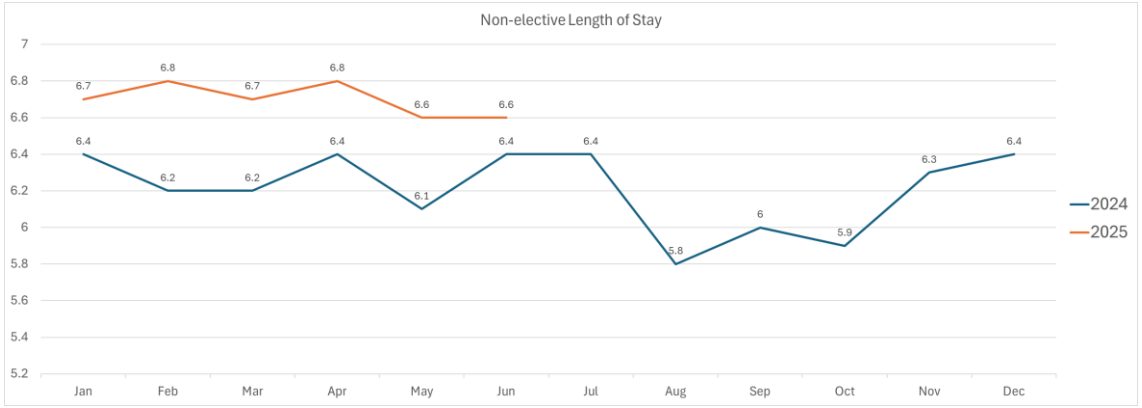
BTO Financial Recovery



The 2024/25 year end position was £1.4m favourable to plan. The 2025/26 focus is on reducing the non-pay financial run rate because this is the top contributor to variance from plan. The change of focus was made in April 2025 and there are early signs of improvement in the data following the increase in focus.

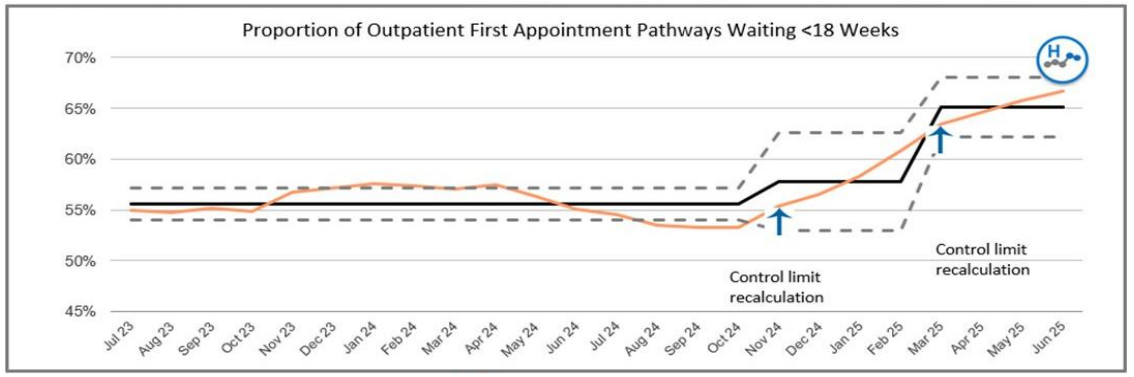
NHS Great Western Hospitals NHS Foundation Trust

BTO Non-elective length of stay



Aiming to achieve a non-elective length of stay below the 2024/25 baseline period for a minimum of six consecutive months. Focused work, led by the urgent & emergency care programme and medicine division is ongoing with changes to patient flow and the model of medical supervision. Early signs of improvement through Quarter 1 of 2025/26.

BTO Outpatient waiting to 1st appointment



Aim to achieve and sustain the standard of 72% of RTT patients waiting less than 18 weeks for their first appointment by April 26. Sustained improvement seen in the first 6 months of focused work. Target has been increased from 68% to the national standard of 72% following greater than anticipated improvement.

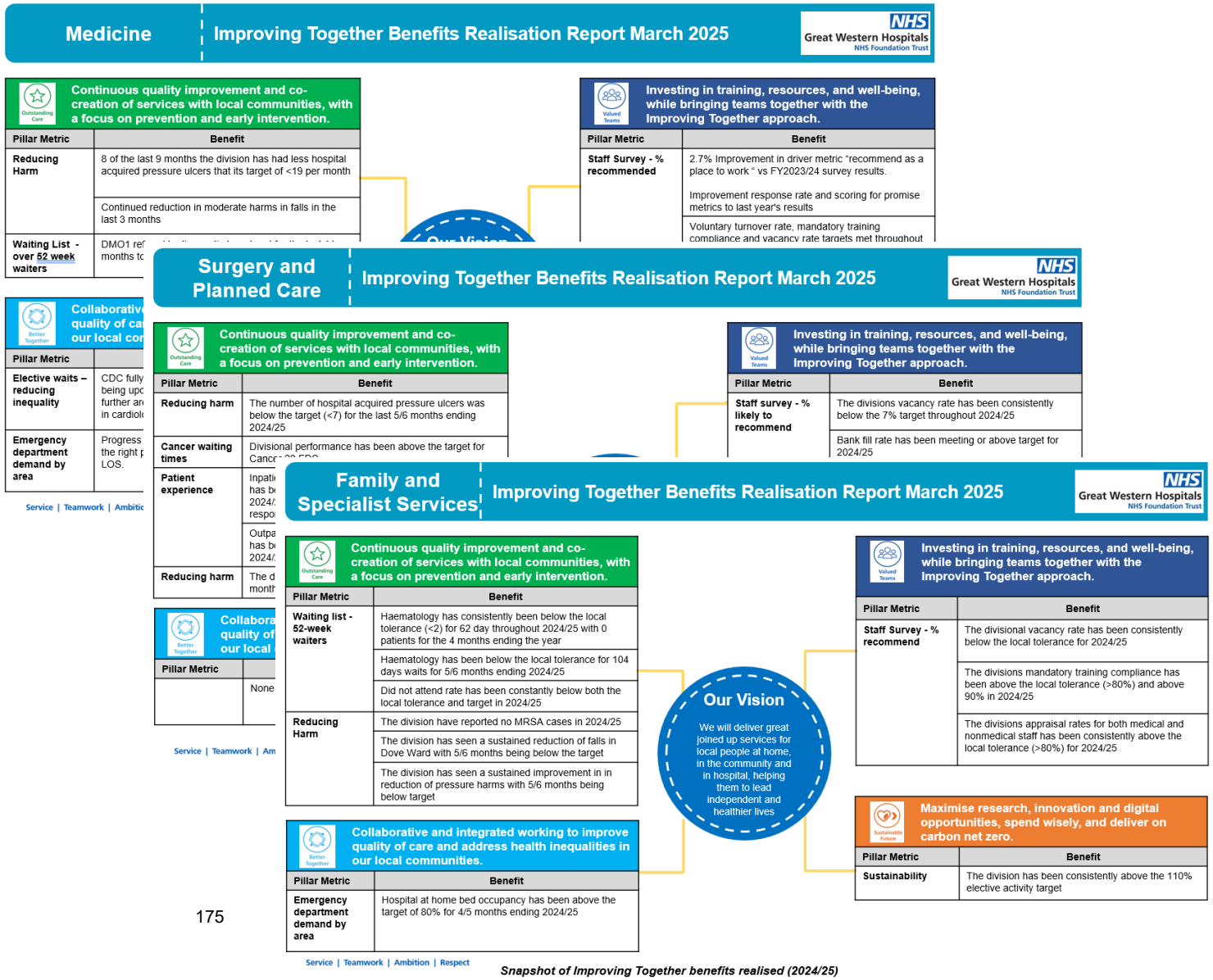
Progress against breakthrough objectives has been supported by

- Greater alignment with Divisional driver metrics
- Increasing clarity on the purpose of breakthrough objectives
- Improved focus on fewer evidence-based countermeasures to support rapid cycles of change
- Increasing familiarity and confidence with the approach in leaders across the organisation

Benefits Realisation

Divisional Benefits

- Divisional benefits realisation is undertaken quarterly and progress on Divisional driver metrics is reviewed via the monthly Executive Review Meetings.
- Divisions have reviewed and updated their divisional driver metrics in response to the refresh of the organisation's breakthrough objectives
- Appendix 2 gives further update on divisional level benefits.



Snapshot of Improving Together benefits realised (2024/25)

Celebrations

NHS Great Western Hospitals NHS Foundation Trust

Frontline team successes: there have been lots of smaller scale successes this year from ideas generated and led by frontline teams. These include

- Inclusive and sustainable theatre hats for birth partners and staff in maternity theatres
- Working with the Emergency Department team on patient transfers, radiology protocols and processes for the ambulatory majors area
- Occupational therapy working together to increase staff morale and well-being
- Embedding Improving Together within corporate induction so that it is part of our culture from the very first day of our staff's journey.

Larger scale transformation: increasingly the Transformation and Improvement team are supporting larger scale change drawing on the same approaches, some successes include

- Working with the clinical education fellows to improve the experience for resident doctors
- Supporting urgent and emergency care transformation including work on "bed idle" time
- Supporting improvement of pathology processes utilising a Rapid Improvement Event
- The Trust pad project supporting reducing inappropriate use of continence pads supporting cost reduction and increased comfort and safety
- Supporting improved stock management processes within ward areas reducing waste and making savings
- Aligning with the ward accreditation programme to support wards to improve compliance to the standards

"Improving Together helped us to approach the problem in a structured way. The team helped us gather evidence and get a better understanding of the issue which meant we were able to come up with meaningful solutions"

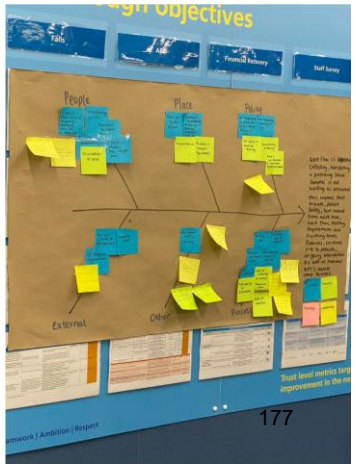
Transformation

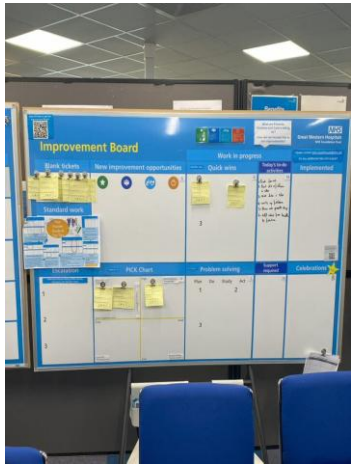
Great Western Hospitals NHS Foundation Trust

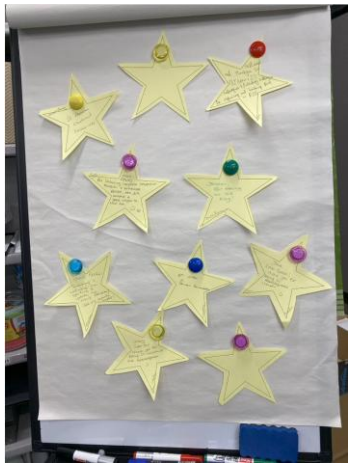
Rapid Improvement Events

- As part of our commitment to rapidly respond to data, insights, and opportunities, we have evaluated various change methodologies and implemented a standardised process for Rapid Improvement Events (RIEs).
- An RIE is a focused, short-term, collaborative event designed to understand and improve a specific area or process without requiring significant investment. It brings together the right people, providing them with dedicated time to address long-standing issues. Utilising scientific thinking, the team develops hypotheses and conducts change experiments, using measurement to demonstrate results.
- This standardised approach was successfully tested as part of a proof of concept in 2025, focusing on the process for requesting, collecting, transporting, and processing blood samples within key departments. The vision was to increase the rate of requests being made electronically and correctly.
- The post-RIE 90-day review confirmed that improvements made during the event have been sustained, with a 6% improvement Trustwide. Further improvement actions are being progressed by key stakeholders as we transition to business as usual, with Transformation support available where required.

There were Go & See visits in the Children's Unit and Emergency Department which gave pathology staff the chance to see how the requesting system is used in practice and understand how users interact with requests. This led to improvements and improved relationships.







Transformation

Benefits Realisation

During 2024/25 there has been an increased focus on benefits realisation. This has included:

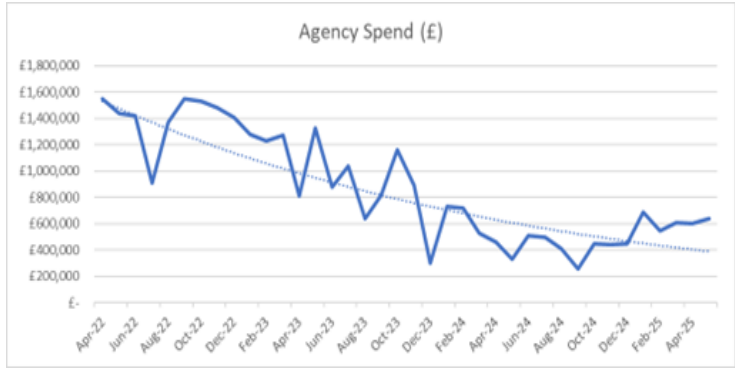
- Working with The Way Forward Programme to bring together benefits from Bed Reconfiguration, Medical Assessment Unit investment and the Integrated Front Door to support a combined benefits ownership and tracking process. Supporting the handover of benefits realisation to operational teams.
- Supporting Trust Resource Reallocation & Investment Group (TRRIG) the review of benefits from investments made over the last 2 years. Significant investments have been reviewed against the intended benefits within business cases identifying areas of good practice and highlighting further work needed. Reviews have included theatres investment, stroke and imaging business cases.
- Safer Staffing regular 6-monthly benefits review that has shown 81% of the anticipated benefits have been realised including significant patient safety and quality improvements alongside reductions in temporary staffing costs.
- Increasing benefits realisation capability within the organisation has been identified through our training needs analysis and forms part of our forward plan for 2025/26.

Safer Staffing

Benefits Realisation

Project Objectives - % of Benefits Achieved

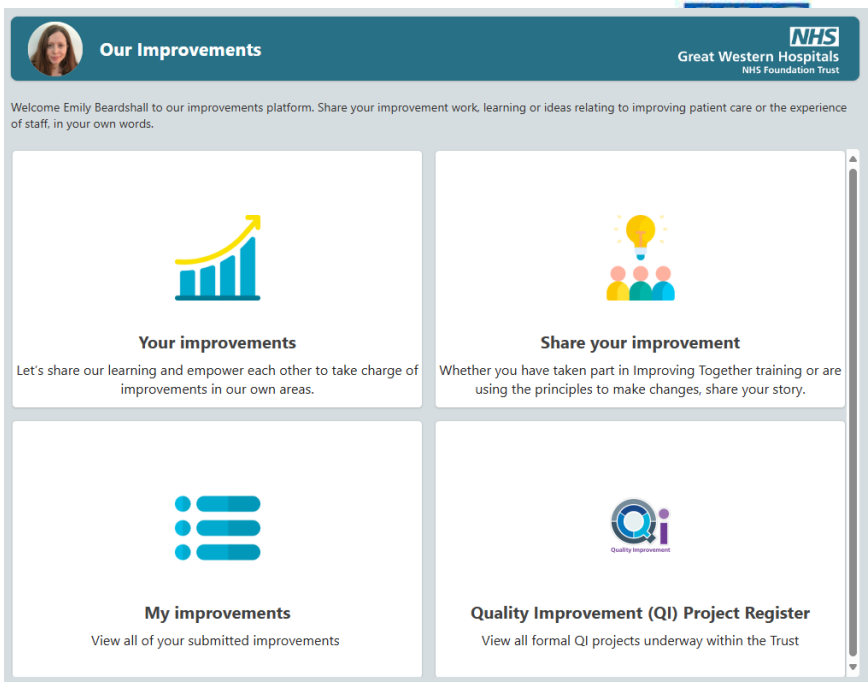
Objective	Achieved
Comply with national safe staffing guidance	100%
Improve patient safety	80%
Improve patient outcomes	0%
Improve patient experiance	67%
Improve staff development, experience and retention	95%

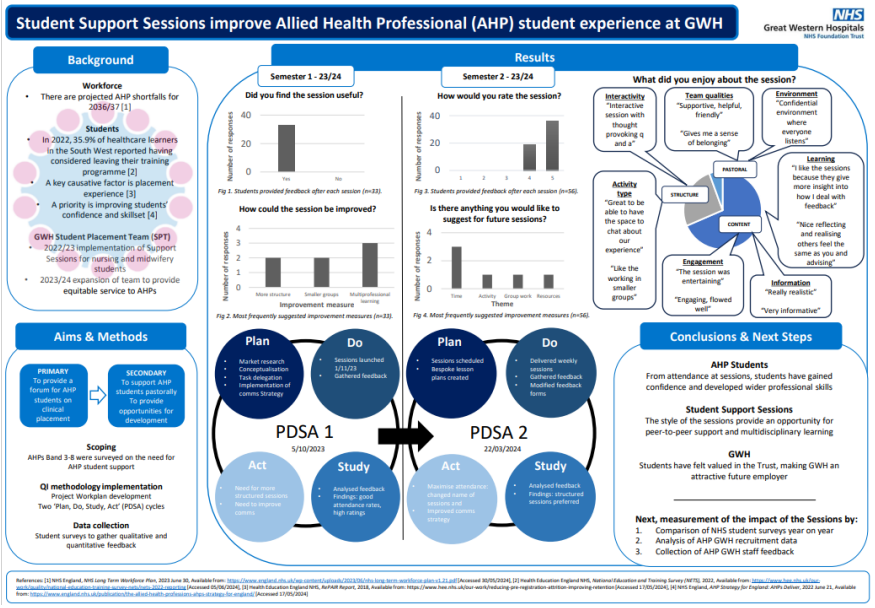


Quality Improvement Networks

Quality Improvement Projects

- In the third year of deploying the Improving Together approach, the Trust has strengthened its integration with traditional improvement functions, including clinical audit, research, and quality improvement, through the implementation of a Quality Improvement Projects (QIPs) working group.
- This working group includes stakeholders from Clinical Audit, Research, Coach House, and Transformation, and has been established to provide colleagues with advice, guidance, and resources, alongside a mechanism to register QIPs. This supports their revalidation, university portfolios, or routes to publication.
- In 2024/25, 56 QIPs were registered, aligning with the Trust's vision and strategic pillars, of these 51 aligned to the outstanding care pillar.
- Staff have been encouraged to share any positive changes or improvements they have made in their area in the Staff Improvement Forum. This is a powerful way to inspire each other and drive continuous improvement, while helping to create a collaborative environment where we can innovate and solve challenges together.
- The forum is a place to share improvement ideas and upload the outcomes of staff work including QI posters and presentations. It seeks to support staff to build on findings and work of people who have explored similar improvements previously
- To date over 200 colleagues are members of the Staff Improvement Forum, with 155 improvements shared which have been viewed 363 times.
- We have shared the Staff Improvement Forum across the BSW Hospitals Group and the wider Operational Excellence Improvement Directors Network.



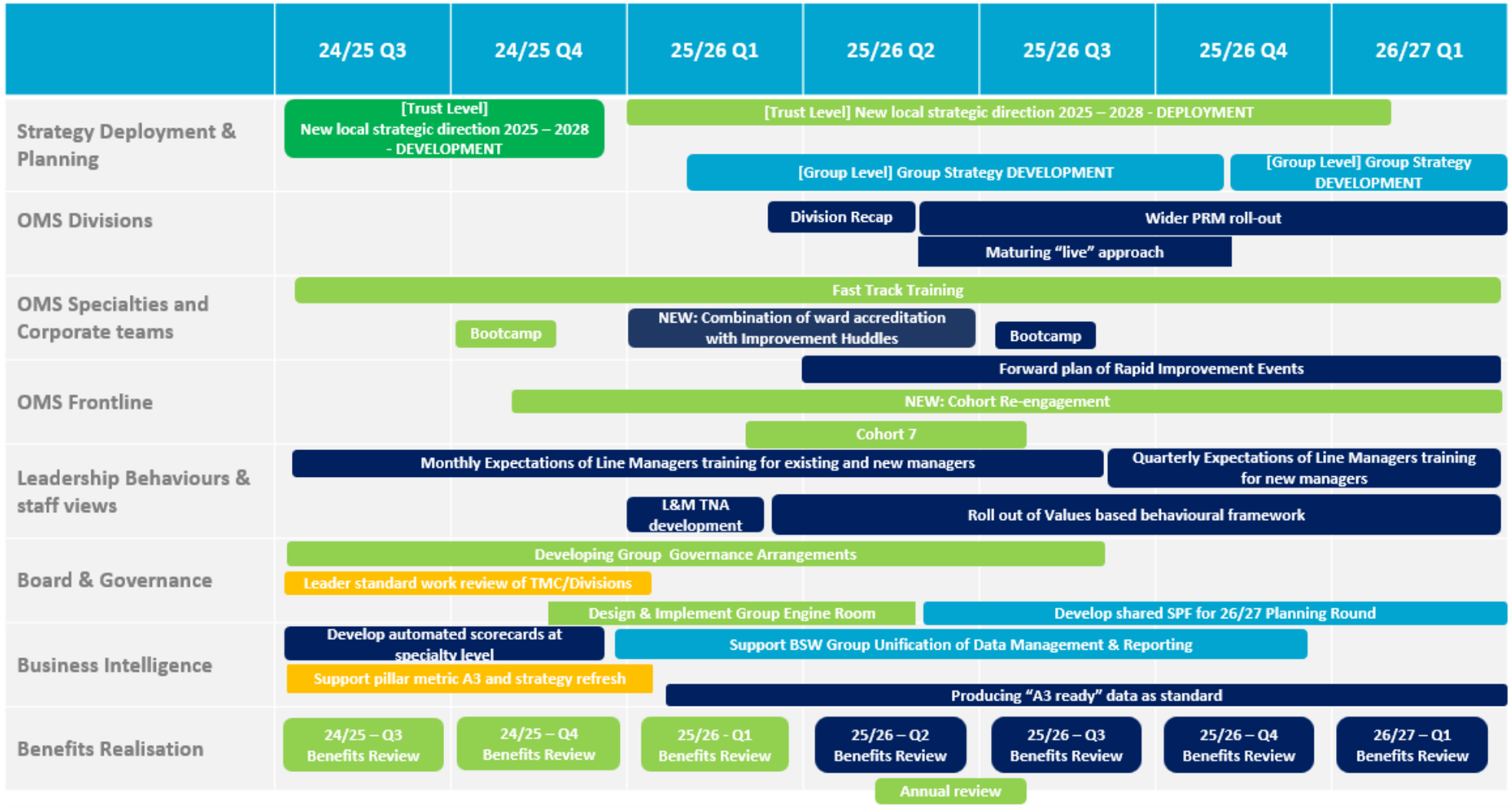


Future Focus

Improving
together

Future Roadmap

Great Western Hospitals NHS Foundation Trust



- The Improving Together deployment roadmap was refreshed in October 2024.
- The Improving Together Steering Group lead the roadmap delivery
- Continuing to develop at pace is crucial recognising progress needed across the entire OMS.
- There is an increasing emphasis of the development of the management system at Group level to support delivery priorities (light blue milestones)

Connecting with the Teams

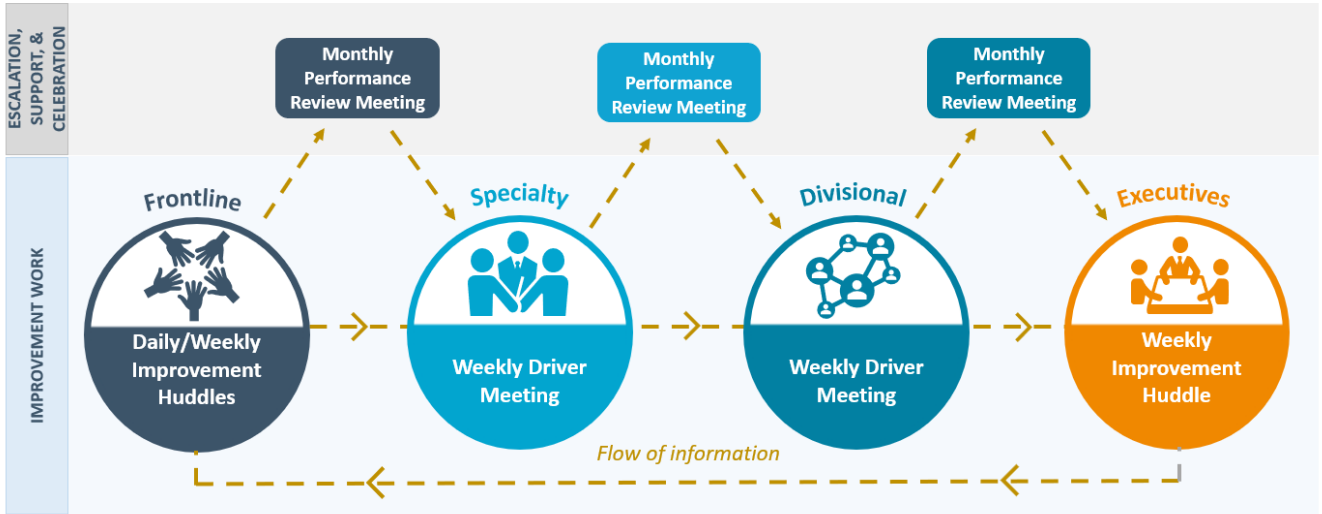
Great Western Hospitals NHS Foundation Trust

Performance Review Meetings

During 2025/26 we are focusing on further embedding performance review drawing on learning from the objective dialogue approach at RUH.

- Support the establishment of Group management routines and create strategic alignment to the Group strategy and SPF.
- Continuation and refinement of the weekly Executive Huddle to support prioritisation and focus on improvement delivery. Good continuation of Executive Review Meetings; divisional teams also have good adherence to the process standard work.
- Following Trust Management Committee discussion focus on identifying and connecting with one driver for each frontline team. Working with divisions to agree “model cells” within divisions to relaunch specialty scorecards and performance review meetings
- Involvement of divisional and specialty teams in “drop-in” sessions as part of the frontline cohort training to allow frontline teams to build rapport and agree drivers and huddle approach with speciality and divisional colleagues as well as sharing and celebrating successes.
- Simplification of the performance review meetings approach for frontline teams – recommending monthly, 30-minute stand up meeting in front of huddle boards to reduce administration and maximise dialogue

Daily Ops and Performance System



Daily/Weekly Improvement Huddle – A departmental approach to discuss and share improvement ideas with a focus on specific driver metrics
Weekly Driver Meeting - To review, discuss, and decide how to achieve the driver metrics selected
Monthly PRM (Performance Review Meeting) – Report on and showcase progress with driver metrics, escalate areas where required

Year 4 focus

Great Western Hospitals NHS Foundation Trust

Conclusions & Next Steps: Assessment against the evaluation model shows that implementation of Improving Together is making good progress and we are learning from what is working well and refining where needed. Adaption has worked well during year 3 to increase the focus of improvement work and to deliver benefits more consistently than in year 2. However, the sustainability of frontline routines remains challenging and it is a good time to review how we best support frontline teams focusing on approaches that are feasible given resource constraints. The outcome of the review has informed the following priorities for year 4.

1. Strengthening Cross-Organisational Collaboration (Group Working & BSW Integration)

- As Improving Together becomes embedded across the BSW Hospitals Group next year will focus on deepening collaboration through a shared Strategic Planning Framework (SPF) and aligned routines.

2. Accelerating frontline ownership & sustainability:

- Embedding performance review meetings across all levels
- Increasing focus on improvement tools and support with overcoming barriers, continuing to widen re-engagement activities
- Simplifying huddle processes, focusing on building improvement into existing operational routines, and sustaining fast track rollout across teams

3. Elevate staff and patient/public voice. We will scale initiatives that:

- Amplify staff feedback into huddle themes and A3s
- Embed patient voice in Rapid Improvement Events and quality improvements
- Increase use of the Improvement App and visibility of success stories

4. Support priority transformation programmes

- The launch of a cross-site Shared EPR (Electronic Patient Record) presents a vital opportunity to unify improvement culture, processes, and metrics.
- Ensure that digital transformation translates to tangible improvements in patient safety, experience, and clinical staff productivity.
- Embedding the NHS 10-year plan priorities through continuous quality improvement supporting population health management and left shift in care pathways

Appendices

Improving
together

Appendix 1 - Training Roll-Out

Frontline Teams & Departments

Great Western Hospitals NHS Foundation Trust

Teams who have received training

S&PC		Medicine		FASS		Corporate
Cohort	Fast-track	Cohort	Fast-track	Cohort	Fast-track	Fast-track
• SAU • Meldon Ward • Trauma Ward • Aldbourne • Saturn Ward • Critical Care	• Private Patients	• Teal • DoPs • Linnet Ward • UTC • ED • MAU • Jupiter • Falcon • Mercury • Neptune	• Pharmacy • Neuro / Stroke Speciality Tri	• Outpatients • Beech • Gynae • Neonatal • Hazel Ward & WHBC • Delivery • Children's Unit • Dove	• Acute OT • Acute Physio • Anticoagulation • Front door team • Cancer Speciality Tri • Paediatrics Tri • Quality Governance • Speech & Language	• Academy • Estates • Finance • Recruitment • Workforce • Occupational Health • Discharge Lounge • Research & Innovation • Liden

- Sustainability varies across the areas listed
- 6 trained teams have been transferred to HCRG

Appendix 2a: Divisional Benefits Realisation

Medicine Division

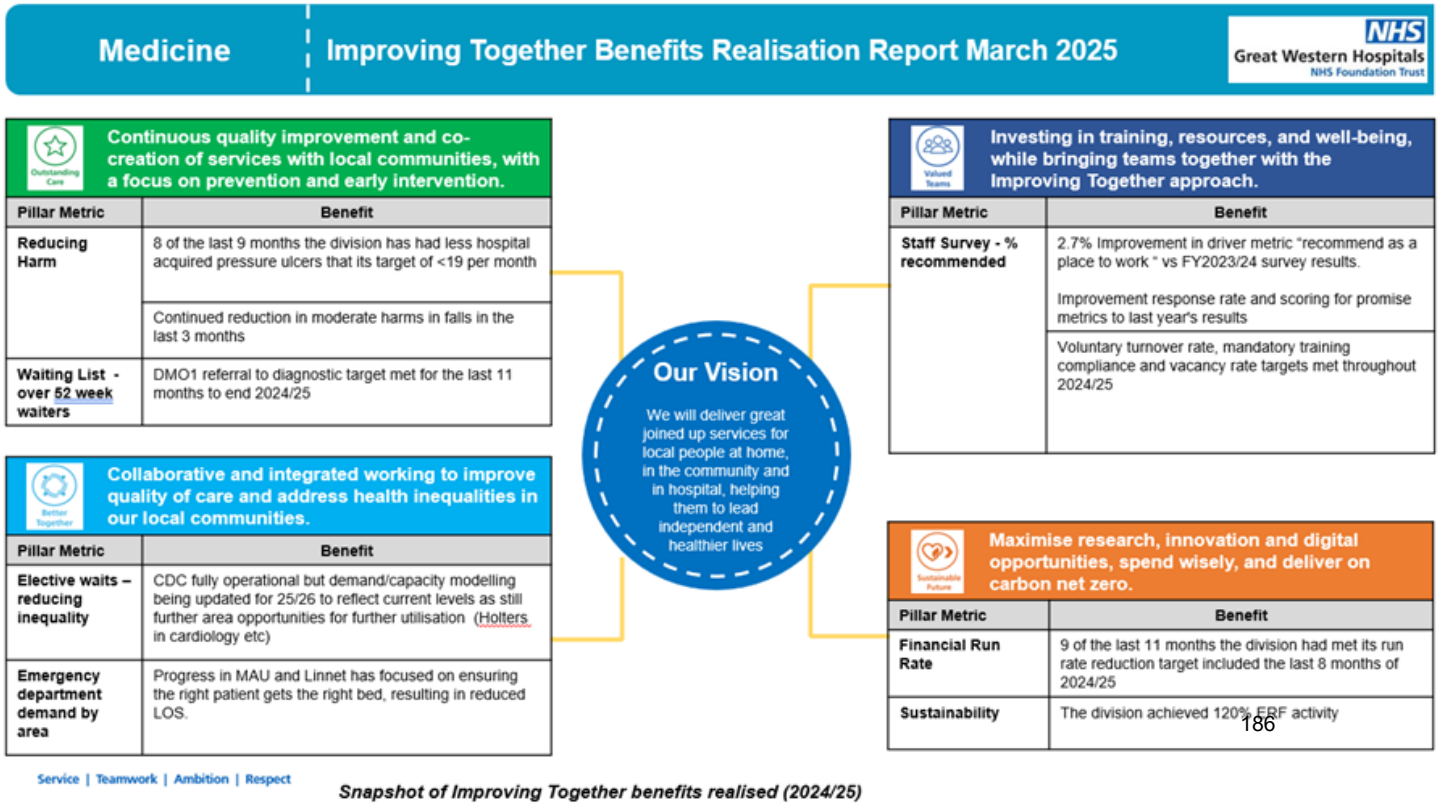
Neuro-pharmacist: has improved safety and efficiency of our DMT treatments (MS patients).

New research involvement (partially made possible due to consultant recruitments over the last year – most with research experience).

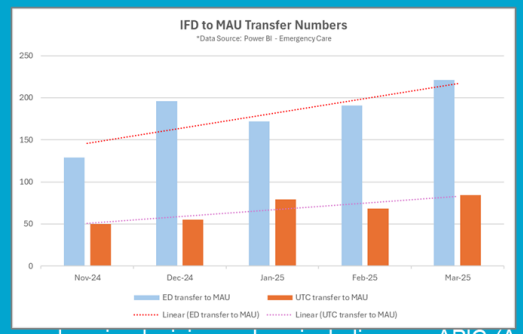
MND research grand success: Sara Mazzucco and team (had been on the intranet)

CITADEL study: (looking into AI tools of EEG analysis) – currently in the recruitment phase

Emergency Department: UniWee has received the support of NHS supply chain.



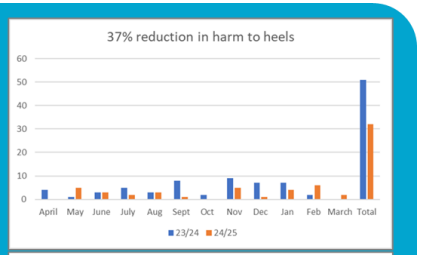
Snapshot of Improving Together benefits realised (2024/25)

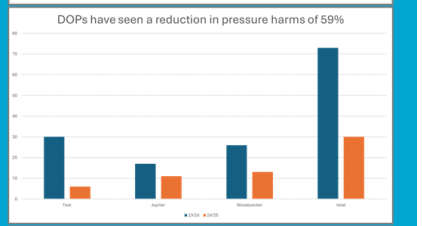


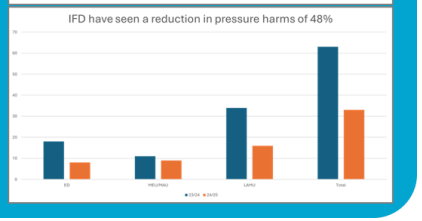
- Increased senior decision makers including new APIC (Acute Physician in Charge) implemented during February, held <24hour discharge position – and significant improvements are being seen in MTD March 2025.
- MAU / ED SOP implementation in February to support proactive transfer from ED/UTC to MAU / SDEC services.
- Standard operating procedure and criteria implemented for MAU escalation space
- MAU pathway launched 31st March 2025
  - Feedback process implemented – digital portal
  - Acute Med Tri / Div Tri to review workforce (transfer times MAU>Linnet)

33% reduction in hospital-acquired pressure injuries year on year
2023-24 there were 249
2024-25 there were 167

No Category 4 pressure injuries reported from September 2022







Appendix 2b: Divisional Benefits Realisation

Family and Specialist Services Division

Last Chance Team: Friday 14th February saw the Last Chance Team book their 10,000th patient into an unutilised slot.

Cancer Services: The Straight to Test Automation for Cancer Services has entered User Acceptance Testing with an official implementation date being outlined for the end of March.

Wheelchair services: saw a reduction in the waiting list for an initial appointment.

Meadows: ambulatory services successfully relocated to the Meadows Unit

Family and Specialist Services | **Improving Together Benefits Realisation Report March 2025**

NHS Great Western Hospitals NHS Foundation Trust

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

Pillar Metric	Benefit
Waiting list - 52-week waiters	Haematology has consistently been below the local tolerance (<2) for 62 day throughout 2024/25 with 0 patients for the 4 months ending the year
	Haematology has been below the local tolerance for 104 days waits for 5/6 months ending 2024/25
	Did not attend rate has been constantly below both the local tolerance and target in 2024/25
Reducing Harm	The division have reported no MRSA cases in 2024/25
	The division has seen a sustained reduction of falls in Dove Ward with 5/6 months being below the target
	The division has seen a sustained improvement in in reduction of pressure harms with 5/6 months being below target

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

Pillar Metric	Benefit
Emergency department demand by area	Hospital at home bed occupancy has been above the target of 80% for 4/5 months ending 2024/25

Our Vision

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

Investing in training, resources, and well-being, while bringing teams together with the Improving Together approach.

Pillar Metric	Benefit
Staff Survey - % recommend	The divisional vacancy rate has been consistently below the local tolerance for 2024/25
	The divisions mandatory training compliance has been above the local tolerance (>80%) and above 90% in 2024/25
	The divisions appraisal rates for both medical and nonmedical staff has been consistently above the local tolerance (>80%) for 2024/25

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

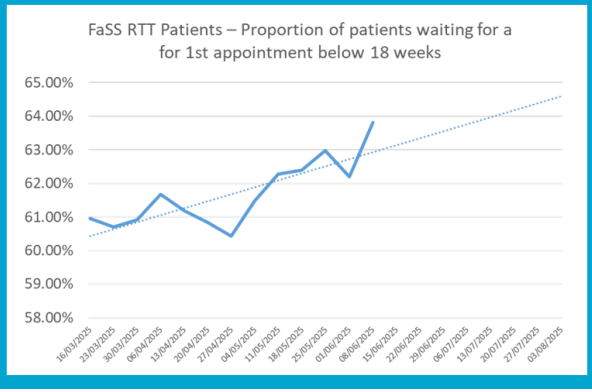
Pillar Metric	Benefit
Sustainability	The division has been consistently above the 110% elective activity target

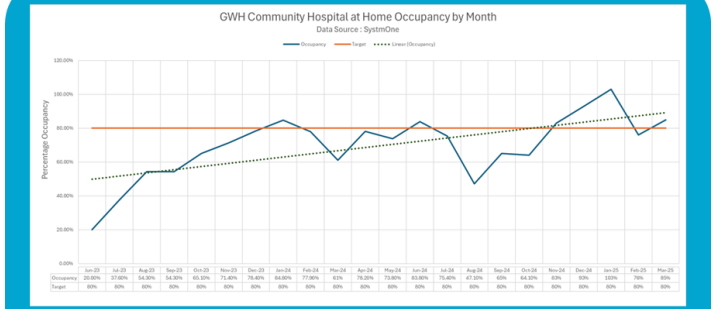
Service | Teamwork | Ambition | Respect

Snapshot of Improving Together benefits realised (2024/25)

Wait to first outpatient: there has been a significant improvement in the number of patients waiting less than 18 weeks for their first outpatient appointment.

There has been a focus on gynaecology and paediatrics to support pathway and booking process improvements alongside increasing capacity.





Implementation of elastomeric devices (IV administration for TDS or QDS doses) to address top contributing reason for patients not being suitable for admission to hospital at home.

Close working with Primary Care Networks to cocreate pathways designed to support GP's and not hinder saw marked increase in referrals to the service.

Design and recruitment of medical model to increase capacity, skill and future proofing of a new developing service.

*As ICC Division

Appendix 2c: Divisional Benefits Realisation

Surgery and Planned Care Division

Private Patient: rebrands successfully launched and chemotherapy unit opened in Meadows space

Improved medical training data within General Surgery

Improvements seen across all People Promise questions in Staff Survey compared to last year

2 x Successful NHSE visits to Theatres concerning Day Case rates and overall efficiency targets

SPC budget 24/25 come in under forecast and £4m less than previous year

Surgery and Planned Care | **Improving Together Benefits Realisation Report March 2025** | NHS Great Western Hospitals NHS Foundation Trust

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

Pillar Metric	Benefit
Reducing harm	The number of hospital acquired pressure ulcers was below the target (<7) for the last 5/6 months ending 2024/25
Cancer waiting times	Divisional performance has been above the target for Cancer 28 FDS
Patient experience	Inpatient Friends and Family likelihood to recommend has been constantly above the 80% target throughout 2024/25 and Jan 2025 onwards seen increased response rate to >55%
	Outpatient Friends and Family likelihood to recommend has been constantly above the 80% target throughout 2024/25
Reducing harm	The division has reported no MRSA infections for 20 months

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

Pillar Metric	Benefit
	None identified

Our Vision

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

Investing in training, resources, and well-being, while bringing teams together with the Improving Together approach.

Pillar Metric	Benefit
Staff survey - % likely to recommend	The divisions vacancy rate has been consistently below the 7% target throughout 2024/25
	Bank fill rate has been meeting or above target for 2024/25
	Voluntary turnover rate has been below the divisional targe of <11% for 2024/25
	Mandatory training compliance has been above the divisional target of >85% for 2024/25

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

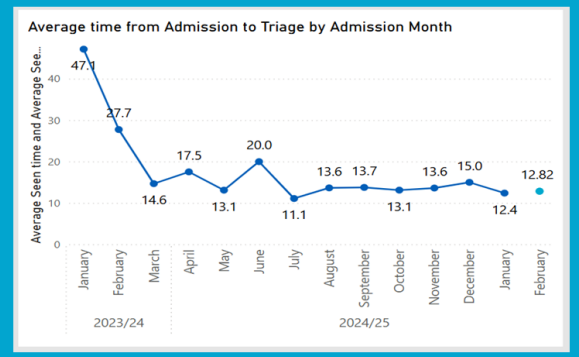
Pillar Metric	Benefit
Sustainability	Agency spend as a % of total spend has been below the 5% target throughout 2024/25

Service | Teamwork | Ambition | Respect

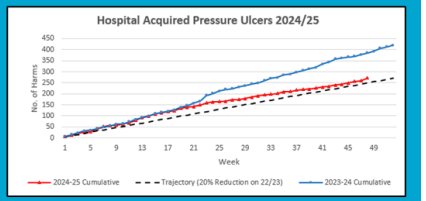
Snapshot of Improving Together benefits realised (2024/25)

Maternity Triage

Staffing model options developed to progress with People Operations support to introduce rotational posts.
24/7 single location model launched on 13th January after consultation with staff. This supported a dedicated single phone number access for maternity from 1st April, to positively impact patient experience, waiting times at night and data quality.
Change in service to 24/7 model positively received by staff with clear escalation guidance in place.



*As SWC Division



In February 2025, the Division had 1 HA pressure harm, This is a 50% reduction from January of which is normally a high month for harm across the Trust.

Trauma has had two consecutive months of zero Pressure Harm. Trauma has had x1 Cat 2 in four months (December).

*As SWC Division

Appendix 3: Year Ahead Training Plan

Great Western Hospitals NHS Foundation Trust

Coach House Planning

2025/2026			2026/2027			
Q2 Jul- Sept	Q3 Oct - Dec	Q4 Jan-Mar	Q1 Apr – Jun	Q2 Jul - Sept	Q3 Oct-Dec	Q4 Jan-Mar
Cohort 7	Pharmacy	Outpatients	Cohort 8	Elective Theatres		
Supporting sustainability & ad hoc requests						
	• Senior Leadership Team • Clinical Pharmacy Team • Pharmacy Community Services Team • Medicines Effectiveness Team • Clinical Trials Team • Dispensary Services Team • Workforce, Training and Education Team • Cancer Services • Aseptic Services • Procurement and Distribution • Homecare • Antimicrobial • Pharmacy IT Team	• Wren • Osprey • Booking Team • Management team	• Woodpecker • Kingfisher • Ampney • Acute Cardiac Unit	• Day Surgery/ Daisy • Anaesthetic • Practice Education Team • Holding bay • Orthopaedic Scrub • Recovery • Pre-assessment? • Elective admissions?		

Report Title	**Inclusion & Health Inequalities Annual Report April 2024 – March 2025**				
Meeting	**Board**				
Date	**11/09/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Jude Gray, Chief People Officer				
Report Author	Sharon Woma, Head of EDI and HI				
Appendices	Annual report, PowerPoint				

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 sets our how the Trust has met the Public Sector Equality Duty (Equality Act 2010), highlighting an extensive programme of work carried out across the Trust to improve inclusion and equity for our workforce and patients. The data included shows incremental progress and highlights areas for improvement which has informed the action plan. The action plan is supported by engagement with the Trust Board and staff network leads on 14.08.25.
The EDI and HI programme of work is overseen by the Inclusion & Health Inequalities Subcommittee to ensure that our action plans are delivered and that progress is made against the metrics that we use to measure performance.

Report

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

The EDI Lead, with the support of key stakeholders has prepared the Trust's 2024-2025 Inclusion & Health Inequalities Annual Report. As agreed by the Board, we have reduced the amount of reporting to enable a greater focus on delivery, and we are presenting a single report that showcases our achievements.

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

By publishing our equalities information annually, we are able to demonstrate due regard for the Public Sector Equality Duty (section 149 of the Equality Act 2010) - to eliminate unlawful discrimination; advance equality and foster good relationships between communities who share different protected characteristics.

The new EDI/HI strategy plan for 2025-2028 has been published, which provides direction for the next four years; the EDI/HI action plan published in this year's annual report for the year ahead, represents the foundation work that is needed to support our new strategic plan. The plan will be dynamic in nature to reflect the need for change including adapting to meet the emerging system needs from our partnership arrangements.

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	• Inclusion & Health Inequalities Subcommittee • Trust Management Committee • People & Culture Committee
Next Steps	Review and approval: • Trust Board

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

Explanation of above analysis:

The data analysis that underpins this report (see performance section) highlights that our disabled staff and ethnic minority staff continue to experience unprofessional behaviours like bullying and harassment and discrimination disproportionately, these staff are also less like to feel they have equal opportunities for pay and progression. The Trust has seen improvements in WDES scores for 5 metrics, 3 have remained relatively the same and 4 have worsened; the Trust has seen improvements in WRES scores for 2 metrics, 5 have remained relatively the same and 2 have worsened. The data also highlights a gender pay gap in favour of male staff, the gap has increased by £0.48 since last year. We will continue to deliver the key programmes of work initiated in 2024-25, which are anticipated to have the greatest impact, however the benefits will be realised over a longer period of time.

Recommendation / Action Required

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	Jude Gray, Chief People Officer
Date	**01/09/2025**

Equality, Diversity & Inclusion

NHS
Great Western Hospitals
NHS Foundation Trust

DRAFT

Equality, Diversity & Inclusion & Health Inequalities Annual Report

April 2024 – March 2025

Contents

Accessibility Statement

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

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

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

Legal Statement

This document sets out how we have met the legal duties set out in the Equality Act 2010 – the Public Sector Equality Duty and the Health & Social Care Act 2022 and our obligations set out in the NHS Standard Contract 24/25 Service Condition 13 (SC13) – Equity of Access, Equality and Non-Discrimination. The report outlines the work undertaken to meet our commitment to improve healthcare and health and wellbeing for all and to reduce health inequalities for our patients, local population and staff. We have also highlighted some of our broader equality, diversity and inclusion work that supports our objectives set out in the Trust's Equality, Diversity & Inclusion (EDI) Strategy 2020-24. A new EDI strategic plan was published in June 2025, which will help us to make progress against the objectives set out in the NHS England's EDI Improvement Plan (6 High impact actions), the strategic plan also aligns with the aims of the new Trust strategy.

Executive Summary

The annual Equality Diversity & Inclusion (EDI) and Health Inequalities (HI) report reflects a year of progress in our pursuit of equity across the organisation. This report is benchmarked against our Equality, Diversity and Inclusion (EDI)/Health Inequalities (HI) objectives, the NHS England six High Impact Actions and our system's Health Inequalities Strategy.

We have strengthened inclusive leadership, through Board-level commitments, involving more staff and patients in shaping the EDI and HI agenda and the provision of training and development.

We also hosted our first EDI conference, which focussed on allyship. Progress has also been supported by new training for staff including Cultural Competence and EDI Champions training and actions our divisions are taking to address discrimination.

Staff wellbeing remains central to our aims – we have expanded occupational health services and our staff have access to 24/7 support.

The report amplifies not only our resounding commitment to address EDI/HI issues within our organisation, but also in further improving our understanding of relevant data.

Our declaration in 'making inclusion everyone's business' centres around a summary of awareness raising, improvement in data quality and making data insights available, leading to enabling a three-year health inequality action plan, around the Core20Plus5 population and other activity.

Recognition is given to the advancement of technology echoed in the NHS 10-year Plan but also in our local work around inclusion.

Looking ahead, our priorities include further enhancing data quality, engaging with staff and patients to understand their lived experience; supporting and developing our workforce, and including the continuation of projects that address the abuse and discrimination our staff experience. We will also introduce a Shared Electronic Patient Record to improve how we deliver care across the BSW Hospital Group.

This report supports our vision and new strategic direction.

Lisa Thomas
Managing Director
Great Western Hospitals NHS Foundation Trust

Introduction: One Vision, One Voice

Welcome to Great Western Hospital's 2024-2025 Equality, Diversity & Inclusion (EDI) and Health Inequalities (HI) Annual Report. The report sets out how we have made progress against our EDI/HI objectives over the year – driven by our shared vision, collective voices and commitment to *improving together*. Much of the work in the report has been shaped and delivered by our staff who are more engaged and involved in making change happen.

We have focussed on improving equity in the workplace including addressing unprofessional behaviours, across the Trust, all Divisions have been addressing discrimination, our EDI Driver Metric, and they have also delivered targeted interventions in response to staff survey data. This has enabled us to sustain efforts throughout the year; including taking a data-driven approach to identify and support teams or departments where there are higher levels of reporting. We have also followed through on our commitment to improve the data that helps us to target health inequalities, and this work is ongoing. You can read more about the data improvements and the metrics we monitor in the pages of this report. We have also talked to staff and patients about their lived experience, this engagement helps us to look beyond the data and deepen our understanding of the impact of our policies, practices, services and culture across many groups of people.

Our staff help us to make GWH a great place to work. We have hundreds of staff who help us make GWH a great place to work. From mental health first aiders and health and wellbeing champions to sustainability champions, coaches, Scope for Growth ambassadors, mentors, staff network members, EDI champions and inclusive recruitment champions. These staff give their time to equip and support others to thrive in the workplace and to make our processes more equitable and fairer. In addition, hundreds of volunteers support our staff and patients every week, working alongside staff as partners; and you can read more about volunteering in the 'Improving Together' section of this report.

To enable our champions to succeed, we offer a range of high-quality training and this year we experimented with bite-size A.I. training to give staff an immersive experience in a safe environment that would enable participants to reflect, share their views and receive responsive feedback. We have leadership programmes aimed at aspiring junior staff, middle managers right up to our most senior staff, including apprenticeship opportunities. This will ensure that we have a strong, diverse and well-trained workforce who can meet the needs of an evolving NHS and technological advancement and serve our patients and communities in the best way possible.

We also work with patients who co-produce with us and share invaluable insights that help us to work towards healthcare equity.

In 2025-26 we will continue to focus on 'making inclusion everyone's business', this will include raising awareness around health equity, improving our health inequality data and making data insights readily available for the wider workforce, developing a 3-year health inequality action plan to transform our work around our Core20Plus5 populations; increasing the number of staff who volunteer to drive change in their departments, and further explore the use of A.I. to enable staff to learn independently – particularly staff who find it difficult to step away from their duties to attend regular training.

The Trust has recently published a new strategy and the strategic plans which deliver its objectives coincide with the publication of the Fit for the Future 10 Year Health Plan 2025. Thousands of people have informed the plan which will see the NHS place greater emphasis on preventative measures including addressing inequality drivers like obesity and inactivity; provide services that are tailored to the lived realities of a diverse population; bring care closer to home in our communities; improve digital and non-digital access channels and harness technological innovation. We will also equip our workforce to enable this transformation to take place.

We have published a new EDI/HI strategic plan in May 2025, which is informed by the Trust strategy. The Plan is a roadmap for the future, which will also help us to align our work with our Integrated Care System and regional EDI and health inequality plans as we work towards our collective goals. The creation of this plan is only made possible by a supportive and informed Board and Executive Team who are committed to the GWH vision 'great services for local people at home, in the community and in hospital, enabling independent and healthier lives' – recognising that a healthy and supported workforce will result in great care for our patients. Our Board will continue to help to shape and support the EDI and HI agenda and have made EDI commitments for the second year running. The action plan at the end of this report reflects how we will deliver against year one of the new plan, with measures to evaluate our progress.

We hope that you find this report engaging and that you will join us in improving equity for our staff, volunteers and patients. To get involved contact gwh.inclusion@nhs.net.

Sharon Woma
Head of EDI & Health Inequalities

Our Values

We are guided by our clear values Service, Teamwork, Ambition and Respect, which are underpinned by the NHS constitution's ethos, we are committed to compassion, dignity and equality. We work as a team and partnership across the BSW system to achieve the best outcomes for our patients and communities.

Service We put patients, service users and our diverse communities at the heart of all we do.	Be compassionate	We notice what people need and respond with care and honesty, even when time and resources are tight.
	Be dependable	We keep our word, act with integrity and take responsibility for what we say and do, especially when it's hard.
Teamwork We work together across teams, roles and boundaries, supporting each other and valuing difference because no one delivers great care alone.	Be inclusive	We make space for every voice, break down barriers and help others feel they belong.
	Be collaborative	We solve problems together, share responsibility and support each other to grow and succeed.
Ambition We embrace diverse perspectives, evidence and lived experience to continuously learn and improve for our patients, our teams and ourselves.	Be curious	We ask questions, encourage others, think and stay open to learning, even when its uncomfortable.
	Be courageous	We speak up, learn from mistakes, do what is right and support others to embrace feedback, even when it means challenging unfairness or harm.
Respect We show people they matter, treat everyone with dignity, listen carefully and welcome difference.	Be thoughtful	We speak and act with care, treating everyone fairly, especially those who feel excluded.
	Be open	We ask for feedback and welcome different views, even when they challenge our assumptions or authority.

Figure 1: STAR values

Strategic Aims & Objectives

The EDI Strategy 2020-2024 sets out our objectives which have directed our work over the past four years, this report focuses on initiatives delivered in the financial year April 2024 to March 2025. The objectives are:

Figure 2: EDI Strategic Objectives

We have recently published our Strategic Plan for 2025-2028, our staff are keen for us to retain the same objectives and deliver against them with a greater sense of ambition and urgency. The new strategic plan can be found on the Trust's website.

Our People, Patients & Communities

We work with and serve a diverse community of people from all walks of life. Our Trust employs 6,056 staff including apprentices who are supported by 595 volunteers. We are proud to be an Inclusive Employer, a Disability Confident Employer and a Veteran Aware organisation – we have signed the Veteran's Covenant and achieved the Pride In Veterans Standard.

A profile of our staff, patients and Swindon population is included in the table below. The proportion of male and female staff has remained the same since 2023, 82% female and 18% male. 58% of staff are full-time and 42% part-time. We have seen an increase in ethnic minority staff (by 3%) and disabled staff (by 1%), with no increase in LGB staff, however there is a greater prevalence of staff who have not stated whether they are disabled (16% of staff) or shared their sexual orientation (27% of staff) in our staff records.

These incomplete datasets hinder accurate analysis, and this might mask patterns of inequity. Over time, disclosure rates are improving for all groups, we have implemented changes to the Electronic Staff Record (ESR) including annual reminders and raised the profile of Equality, Diversity and Inclusion including hosting regular awareness events. We will continue to promote the importance of sharing protected characteristics.

Table 1: Workforce and Patient Demographics

	Female	Male	BME	White	Disabled	LGB	Hetero-sexual	Religion / Belief (all)
Staff	82%	18%	30%	63%	5%	2%	70%	57%
Volunteers	75%	25%	31%	63%	6%	4%	73%	60%
Patients	54%	46%	17%	76%	N/A*	N/A*	N/A*	47%
Swindon	50%	50%	19%	81%	16%	2%	90%	60%

*The Trust does not hold robust data for these fields.

30% of our staff are aged between 31 and 40 years old, and 22% aged between 41 and 50 years old. In comparison, 7% of staff are 25 and under and 7% are aged between 61 and 70+.

41% Female

12% BME

12% Disabled

Board Diversity

The Trust Board includes seven executives and ten non-executives. Seven (41%) are female and ten (59%) male, two (12%) are from an ethnic minority background and two (12%) are disabled or living with a long-term health condition. We also have two Associate NEDs. The Associate role can act as a pipeline to improve the diversity of the board, both in terms of skills and protected characteristics.

Figure 3: Board diversity

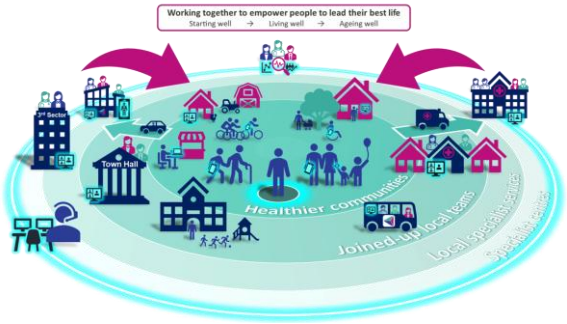
Our Integrated Care System

"We listen and work effectively together to improve health and wellbeing and reduce inequalities."

The BSW Integrated Care Strategy Vision.

The Trust is part of a group of organisations who work closely together as an Integrated Care System – Bath and Northeast Somerset, Swindon and Wiltshire (BSW) Together Integrated Care System (ICS) and includes the Integrated Care Board, our three local authorities, three hospital trusts, independent providers, a mental health trust, an ambulance trust and voluntary sector organisations. Collectively we take responsibility to improve the health and wellbeing of local people and our workforce; to tackle health inequalities including improving health and care access, experience and outcomes for everyone.

Within the system, the Trust operates in a group model, the BSW Hospital Group, made up of GWH NHS FT, Salisbury NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust. We have worked collaboratively over several years, and we are in the process of changing how we collectively function. These changes will help us to pool resources more effectively, reduce duplication of services, increase shared governance, standardise practices across the group and reduce costs, increase buying power and increase capability to invest in innovation and digital infrastructure. The group relationship will also provide an opportunity to address systemic inequalities in our staff and patient populations; we anticipate that future EDI and health inequalities plans will be centred around a group approach.



Co-creating our GWH culture

Inclusive Leadership

Inclusive leadership is central to achieving the aims set out in our strategic plan – to improve representation, support our staff to thrive and succeed and to deliver equitable healthcare. We have continued to embed inclusive leadership through leadership training and development, the appraisal system, and promotion of our leadership behaviours.

The Trust hosted its first EDI conference in November 2024, with a focus on allyship, this built on the foundations laid at our Leadership Conference the preceding year, when we launched the leadership behaviours. EDI is also embedded in our leadership programmes ensuring staff have regular opportunities to learn and apply principles that support inclusion.

The Trust participated in the Diversity in Health and Care Partners Programme, alongside NHS organisations across the country. The leadership programme helps organisations to advance equality, diversity and inclusion through a year-long series of masterclasses with board and staff representatives – with access to thought leadership and tools to help organisations at the forefront of EDI practice.

We are also undertaking a programme of work to develop the organisational culture, including inviting staff to shape a values-led behaviours framework. This extensive cultural change programme will continue over the next three years.

Our commitment to change and the actions throughout the year, and highlighted in this report, has led to an improvement in some of the metrics we use to measure progress, including the Equality Delivery System's Domain Three which measures inclusive leadership, you can read more about these improvements in the EDS report, see the performance section.

Equitable access, experience and outcomes for our workforce

People Promise improvements Staff Survey results

The NHS People Promise is a commitment to creating a positive and inclusive working environment for all NHS staff. It outlines key themes that reflect what matters most to staff, such as compassion, recognition, safety, learning, flexibility, teamwork, engagement, and morale. The following analysis compares the Trust and Benchmarking Group Scores from 2023/24 to 2024/25, highlighting areas of improvement and decline.

We have slightly improved our score for 'we are recognised and rewarded', 'we are safe and healthy', 'we are always learning', 'we work flexibly' and morale.

Scores have slightly declined for 'we are compassionate and inclusive', 'we each have a voice that counts', 'we are a team' and 'staff engagement'.

Table 2: People Promise Scores

Indicators	2024/25		2023/24		2022/23	
('People Promise' elements and themes)	Trust Score	Bench-marking group score	Trust Score	Bench-marking group score	Trust Score	Bench-marking group score
People Promise:						
We are compassionate and inclusive	7.23	7.21	7.25	7.24	7.16	7.18
We are recognised and rewarded	5.92	5.92	5.91	5.94	5.64	5.72

We each have a voice that counts	6.69	6.67	6.71	6.70	6.64	6.65
We are safe and healthy	6.14	6.09	6.11	6.08	5.83	5.88
We are always learning	5.71	5.64	5.69	5.62	5.38	5.35
We work flexibly	6.42	6.24	6.41	6.20	6.24	6.00
We are a team	6.77	6.74	6.78	6.75	6.64	6.64
Staff engagement	6.82	6.84	6.85	6.91	6.70	6.80
Morale	5.93	5.93	5.91	5.90	5.65	5.68

Our staff survey data also indicates that staff experience abuse from patients and the public. Over 24.4% of staff experience bullying, harassment and abuse, 9.6% experienced discrimination, 12.8% physical violence and 8.8% were the target of unwanted behaviour of a sexual nature in the workplace from patients, service users or the public (GWH Staff Survey Results 2024). Our data shows that ethnic minority staff experience a higher level of discrimination than other groups.

The Trust is committed to protecting staff from abuse from third parties, the onsite security team attend call outs, we have policies in place to guide staff and specialist training for frontline staff including Maybo (a de-escalation course) and conflict resolution. In July 2025 the Trust is engaging with staff to understand more about their experiences and to identify what initiatives are having the biggest impact, we will also re-launch the 'Never OK' campaign, which reinforces a clear message that abuse is unacceptable, and will launch our 'GWH Guide to Addressing Racist Incidents' and its accompanying workshop.

NHS EDI Improvement Plan

The Trust has implemented the NHS EDI Improvement Plan to address staff inequalities. Our action plan for the year has been mapped against its high impact actions below:

High Impact Action One (HIA1): Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. *GWH EDI Objective 1: Inclusive & Compassionate Leadership*

Embed 'listening to you' sessions with staff and patients	Engaged with staff and patients to understand their lived experience – insights from engagement help to improve inclusive decision-making and inform actions. The board continue to invite staff and patients to share their experience with the board.
Increase support and involvement with staff networks	The Board and staff network representatives participated in a joint workshop where they reviewed data and collectively shared feedback that has been used to shape the action plan for 2024-25 and the new Strategic EDI 3-Year Plan.
Improved ED&I documentation at Board Meetings including ED&I Data and ED&I references in submitted papers	The board papers have been developed including risk a assessment framework which staff complete to help the board to be better informed around the impact of their decisions. This will be followed up with Health Inequalities training for the Board in 2025-26.

High Impact Action Two (HIA2): Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity. *GWH EDI Objective 2: Represented & Supported Workforce.*

Create and implement a talent management plan to improve the diversity of executive and senior leadership teams.	Established a Moderation Board in October 24 to assess line reports for current Execs to identify skill gaps, and readiness for succession. Re-launched Stay & Thrive conversations, including publication of 'Stay Conversations' template in October 2024. Offer career development opportunities through apprenticeships for senior staff, Scope for Growth career coaching and mentorship programmes.

	28 Inclusion Recruitment Champions available to support interviews for Band 8B and above roles.
Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan.	Appointment of a People Promise Manager – one year programme to improve workforce experience, bringing structure and pace and staff centred insights to our retention efforts. Partnered with local organisations to deliver Project Search work experience programme for people with learning disabilities – to support them into employment; and deliver Dare to Doctor and similar programmes. six young people took part this year and three have found paid employment. We also partnered with New College Swindon to deliver Pathway to the Future, 13 students from areas of deprivation participated in a year-long programme, where they were prepared for interviews and gained practical skills.

High Impact Action Three (HIA3): Develop and implement an improvement plan to eliminate pay gaps. *GWH EDI Objective 2: Represented & Supported Workforce*

Undertake analysis of other staff groups	Ethnicity pay gap introduced in this year's reporting.
Review recommendations from Mend the Gap	Launched Trust-wide mentoring programme in November 2024. Promotion will continue in 2025-26. Targeted outreach to promote the bonus award schemes and to encourage female consultant participation. Launched Flexible Working through ESR and created a monthly dashboard to track flexible working applications, along with ESR guides and toolkit and Trust-wide comms. Leadership development opportunities across all banding – e.g. Learn to Lead for Bands 2-3 offered and Aspiring Leaders for Bands 4-6, Developing Leaders for Bands 7, 8a and 8b. A leadership programme was launched for new consultants in post for 2 years or less. Staff can also access a range of external programmes including NHS Academy's Edward Jenner, Mary Seacole and Rosalind Franklin. Sixty-five of our female staff are apprentices and eighteen are male, 60% are White and 27% from a BME group. Engagement and support for carers provided, including Carers Staff Network.

High Impact Action Four (HIA4): Develop and implement an improvement plan to address health inequalities within the workforce. *GWH EDI Objective 3: Support our patients and communities to achieve better life outcomes. And Objective 2.*

Improve Data Quality	Electronic staff records prompt staff to update their information annually. Data highlighted during routine EDI training to raise awareness. There was a review of historic flu vaccine uptake data by deprivation index with targeted engagement to encourage staff who under-utilised the service to receive the flu jab in 2024. We have developed a data quality improvement plan, which will enable the Trust to improve our understanding of health inequalities in the workforce.
Deliver impactful health and wellbeing services for all staff	Improved online Employee Assistance programme – Staff can access 24/7 counselling, financial advice, and salary sacrifice schemes are available for home, technology and the introduction of cycle purchases. Count Me In initiative launched by joint staff networks, small funding was made available, including wellbeing boxes for staff and resources for staff who are neurodiverse. Occupational health has delivered 1,957 management referrals, 2,210 pre-employment checks, and over 1,400 OH nurse appointments and we have expanded access to self-referrals for mental health and physiotherapy support. Plus 925 individual therapy sessions, with 92% of those completing therapy showing clinical improvement and nearly 1000 staff benefited from group-based wellbeing sessions. 10% of our staff have accessed the new Wagestream service which enables staff to better manage their pay; and 97 staff attended two pension workshops (November 2024 and February 2025), with further workshops scheduled for 2025-26.

	The Trust has a Guardian of Safe Working Hours who oversees the working hours that doctors in training are asked to do under the 2016 contract. The Guardian acts as a link to highlight issues raised by Trainee Doctors at Trust Board level.
Reduce bullying, increase civility and have a robust approach to all abuse and harassment	62 EDI champions support staff across their departments to address any unprofessional behaviours; our staff network chairs provide advice and guidance to staff and staff use other formal channels including Freedom to Speak Up Guardians and HR to raise concerns and seek support. The Trust has a staff survey working group, including divisional representatives who lead on local action to improve their staff survey data, there was a Trust-wide focus on addressing discrimination and all divisional representatives took action, supported by their local EDI Champions. Datix (incident reporting database) was updated last year to capture incidents that are linked to discrimination and this data is monitored through the Trust's strategic committee that oversees Equality, Diversity and Inclusion.
As an Anchor Institute, make a positive impact by offering routes to employment, good work and career development	The Trust offered a series of Dare 2 events, which are two-day summer schools for Year 12 students who aspire to work in healthcare – the programme included Doctor-2-Doctor (20 participants), Dare-2-Nurse (8 participants), Dare-2-Midwife (25 participants), Dare-2-Care (8 participants) and Dare-2-AHP (25 participants). See HIA2 for other work experience initiatives. We will expand the initiatives on offer in 2025-26 and take part in system initiatives to support care-leavers into employment.

High Impact Action Five (HIA5): Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff. *GWH EDI Objective 2: Represented & Supported Workforce.*

Train and develop International Recruits	Supporting information from employers (SIFE) references have been introduced to support internationally educated staff to register with the NMC. Ten staff have completed the programme as at 31.3.25, with a further six predicted to finish at the end of April. Staff are supported by a SIFE lead and clinical practice educators to prepare for the OSCE exam and meet the NMC criteria. Delivered Student Nursing Associate (SNA) apprenticeship in collaboration with Oxford Brookes, which bridges the gap between the Health Care Support Workers qualification and Registered Nursing. Staff are released one day a week to attend university. We are supporting seven internationally educated nurses (IENs) who have enrolled on the Florence Nightingale Foundation leadership development programme for nurses and midwives and staff have taken part in leadership away days aimed at ethnic minority and internationally educated nurses. The Trust's Equality Lead Nurse (funded until 31.03.25) has supported internationally educated nurses to acclimatise to the Trust and represents their voice at key strategic meetings.

High Impact Action Six (HIA6): Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. *GWH EDI Objective 4: Let every voice be heard. And Objective 2.*

Improve awareness and understanding of key issues and promote behavioural change	Launch of Expectation of Line Managers training to equip line managers to lead their teams well – over 500 have attended; and development of TED tool to help teams improve effectiveness. EDI embedded in leadership programmes, preceptorship and some mandatory study days. EDI Conference in November 2024, focus on 'Allyship' including Bystander training. Around 90 leaders attended. Staff Networks initiatives included Pride celebrations, stand at Swindon & Wiltshire Pride and Black History Month and spoke at external events during key diversity calendar dates. Networks have formed a joint network to improve collaboration.
Improve staff engagement	Staff involved in Improving Together, using the Trust's continuous improvement methodology to help co-design EDI initiatives. Staff also act as local champions and are involved in driving change in their department and division.

	During the spring of 2025, there was Trust-wide engagement with staff to gather their views to shape the Trust's new values-led behaviours, which will launch in 2025-26.
Create a safe environment for all staff	Developed the Sexual Misconduct Policy and implemented best practice actions. Introduced 'Understanding Sexual Misconduct in the Workplace' training on ESR eLearning in January 2025. Deliver a range of EDI-related training – including Cultural Competence; Addressing Unprofessional Behaviours; EDI Champions workshop; Inclusive Recruitment Champions training; Bystander training. Compassionate conversations masterclass with 'A Kind Life' to explore the compelling evidence supporting compassion in healthcare, while developing powerful and practical skills for compassionate communication – attended by 143 people over 3 sessions. Our Freedom to Speak Up Guardians hosted a series of online events during Freedom to Speak Up Month October 2024 to promote speaking up, featuring special guests and case studies centred around themes like 'international staff' and 'improving patient safety'.

In 2025-26 we will focus on developing and implementing a values-led behaviours framework; expanding our team of EDI champions and other volunteers; equipping staff with the skills to address unprofessional behaviours from colleagues and harassment and abuse from patients; delivering targeted interventions in departments in response to local data insights and supporting staff to live healthy and fulfilled working lives.

Key strategic groups oversee this programme of work including The Trust Wide Staff Survey Working Group, Inclusion & Health Inequalities Sub-committee and the People and Culture Committees.

Learning and Development

The Trust launched Expectations of Line Managers one-day workshop to equip all line managers with the tools and knowledge to lead and manage people., the Trust has a target of 90% of existing managers and 100% of new managers, Band 6-8C, to attend this training. New managers will be invited to attend within 6-months of joining the Trust, offering them the best opportunity to get to know our local processes and to know what is expected of them as people managers. We also provide development programmes for staff who are keen to step into leadership roles, this includes the Aspiring Leaders 6-month programme for Band 4 to Band 6 staff and this year we also facilitated bespoke leadership training for ethnic minority staff.

EDI-related training has included Cultural Competence; Bystander training; Addressing Unprofessional Behaviours training and bespoke training for our EDI Champions and Inclusion Recruitment Champions and 94% of our staff have attended our online mandatory EDI training.

The Trust is exploring the use of artificial intelligence in training and development. We delivered a six-month pilot, trialling immersive virtual reality training, just over 180 staff enrolled on the programme and had access to over 30 workshops ranging from EDI to conflict resolution and interview and presentation practice, with 3112 training minutes. This has supported staff to practice managing conversations or challenging poor behaviour in a virtual environment and receive feedback based on their response. We will evaluate the pilot and consider how this technology can be expanded to support health inequalities awareness and tailored to respond to the needs of healthcare professionals in the BSW system.

The Trust developed a mentoring programme in November 2024, which is still in its infancy, we have delivered two Introduction to Mentoring workshops (February and April 2025) and will pilot mentoring which is accessible to all staff until April 2026. We have harnessed A.I. to match mentors and mentees and to provide a reporting system, this will help us to identify trends that

will inform learning and development and reduce the need for administrative input. Mentoring is known to benefit under-represented groups of staff and should have a positive impact on our metrics that measure equal opportunities and career progression over time.

Improving Together

Our staff are at the heart of change initiatives, including the EDI and health inequalities work. We use a continuous improvement methodology across the Trust called 'Improving Together'. This ensures that staff can help to shape EDI-related projects and have a say in the decisions the Trust makes that affects them. Staff can get involved through varied forums, workshops, team initiatives and through our networks. In the past the staff have helped to design EDI-training and to shape the EDI initiatives, this work will continue in 2025-26, in July, staff will take part in an initiative to address patient abuse and harassment.

Staff Networks

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

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

Staff networks play an important role in the life of the Trust. Our staff networks engage with the Board and key strategic groups to help inform EDI plans and they act as supportive spaces for their members and welcome allies (who might not share the same protected characteristics as the beneficiaries of the network) who help to deliver various initiatives including engagement and workshops. In August 2024, the networks formed a joint group to enable them to co-deliver initiatives and to identify shared priorities. The Joint Network's inaugural project is 'Count Me In', a small grant that is available to staff in the Trust who want to deliver local projects to address inequalities – 12 teams were awarded a grant in January 2025. Winners included the Library who purchased two reader pens to support students with dyslexia and the Warfarin team purchased warfarin readers that can be loaned to patients who cannot afford a device. This fits in with the Trust's ethos to make Inclusion everyone's business, by resourcing projects that can make a difference.

Equality Diversity Inclusion (EDI) Champions

The Trust launched a programme to recruit, train and deploy EDI Champions in January 2024, this is a voluntary role which staff opt into. The champions support staff who experience unprofessional behaviours and promote inclusion in their ward or office area. The programme was evaluated in January 2025 to identify the impact of this group. At the time, the Trust had 62 EDI Champions, with over 200 hours of activity logged – our champions have supported or signposted other staff and managers; shared ideas for improvement with HR and other departments; volunteered to deliver training or to deliver an event; shared resources with their team; spoken at internal and external events; and hosted events to celebrate diversity days with their teams. 41% of champions have reported they have had a positive impact on their team and 20% said they have had wider impact across their division or the Trust; overall 47% of champions feel their presence and actions enable behavioural change.

The ambition is to have representatives in every department. Our 2025/26 action plan will include a focus on further recruitment.

Inclusion Recruitment Champions

The Trust launched its Inclusion Recruitment Champions programme in November 2023, when its first group of IRCs were trained to sit on interview panels. The Trust currently has 25 recruitment champions, a volunteer role, who sit on interview panels for 8B and above roles. The champions provide an additional level of assurance that interviews are free from bias, whether conscious or unconscious, ensuring a fair and inclusive process. The group is part of our wider programme of work managed by Recruitment and Resourcing teams, to improve representation in senior roles. In response to requests from recruiting managers, the Trust will identify and train additional volunteers across 2025/26 who can sit on interview panels for any banding. We will evaluate their impact late 2025.

Volunteers

Our volunteers make a huge contribution to the health and wellbeing of our local population, giving their time, skills and expertise freely to support people in need. Volunteers are crucial for the NHS's vision for the future of health and social care, as partners with, not substitutes for skilled staff. We currently have 595 volunteers, with a further 44 in the recruitment process. The longest serving volunteer has been with the Trust for 21 years. Volunteers commit a minimum of three hours a week for six months, this totalled 55,545 volunteer hours over the year – the equivalent of 28 full-time members of staff.

They are involved in a range of services including:

- The OWLS Service, the Outpatient Welcome & Liaison Service is a 'buddy' programme for patients with mobility issues, disabilities, dementia or who are anxious about coming into hospital.
- Active Responder Service are volunteers who respond to where the need is greatest across the hospital, they help out with pharmacy runs and urgent ward needs.
- Volunteers also befriend patients, they provide companionship and wellbeing support, assisting with feeding, tea rounds, replenishing stock for staff and making up beds.
- Other volunteers are provide administrative support, are live presenters on the hospital radio, welcome and signpost patients and take the tea trolley around the hospital to give staff a welcomed tea break.

Tackling Health Inequalities

Our health inequalities work continued to evolve in 2024, in line with the BSW Inequalities Strategy Implementation Plan and the Core20Plus5 framework. We have focussed on system-wide initiatives and work has centred around reducing disparities in access, experience and outcomes for minoritised and marginalised patients and staff.

Over the year, we have completed the actions set out in the Health Inequalities Action Plan, including engagement with our local population, 19 events were hosted by the Patient Experience & Engagement Lead, in addition to attending community events. The Board, as part of their EDI commitments, hosted an event in the Swindon town centre in October 2024, where members of the public were able to share their experience of accessing health services with board representatives.

We have started to embed the Improving Together continuous improvement ethos into patient engagement; this will enable patients to be part of service design and improvement. In July 2024 patients met at the Trust to share their ideas of improving the way we communicate with patients and understand their perceptions around moving to fully digital platforms. Insights from this engagement have been used to inform decision making.

We have also improved the quality and completeness of our datasets across services, analysing waiting lists to detect inequalities in the most challenged areas and improved demographic data to support performance reporting. You can read more about this in the section below.

As an Anchor Institution, we work with system partners to address the social determinants of health, this includes providing work experience and employment to people from poorer socio-economic backgrounds, buying local when possible and reducing our environmental impact.

We partnered with Project Search, New College Swindon, Swindon Borough Council and Swindon SEND Family Voice to host eight interns who rotated around three different placements. After the success of our first year of Project Search, our second cohort started in September 2024. Project Search is a transition-to-work programme to assist students (age 18-22) with developmental disabilities to obtain job skills that make them marketable in the workforce. During the summer of 2025 two of the students have gone on to find employment.

We are committed to providing a sustainable health and care system that delivers high quality care and improved public health without exhausting natural resources or causing ecological damage. In 2021 we published our first Green Plan which focussed on reducing the carbon footprint in eight areas including estates and facilities, travel and transport, medicines and our workforce.

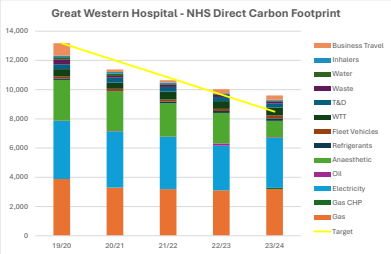


Figure 3: Carbon footprint measure

We measure our carbon footprint annually and set interim targets for reduction, with a commitment to be Net Zero by 2040.

During 2024-25 work included undertaking a Climate Change Risk Assessment and Adaptation plan as part of the BSW Hospital Group to help us to increase resilience from climate change related impacts; a capital project was completed for recycling bins, now all departments have at least one recycling bin and 110 staff signed up as Sustainability Champions, some of whom have been assigned to small projects within their departments. Initiatives have taken place across all eight areas.

Improving our Data and Insights

In 2024/25 significant progress has been made around the routine reporting of performance information split by key indicators such as ethnicity, deprivation, age and gender. As shown in the examples below, a number of key dashboards have been developed with specific stratification and segmentation by these demographic areas, providing enhanced visibility of these patients for staff and enabling targeted action as necessary.

Increase size of diagrams in the final draft for publication

Figure 4: Health Inequalities data

In addition, under the NHSE Statement on Information on Health Inequalities published in November 2023, the Trust along with BSW ICB is required to record and report on a variety of key metrics related to Health Inequalities, with specific focus on the following as an Acute trust:

- Elective activity vs pre-pandemic levels split <18 and >18, split by ethnicity and deprivation
- Emergency admissions for <18 split by ethnicity and deprivation
- Adult inpatient services offering smoking cessation
- Maternity inpatient settings offering smoking cessation
- Tooth extraction admissions for decay for children admitted as inpatients aged 10 and under

As shown below, each of these metrics is being actively reported on within the Trust, enabling cross demographic comparisons in these key areas, the ability to identify time-based trends and the impact of any specific interventions that are undertaken. In 2025/26, further work will be undertaken to ensure alignment with the associated work being done in this area at an ICB level and also how we can better share learning and best practice across the wider Hospital Group.

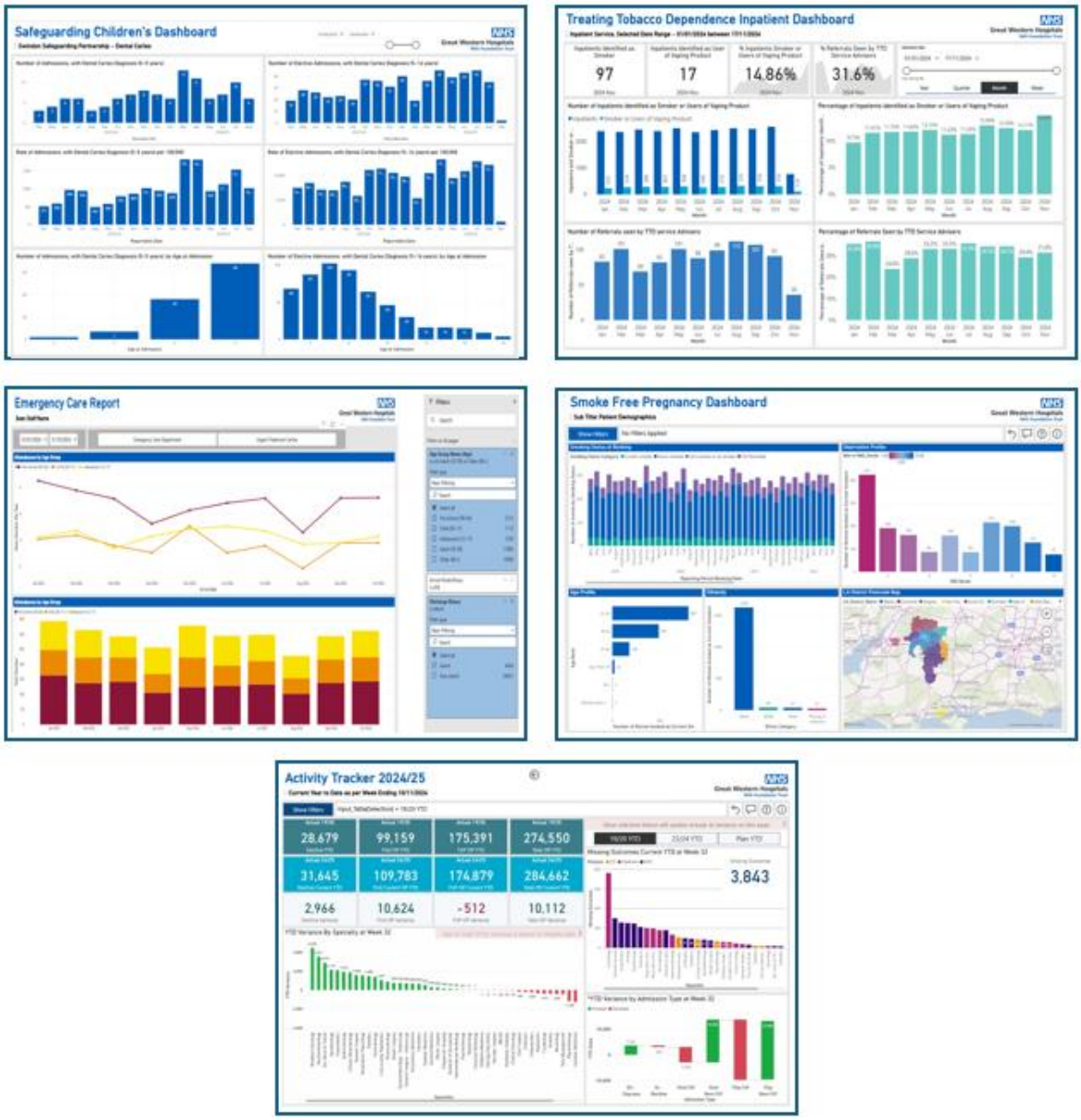


Figure 5: Health Inequalities data

In addition, we have liaised closely with colleagues at BSW ICB around Health Inequalities and Population Health data and initiatives, particularly through the monthly BSW ICS Population Health Intelligence Forum. The BSW ICB data team have also created a suite of Population Health/Health Inequalities reports, including Core20Plus5, that are hosted on the ICB reporting portal as shown below and readily available to users across the ICB.

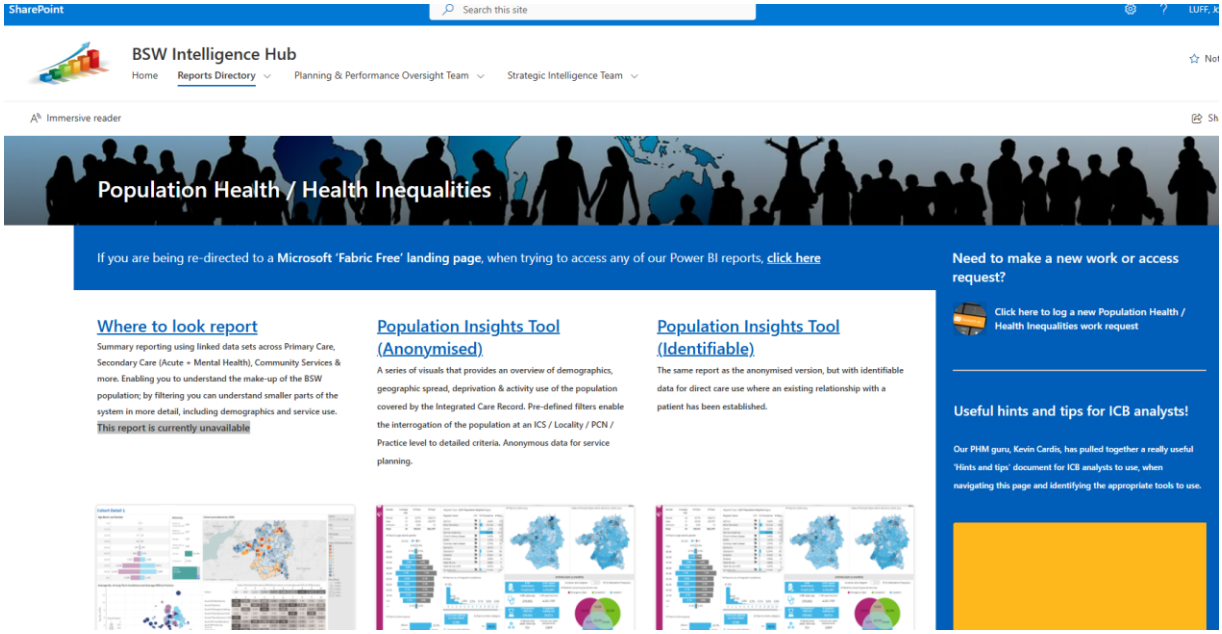


Figure 6: Health Inequalities Reporting

Developing our approach to addressing Health Inequalities

The NHS launched the Patient Safety Healthcare Inequalities Reduction Framework in May 2025, which introduces five principles:

Principle 1	All staff, patients, service users, families and carers have access to information, translation and interpretation services when needed.
Principle 2	All healthcare staff receive undergraduate patient safety training, ongoing training, and accessible resources that improve their awareness and understanding of healthcare inequalities related to patient safety risks.
Principle 3	Accurate and complete diversity data are collected for protected characteristics and inclusion health groups on digital platforms. (Including disaggregated data).
Principle 4	Representatives of diverse communities are involved in the design and delivery of improvements aimed at reducing patient safety healthcare inequalities. This co-production involves drawing on the knowledge and experience of patients, service users, carers, families, communities and staff.
Principle 5	Improve the understanding of patient safety healthcare inequalities and drive improvement through identifying priority areas for research.

This framework aligns with previous policy including NHS England's Core20Plus5 Framework (adults and children and young people), the NHS Long Term Plan, the EDI Improvement Plan (High Impact action to address workforce health inequalities) and key actions outlined in the NHS Standard Contract between the commissioners and the Trust – to restore services inclusively; mitigate against digital exclusion; ensure datasets are timely and complete; to accelerate preventative programmes and ensure leadership and accountability. This framework is very timely, as the Trust is preparing to refresh its Health Inequalities Action plan, which will support actions for the coming three years. Our comprehensive plan will also

respond to evolving regional and Integrated Care System strategic plans; and will be shaped with the support of the Trust Management Committee later in the year.

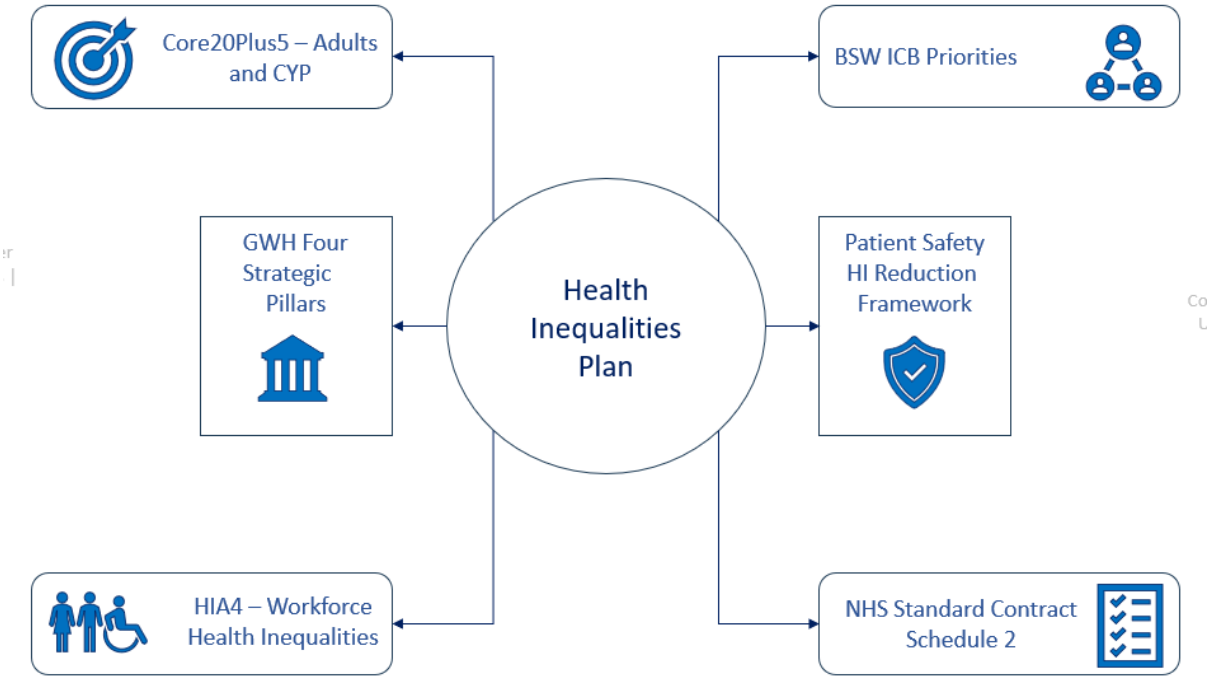


Figure 7: Health Inequalities Plan framework

Our Priorities for 2025-2026

Our report highlights the extensive efforts we have made to improve equity for our workforce and patients. With some good progress made:

We have a more diverse workforce (staff and volunteers), with an increase in disabled and ethnic minority staff and we provide development opportunities for staff to progress into senior roles; we know our data gaps can mask inequities and will continue to raise awareness about the importance of sharing protected characteristics.

We have switched focus from international recruiting nurses, to helping our talented international recruits to meet the requirements for NMC registration and to access development opportunities. Where we have 'hard to fill' clinical and medical roles, we will support international recruits who meet the selection criteria, to relocate.

We are preparing a workforce for the future, this includes professional development, training, career guidance, coaching and mentoring. Leadership development is available for staff in any profession or banding and we continue to offer apprenticeship roles. We have leveraged technology to train our staff, including the use of A.I. to deliver immersive EDI and soft skills training. We have launched the Expectations of Line Managers programme in November 2024, and this programme has been submitted for consideration for an HPMA award. The purpose of this programme is to equip line managers with knowledge, skills and confidence to enable them to be excellent line managers. We know that colleagues' relationship with their manager is key and enables high performing teams who can give outstanding care to patients.

We recognise that some of our staff disproportionately experience inequalities, across health outcomes and working life experience and more broadly the wider social determinants (housing, education, environmental factors etc), in response we deliver a programme of work to address this imbalance including a robust occupational health and health and wellbeing service, a Trust-wide effort to address discrimination and other unprofessional behaviours, established divisional working groups and a network of volunteer staff who champion inclusion and equity.

The NHS EDI Improvement Plan (High Impact Action 4), sets out a requirement to address health inequalities in the workforce, including reducing bullying and discrimination, which can lead to ill health, absenteeism and staff turnover. The Trust re-launched the Never OK campaign in June 2025, in partnership with Wiltshire Police, putting a spotlight on the personal impact of abuse, whilst reminding staff, patients and visitors that abuse of NHS staff is never OK. This will be coupled with a 'Guide to addressing racist incidents' which will help staff to respond and a Safe to Speak survey will be undertaken during the autumn and winter months to understand the lived experience of staff and identify good practice from across the Trust to enable shared learning.

We have a common aim, with our system partners, to improve the health and wellbeing of our local population and to prevent illness. Improving our datasets has been a priority for 2024-25, this has given us more insights into our patients, but there is still more work to be done to meet the needs of our Core20Plus5 population groups, which will be reflected in a new Health Inequalities three-year plan, due to be launched in the New Year 2026.

We recognise we have a long way to go to get to equity, which means we have to do things differently for some groups; a necessary step in achieving equality. To support this, we have recently published our 2025-2028 EDI and HI Strategic Plan, which sets out high-level ambitious objectives and aims to drive progress across both workforce and patient agendas; with a commitment to build detailed action plans annually that responds to the changing needs

of our staff and patients and the data we monitor. Some of our 'year one' (the financial year April 2025 to March 2026) initiatives are highlighted in the following section.

Looking ahead

In our next reporting year, 2025-26, we will continue to respond to the six high impact actions in the NHS EDI Improvement Plan, to improve equality, diversity and inclusion for staff.

- Including supporting staff to address harassment, bullying and abuse. The Trust-wide Never OK campaign will ensure that all staff, patients and visitors receive a clear message.
- Eliminating discrimination will continue to be the EDI Pillar Metric (Trust-wide focus for improvement) and this will have a positive impact on bullying, harassment and abuse, which also disproportionately impacts disabled and ethnic minority staff. An intrinsic part of our improvement plans includes empowering and mobilising our EDI champions who can take local action and the work of our divisional leads who are responsible for driving change in their departments. We want to increase the number of EDI champions in the Trust so that all staff can have access to this trained group.
- Staff from minoritised backgrounds are under-represented in senior leadership roles and we have maintained a gender pay gap in favour of males (£7.32), we will continue to provide leadership development opportunities, for example mentoring, coaching and Scope for Growth conversations, utilise our Inclusion Recruitment Champions for Band 8B and above interviews and provide opportunities for staff to speak-up about their concerns, including engagement with board representatives and we will tailor support for our internationally educated staff. As an anchor institution, we will continue to target groups from poorer socio-economic backgrounds, including introducing a guaranteed interview scheme for Care-Experienced Young People (CEYP) and delivering Dare 2 Doctor, Project Search and similar schemes.
- The health and wellbeing of our staff is essential to our success. We will offer in-person and online support for staff and continue to recruit and train Mental Health First Aiders and Health & Wellbeing Champions and deliver health and wellbeing days and Schwartz Rounds alongside our proven occupational health services. Our staff also experience health inequalities and improvements in our datasets will help us to provide the right support.
- We will explore the use of artificial intelligence (A.I.) bespoke scenario-based training modules to help staff to navigate difficult conversations and to de-escalate; and introduce health inequalities training to equip staff to engage in improvements.
- And seek opportunities to improve workplace inclusion with our BSW Group partners, Salisbury NHS Foundation Trust and Royal United Hospitals Bath NHS FT.

There is an ongoing programme of work to improve the quality of our data for both staff and patients. Gaps in our demographic information can mask inequalities and we will encourage staff to share their information and to update patient records when they have an opportunity.

The new Shared Electronic Patient Record will launch in 2026. The new system will bring patient information together in one place and will be shared across GWH, Royal United Hospitals Bath and Salisbury NHS Foundation Trust; this will improve data quality and help our staff to standardise care processes and deliver care efficiently, effectively and safely and provide a smoother care journey for our patients wherever they are treated. We will also take a system approach to improving Accessible Information Standards, a new system/BSW group will form later in the year.

Our health inequalities plan will respond to the needs of the BSW Hospital Group, the BSW Integrated Care System and regional and national priorities; and we are committed to engage

and to co-produce with our local population and patients so that we can provide great care, that is inclusive, equitable and accessible.

We invite our stakeholders to take part in this ‘improving together’ journey. If you would like to get involved in equality, diversity and inclusion and health inequalities work, please contact gwh.inclusion@nhs.net.

Measuring Performance

The NHS uses several frameworks to measure our progress against key metrics including the Gender Pay Gap; Equality Delivery System (a self-evaluation tool); the Workforce Disability Equality Standard and Workforce Race Equality Standard which compares the working life experience between different groups of staff to highlight any inequalities; Sexual Orientation Monitoring (SOM) Information Standard; and Accessible Information Standard. The results from these assessments and standards inform our action plans every year and help us to demonstrate our commitment and legal obligations set out in the Equality Act 2010 and Public Sector Equality Duty.

We use these metrics along with talking to our staff and patients to set priorities and actions for the year ahead. This year, engagement has included the 'Slice of Life' which brought staff and board representatives together to discuss their working life experience in an informal setting, in December we held a graduation ceremony for our EDI Champions to promote the opportunity, highlight the work of champions and thank them for their commitment to improving inclusion in their area of work, and board representatives met with patients in a community setting at a Change the Narrative event, to discuss accessibility. Throughout the year our lead Patient Experience and Engagement meets with patients and the public to help improve service delivery. You can read more about this work in the Achievements section of this report.

As a result, we have seen some improvements in the metrics that we use to measure progress highlighted in the performance reports in the following sections.

Accessible Information Standards

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

We currently have a link on our website to advise the public of how they can inform us of any specific needs, and we are then able to add an alert to our main patient administration system to highlight this to all staff.

Our publications and reports can be made available in a number of formats upon request, and we have new resource folders on each of our ward areas to support staff in communicating with patients who may have additional challenges. The practical resources and guidance are particularly helpful when caring for patients who have experienced a stroke or a brain injury, patients who are deaf or hard of hearing, patients with learning disabilities, autism, dementia or patients who do not speak fluent English.

Patients can access British Sign Language (BSL) interpreters, including a video transfer system called SignLive, which can be used in most areas of the trust and is available 24/7 to connect to a BSL interpreter. We also have various hearing loops, amplifiers and systems to support those with hearing loss. A new portable hearing loop can be taken to any area of the hospital. Our Outpatient Welcome Liaison Service (OWLS) provide a team of volunteers who can assist patients on arrival at the hospital, escort them to their appointment, wait with them and escort them back to their transport home.

Work throughout the year has included engagement with diverse communities to understand their needs including people with learning disabilities, complex needs, unpaid carers and the deaf community.

The Trust will introduce a new electronic patient administration system in 2026. The functionality will support us to better identify and flag patients with additional needs, where reasonable adjustments may be needed or where alternative communication processes are required. It is hoped that this will be able to be linked to automatic alert to the appropriate team or department to ensure that the necessary action is taken.

Representatives of the Differently Abled Staff Network, made up of disabled staff and allies continue to provide feedback relating to improving accessibility across the site – progress in this work is severely impacted by financial constraints, however, plans for 2025-26 include improvement to lighting across public footpaths and a trust wide accessibility review to support prioritisation of work.

The Inclusion & Health Inequalities Subcommittee continue to oversee the improvements in Accessible Information Standards. A new lead will be appointed for this programme of work in 2025-26 and there are plans for the formation of a system group.

Equality Delivery System (2024-2025)

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

- **Commissioned and Provided Services:**
    - **Better Health Outcomes**: Ensuring equitable health outcomes for all patients, regardless of their background.
    - **Improved Patient Access and Experience**: Making sure that all patients have equal access to services and receive respectful and responsive care.
- **A Representative and Supported Workforce**: Ensuring that the NHS workforce is diverse and that staff from all backgrounds feel supported and valued.
- **Inclusive Leadership**: Promoting leadership that is diverse and inclusive at all levels of the NHS.

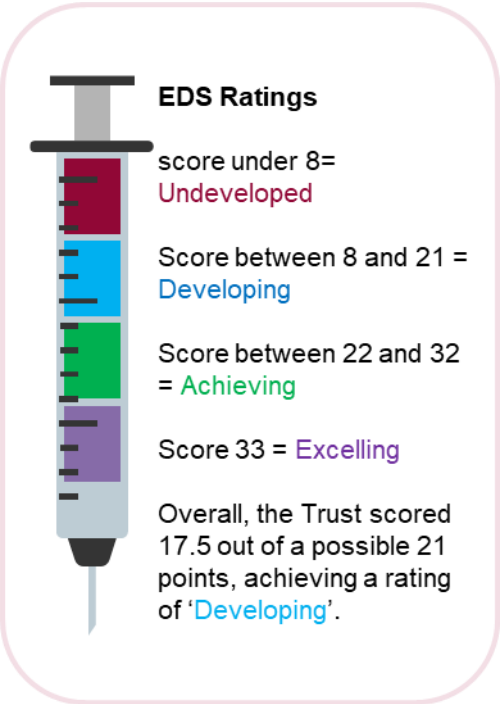


Figure 8: EDS Ratings

There are 18 specific and measurable outcomes across the three domains including reducing health inequalities in the population and workforce; improving patient feedback mechanisms and leadership engagement and governance in relation to the inclusion and health inequalities agenda.

Stakeholders are invited to come along and score a range of evidence under each Domain, and all group scores are totalled to give an overall score.

Currently, Commissioned and Provided Services are scored at system level alongside partner organisations in the BSW Integrated Care System. Workforce and Leadership Domains are scored internally. The Trust will continue to widen participation in this process annually.

Domain One

The BSW Integrated Care Board (ICB) reviewed Maternity & Neonatal Services in 2023 and the Patient Advice & Liaison Service (PALs) in 2024. In response to the review the departments have undertaken work to improve equity in these areas.

Maternity & Neonatal Services Review 2022-23

Maternity and Neonatal Services were evaluated as part of the EDS process in the spring of 2023, the resulting actions included implementing a three-year plan and this progress report highlights work to date. In 2024-25, two years since the review, addressing health inequalities continues to be a priority within the Perinatal service and progress is monitored against the NHS England Three-Year plan for Maternity and Neonatal Services. In the new financial year 2025/26, the department will implement the recommendations made in the 'Patient safety healthcare inequalities reduction framework' published in May 2025 (NHSE).

Since the evaluation, be-spoke EDI training has been delivered to maternity staff which is done collaboratively with the Maternity Voice Partnership and Trust EDI lead. The last cycle had a focus on neuro-divergence and meeting the needs of LGBTQIA+ families with a cultural competency thread woven throughout. Perinatal staff at all levels are encouraged to attend the 'Black Maternity Matters' training provided by NHS Health Innovation West of England. A key component to the training is the development of a QI project to support Black families using perinatal services. These have included the introduction of silk theatre bonnets, to provide better head coverage, for colleagues and service users who choose to use them as well as engagement with the Resuscitation Council UK to ensure language used in teaching is representative of all service users. Oliver McGowan training remains mandatory for all maternity and neonatal nursing staff.

To improve access to maternity triage for women who do not speak English, a "passport" has been created. Passports are provided by the community midwives and support women to present to triage without calling ahead, removing a communication barrier and ensuring timely assessment. Within the antenatal outpatients service a 'Little Box of Calm' is now available containing sensory objects/puzzles. This is provided for neuro-divergent birthing people who may find the hospital environment unsettling. The 'Patient Communication Toolkit' is a pictorial resource that is available to support clear communication for deaf families, those with learning difficulties or those who do not speak English.

The service is currently running a pilot with "Flashcard" communication tools put together by the MNVP (Maternity and Neonatal voices Partnership) and funded by the LMNS (Local Maternity and Neonatal System). The flashcards communicate common problems and requests using visual images and contain translations in six common languages used by perinatal service users.

The neonatal team are working with the Southwest Neonatal Network on a project to improve the inclusivity of images in the neonatal unit. They have also produced posters specifically for Black mothers inviting feedback and signposting to relevant groups and networks.

To improve their ethnicity data, they have embedded an ethnicity requirement for Patient Safety events reportable via Datix, the incident management system, with a safety net to ensure 100% compliance. The outcomes of patient safety events by ethnicity are reported monthly through the governance process. A one-year review of ethnicity data for all patient safety incidents during 24/25 in comparison to booking data is planned to explore over representation of ethnic minority groups. This will be presented in the Q1 25/26 Quarterly Safety Report. Representation of ethnic minority women in the 2024 National Maternity Survey is representative of the local population. This provides assurance of improving equity in patient engagement.

Maternity & Neo-natal 2022-23 Score: Developing Activity

Patient Advice & Liaison Services (PALs) Review 2023-24

The PALs EDS review took place in spring 2024. Since then, the PALs team have worked to improve access to healthcare, including providing all Interpreting and Translation services

across the trust. They have added additional software to enable creation of easy read documents and translated material and routinely promote accessible communication options and reasonable adjustments. The team also facilitate the provision of the Carers Support Passport to improve how we support unpaid carers. The team attend EDI-related training including Oliver McGowan training (autism awareness) and they have appointed an EDI Champion (a member of staff who helps promote inclusion and provides local support). PALs are instrumental in helping the Trust to understand the experience of our patients and the public, through multiple feedback mechanisms, and they work with key stakeholders to support in the identification of themes and driving improvements. The Head of Patient Experience and Engagement has developed a library of lived experience videos to help share direct patient stories and raise awareness amongst staff. These videos include reflections from seldom heard groups such as those living with disability.

To help improve EDI-data quality, the team have recently introduced a trial to capture protected characteristics data during the feedback process, which is shared on a voluntary basis. This includes asking about age, gender, ethnicity, language, sexual orientation, disability and religion with a clear explanation of how the data is to be used.

PALs 2023-24 Score: Developing Activity

Both services can be re-evaluated at a future date to gauge the impact of their improvement initiatives.

Treating Tobacco Dependence & Mental Health Detentions 2024-25

The BSW Integrated Care Board is leading the Domain 1 (Commissioned and Provider Services) review; this work will be completed and reported on by the end of summer 2025 – the three services under review are:

- Maternity treating tobacco dependence service
- Acute inpatients tobacco dependence service
- Mental health detentions

Domains Two and Three Review 2024-25

In March 2025 the Trust undertook an internal review of Domain 2 (workforce health and wellbeing) and Domain 3 (Inclusive Leadership), the results of which are reported below.

A diverse group of staff including staff network representatives met at the Inclusion & Health Inequalities Subcommittee meeting to review and score evidence across the Domain One and Two categories. **Scoring has improved for both Domains, moving the Trust from 'Developing Activity', to 'Improving Activity'**. The facilitator highlighted initiatives which have been undertaken since the 2024 review which has helped to improve the scores:

Workforce health and wellbeing: Introduction of Cultural Competence training; the inaugural EDI conference which focussed on building allyship; recruitment, training and deployment of EDI champions and Inclusion Recruitment Champions; staff involvement in developing EDI initiatives; implementation of the Sexual Safety Charter; a review of speaking up processes, with further work in 2025-26 with staff to shape a behavioural framework; workshop with key staff to learn from important legal cases; roll out of Expectation of Line Management training; increased staff engagement, including meetings with Trust Board representatives, and a suite of health and wellbeing interventions to support staff welfare.

Inclusive Leadership: The Trust Board made EDI-commitments in 2024-25, including meeting with members of staff to understand their lived experience, findings from this listening events have been shared with People Services to help inform future actions; an EDI budget

has helped to improve the impact of initiatives; the board have increased their visibility and support a wide range of diversity awareness days and events and are involved in programmes like mentorship; and their visible endorsement and sponsorship of the EDI agenda helps to send a positive and progressive message across the Trust. The Board approved the three year EDI Strategic Plan 2025-28 with a commitment to an improved evidence-base for EDI initiatives.

Improvements to the EDS process, which has been streamlined to make reviewing a substantial amount of information and scoring easier, has also had a positive impact on the scoring – the information is presented in a more transparent and easily digested format.

Staff, volunteers, patients and members of the public who would like to get involved in future reviews should contact the Head of EDI – gwh.inclusion@nhs.net.

Gender Pay & Ethnicity Pay Gaps

Gender & Ethnicity Pay Gap Reporting

Gender Pay Gap Reporting

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

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

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

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

A Note on Terms

What are the pay gaps?

The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings.

The mean pay gap is the difference between average hourly earnings of men and women.

The median pay gap is the difference between the midpoints in the ranges of hourly earnings for men and women.

What do we mean by pay 'parity'?

In the context of gender pay, 'parity' means that males and females are being paid the same amount for work assessed as of equal value. Parity is therefore a desired outcome.

What do we mean by a 'more positive difference', or 'improvement' on a previous position?

This means that the pay of males and females for a specified measure is closer to parity (see above), than it was when we looked at the measure previously.

What is a 'negative' data measure?

We are adopting the standard convention when looking at pay differences between males and females. A negative measure (for example, a gap of -1.57 as indicated for staff at Band 2 of the pay scale), indicates the extent to which females earn more per hour, on average, than their male counterparts.

Gender pay reporting and equal pay

Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between males and females who carry out the same or similar jobs or work of equal value. In the UK it is unlawful to pay people unequally because they are a man or a woman.

Our Gender Pay Gap data at the snapshot date of 31.03.2025 is: -

The Mean Gender Pay Gap

The mean gender pay gap is £7.32 (26.03%). A small increase of £0.48 (1.99%) since last year.

Figure 9: Mean gender pay gap

All Staff – Female staff earn £0.74 for every £1 a male staff earns (£7.32 less per hour) when comparing the mean pay.

Excluding medical and dental staff – female staff earn £0.96 for every £1 a male staff earn (£0.82p less per hour) when comparing the mean pay.

Medical only staff – female staff earn £0.82 for every £1 male staff earn (£8.45 less per hour) when comparing the mean pay.

Note, the mean pay gap reflects the average earnings and is therefore more sensitive to extreme values (high or low hourly payments). Key drivers for the mean pay gap include under-representation of male staff in lower paid roles and over-representation of male staff in the highest paid roles which skews the average upwards (see quartiles section); female staff are less representative in the highest paid roles and more evenly distributed in the lower and middle tiers of pay, pulling down the average.

Contributory bands in favour of male staff include Band 8d +£3.71 more (8.3% gap), Band 9 +£7.72 (15.8% gap), VSM +£2.01 (3%), medical consultants +£1.72 (2.8% gap) and junior consultants +£2.01 (7.4% gap).

The Median Gender Pay Gap

The median gender pay gap is £3.04 (13.76%). A small increase of £0.42 (1%) since last year.

Figure 10: Median gender pay gap

All Staff – Female staff earn £0.86 for every £1 a male staff earns (£3.04 less per hour) when comparing the median pay.

Excluding medical and dental staff – the gap is in favour of female staff; male staff earn £0.96 for every £1 female staff earn (£0.78p less per hour) when comparing the median pay.

Medical only staff – female staff earn £0.78 for every £1 male staff earn (£11.50 less per hour) when comparing the median pay.

The median gap suggests more subtle inequalities, such as progression or working patterns. The median gap is also driven pay differences in pay between male staff and female staff in higher paid roles (VSM +£4.60, Medical Consultant +£1.83, Medical Other +£0.02 and Band 9 +£8.72) but is more sensitive to distributions with the banding.

Impact of movement in bandings

The largest growth in female staff is in Bands 0-Apprenticeship to Band 5, maintaining a percentage of 61% of female staff in the lower banding, compared to 41% of male staff. There has also been an increase of 90 female staff in the middle banding, Bands 6 and 7, and a smaller increase of 43 male staff in this group, 26% of female staff are Band 6-7, and 18% male staff. The small reduction in the pay gap is helped by the increase in female staff in the Band 6 and above roles, notably female medical consultants have increased by 76. There are more female resident doctors and medical other staff than males, which should help to diversify our consultant pipeline, any barriers to progression would need to be identified.

13% of female staff and 44% of male staff are in senior roles (Band 8a and above), this percentage is relatively the same as 2024 when it was 12% and 41%. Although we have increased the number of male staff in Bands 0-5 and 6-7, overall men remain over-represented in senior roles, largely sustained by an increase in medical consultant doctors, 132 additional male consultants, compared to 76 additional female consultants.

Table 3: Male and female profile across bandings

	Female 2025		Female 2024		Female Difference	Male 2025		Male 2024		Male Difference
AfC Bands <1 to 5	3305	61%	2943	61%	362	515	38%	448	41%	67
AfC bands 6 to 7	1440	26%	1350	28%	90	238	18%	195	18%	43
AfC bands 8a and 8d	214	4%	191	4%	23	84	6%	76	7%	8
AfC band 9	7	0%	6	0%	1	5	0%	5	0%	0
Medical - consultant	167	3%	91	2%	76	283	21%	151	14%	132
Medical - junior	215	4%	212	4%	3	137	10%	169	15%	-32
Medical - other	81	1%	61	1%	20	66	5%	44	4%	22
Non-Exec	4	0%	4	0%	0	6	0%	8	1%	-2
VSM	3	0%	4	0%	-1	4	0%	3	0%	1
	5436	100%	4862	100%	574	1338	100%	1099	100%	239

Pay Quartile Representation

Pay quartiles divide all staff into four equal groups based on their hourly pay, highlighting the proportion of males and females in each pay band, from the lowest to the highest paid earners.

There is an increase of 2.33% in male staff in the upper quartile (the highest paid staff), from 391 last year to 456 this year, female representation in the upper quartile decreased by the same margin, however there was growth in numbers from 986 to 1028 female staff.

An increase in male staff in the middle lower (+25) and lower quartile (+98) has supported a 5.08% improvement in the pay gap.

Male staff continue to be disproportionately over-represented in the upper quartile, just over 30% of male staff are in this quartile – a figure closer to 18% would be representative; female staff are more evenly spread across the lower, lower middle and upper middle quartiles, but under-represented in the upper quartile where the percentage is 69%, a figure of 81% would be representative. This trend will sustain the pay gap.

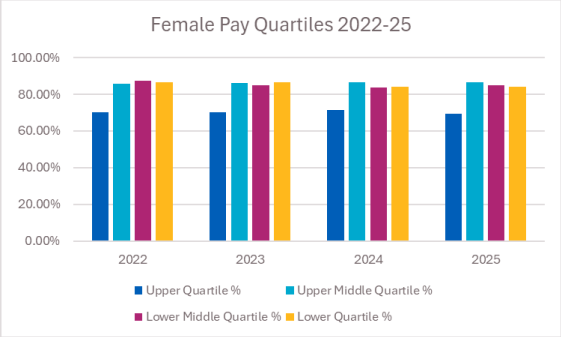


Figure 11: Female pay quartiles

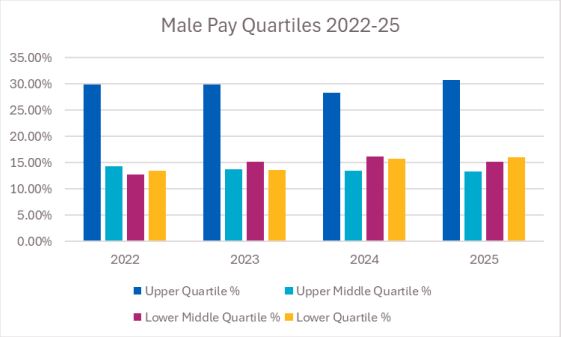


Figure 12: Male pay quartiles

Table 4: Variance in pay quartiles 2024 v 2025

			Variance 2024 - 2025	
Ordinary Pay Quartiles	Male	Female	Male	Female
Upper Quartile %	30.73% (456)	69.27% (1028)	2.33% (65)	-2.33% (42)
Upper Middle Quartile %	13.28% (196)	86.72% (1280)	-0.26% (3)	0.26% (48)
Lower Middle Quartile %	15.20% (225)	84.80% (1255)	-1.01% (5)	1.01% (118)
Lower Quartile %	16.08% (238)	83.92% (1242)	0.31% (25)	-0.31% (104)
Trust Total %	**18.83%** (1115)	**81.17%** (4805)	**0.38%** (98)	**-0.38%** (312)

The Bonus Pay Gap

The gender pay gap for bonus payments shows how bonus/incentive payments were distributed between male and female employees who received bonuses in the 12 months leading up to 31st March 2025.

The Mean Bonus Pay Gap

All staff – The mean bonus payment gap is 30.76% in favour of male staff. Female staff received on average £0.69 for every £1 male staff received. 2.75% of all eligible male staff received a bonus, compared to 0.39% of eligible female staff.

Excluding medical and dental staff – No bonus payments were made to this group of staff. Incentives like 'waiting list initiatives' are included in ordinary pay.

Medical and dental staff – The bonus payment gap is 36.79% in favour of female staff. Male staff received on average £0.63 for every £1 female staff received. 13.58% of male staff and 4.10% of female staff received a bonus.

The mean bonus pay for medical staff is in favour of female staff because it is driven by a few high value awards. See Local and National Awards section below.

Note, due to the small sample size (85 staff), high value awards will skew both the mean and median value, making the data sensitive to outliers. In addition, the bonus payments for medical staff are based on the number of payments made (disaggregated data), in contrast the bonus payments for all staff are based on the aggregated bonus each recipient receives, resulting in a shorter range with higher values, thus resulting in differing values.

The Median Bonus Pay Gap

All staff – The median bonus pay gap for all staff is 62.44%. Indicating typical bonuses are higher for White staff.

Excluding medical and dental staff – No bonus payments were made to this group of staff.

Medical and dental staff – The median bonus pay gap for medical and dental staff is 0%, parity. This indicates fairness in typical award amounts.

Local and National Awards

There were 19 bonus payments (22%) given to female consultants and 66 bonus payments to male consultants, this is under-representative of the gender split in consultants (39% Female, 61% male). Some staff receive more than one bonus payments.

72% of the total bonus payment was received by male consultants. However, although they received payments more frequently, they received more bonuses of a lower financial value. In contrast, more female consultants received the highest valued awards including the top Silver Award which has significantly boosted the average mean bonus payment for female consultants.

Table 5: Gender split across awards

Award Level	Male %	Female %
Bronze to CEA Level 5	71.21%	63.16%
Mid-level CEA 6-9	25.76%	26.32%
National and Silver	3.03%	10.53%

Gender Pay Gap Summary

The Trust has a mean gender pay gap for all staff (both medical and dental and non-medical), of £7.32 and a median pay gap of £3.04, both in favour of male staff. There is slight narrowing of the mean ordinary pay gap since last year (down 0.48p); a small increase of male staff in the lowest quartile has supported an improvement, however male staff continue to be over-represented in the highest paid roles and female staff under-represented in the highest paid roles. The median pay gap has increased by £0.42.

The mean bonus pay gap which only went to medical and dental staff this year, is in favour of female staff, however the proportion of female staff who received a bonus (22%) was not representative of the percentage of female consultants (39%).

The Trust recognises the longstanding contractual factors that sustain the medical pay gap but is committed to supporting improvements. In 2025-26 we will offer a range of development opportunities for medical and dental staff including coaching, mentoring and leadership education. Our staff survey results, when disaggregated demonstrates that female and male staff feel the organisation acts fairly with regard to career progression and promotion to the same degree (56.5% female and 56.4% male respondents felt this). Our Medical Workforce Strategy for 2025-26 seeks to improve equity, this includes debiased recruitment processes, consultant mentorship, Scope for Growth career conversations and medical degree apprenticeships. Interview panel members will also receive anti-bias training and there will be EDI representatives on interview panels for senior medical roles. The aim is to improve representation at senior medical levels and support career progression for all doctors.

We will continue to offer an extensive leadership and development programme for the wider workforce, 82% female, and look for opportunities to improve our recruitment processes to ensure they remain fair and promote and support female staff to apply eligible bonuses.

Ethnicity Pay Gap Reporting

The ethnicity pay gap reflects the difference in average hourly pay between staff from an ethnic minority background (BME) and White staff. This is the first reporting of the ethnicity pay gap by GWH based on a snapshot date of 31 March 2025.

The NHS uses the Agenda for Change (AfC) pay framework, which seeks to harmonise pay for NHS staff across the country. Agenda for Change attempts to deliver on the principles of 'equal pay for work of equal value', this ensures that staff are paid equitably irrespective of their race, ethnicity, or any other protected characteristic. Pay grades are determined by the level of responsibility for each role, and a formal process is used to evaluate and approve all jobs.

At the snapshot date, the Trust employed 1,750 (30%) ethnic minority staff, 3,727 (63%) white staff and 443 (7%) staff are of unknown ethnicity.

The mean and median ethnicity pay gap

Table 6: Mean and median ethnicity pay gap BME and White staff

Ethnic origin grouping	Mean ordinary pay (hour)	Median ordinary pay (hour)
BME	£21.83	£19.38
White	£22.62	£19.10
Not known	£24.40	£19.53
% Difference White – BME	3.6%	-1.45%
% Difference White – Not known	-7.9%	-2.26%

Table 7: Mean and median ethnicity pay gap disaggregated BME staff and White staff

Ethnic origin grouping	Mean ordinary pay (hour)	Median ordinary pay (hour)
Asian	£22.28	£19.52
Black	£20.53	£19.37
Mixed	£22.55	£19.93
Not Stated	£24.40	£19.53
Other	£21.50	£18.43
White British	£22.35	£19.09
White Other	£25.61	£19.71
% Difference White British – Asian	0.31%	-2.21%
% Difference White British – Black	8.12%	-1.43%
% Difference White British – Mixed	-0.9%	-4.36%
% Difference White British – Not stated	-9.19%	-2.26%
% Difference White British – Other	3.78%	3.47%
% Difference White British – White Other	-14.59%	-3.21%

The mean ethnicity pay gap is £0.79, a 3.6% gap in favour of White staff. The median ethnicity pay gap is -£0.28, a -1.45% gap in favour of ethnic minority (BME) staff. The mean pay gap occurs because White staff earn more per hour on average, they are over-represented in the Upper Quartile; 76.37% White vs 23.63% BME.

The median, however, is not affected by extreme values, it looks at the two middle values. BME staff are more concentrated around the middle two quartiles, especially the upper middle quartile 42.01% (see quartiles below). When the BME group is disaggregated, the gap for Black staff is larger than other ethnic minority groups, a mean bonus gap of £1.81 (8.12%) in favour of White staff and median of -£0.27 (-1.43%) in favour of Black staff.

443 staff (7%) are of an unknown ethnicity, this can distort the pay gap accuracy, BME representation and pay statistics could be understated.

Figure 14: Ethnicity mean pay gap

Figure 13: Ethnicity median pay gap

Pay Quartile Representation

Pay quartiles divide all staff into four equal groups based on their hourly pay, highlighting the proportion of White and BME staff in each pay band, from the lowest to the highest paid earners.

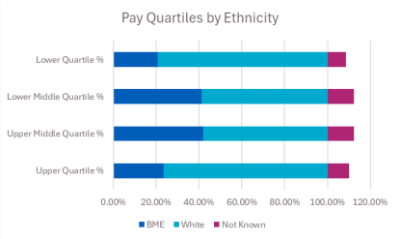


Figure 15: Ethnicity Pay Quartiles

White staff are over-represented in the Upper and Lower pay quartiles (76.37% and 79.10% respectively), leading to a small mean pay gap of £0.79 in favour of White staff. BME staff are concentrated around the median pay, leading to a median pay gap in favour of BME staff.

The Trust's Workforce Race Equality Standard report also highlights that ethnic minority staff are under-represented in non-clinical roles, 11% compared to 36% in clinical roles. This could explain the higher concentration of ethnic minority staff around the middle quartiles who are likely to be in clinical roles.

Table 8: Ethnicity Pay Quartiles

Ordinary Pay Quartiles	BME	White	Not Known
Upper Quartile %	23.63% (323)	76.37% (1044)	10.08% (117)
Upper Middle Quartile %	42.01% (573)	57.99% (791)	12.40% (112)
Lower Middle Quartile %	41.37% (566)	58.63% (802)	12.25% (112)
Lower Quartile %	20.90% (288)	79.10% (1090)	8.56% (102)
Trust Total %	**31.95%**	**68.05%**	**10.62%**
Trust Ordinary Pay Number of Staff	1750	3727	443

The mean and median ethnicity bonus pay gap

All staff - The ethnicity mean bonus pay gap for all staff is 8.24%. Ethnic minority staff receive £0.92 mean bonus for every £1 White staff receive. 24 (1.37%) ethnic minority staff and 55 (1.48%) White staff received bonuses.

Non-medical and dental staff – No bonus payments were made to this group of staff. Incentives like 'waiting list initiatives' are included in ordinary pay.

Medical and dental staff – the ethnicity mean bonus pay gap for medical staff is 62.69%. Ethnic minority staff receive £0.37 in bonuses for every £1 White staff receive,

The mean bonus pay is in favour of White staff because it is driven by a few high value awards. See Local and National Awards section below.

Six staff (1.35%) who received bonuses did not have their ethnicity recorded, this will mean that the bonus gap could be better or less favourable than recorded.

The median is less sensitive to outliers (very high or low values) and is more indicative of what a typical staff will receive.

All staff – The median bonus payment gap for all staff is 35.81% in favour of Ethnic minority staff. This is because fewer BME staff received a bonus; and the distribution of payments is more compart (fewer very low and very high values).

Non-medical and dental staff – No bonus payments were made to this group of staff.

Medical and dental staff only – The median bonus payment gap for medical/dental staff is 12.36% in favour of White staff, indicating typical bonuses are higher for White staff in this group. Ethnic minority staff receive £0.87 for every £1 White staff receive.

Note, due to the small sample size (85 staff), high value awards will skew both the mean and median value, making the data sensitive to outliers. In addition, the bonus payments for medical/dental staff are based on the number of payments made (disaggregated data), in contrast the bonus payments for all staff are based on the aggregated bonus each recipient receives, resulting in a shorter range with higher values, thus resulting in differing values.

Local and National Awards

There were 24 bonus payments (28%) given to consultants from an ethnic minority background (4 payments to Black staff and 20 to Asian staff) and 45 bonus payments to White consultants, the ethnicity was not recorded for six payments – there were 85 bonus payments in total, a consultant can receive more than one payment.

The bonus payments to ethnic minority consultants are slightly under-representative, 28% of eligible staff received a bonus, compared to 30% of the total workforce being from an ethnic minority background. The bonus payment gap is in favour of White consultants because more White consultants received higher paid bonuses; 31% of White consultants who received a bonus, received the Clinical Excellence Award (CEA) between Level 6 and 9; and 4% of White consultants received the highest awards. Most consultants from an ethnic minority background received the lower valued awards, 71% of BME consultants who won an award received a Bronze or Level 1 to 5 CEA award. The clinical awards are more likely to be received by senior consultants or long-serving consultants and ethnic minority staff are under-represented in senior roles.

Twenty awards were made to Asian consultants and four to Black consultants.

Table 9: Ethnicity split across awards

Award Level	White %	White Other %	BME %	Not Stated %
Bronze to CEA Level 5	64% (29)	90% (9)	71% (17)	67% (4)
Mid-level CEA 6-9	31% (14)	10% (1)	2% (5)	33% (2)
National and Silver	4% (2)	0% (0)	8% (2)	0% (0)

Ethnicity Pay Summary

Our data highlights that staff from minoritised backgrounds are under-represented in senior leadership roles and are centred around the middle grades. Interventions that support progression is important for this group. We will continue to provide leadership development opportunities, for example mentoring, coaching and Scope for Growth conversations, utilise our Inclusion Recruitment Champions for Band 8B and above interviews and provide opportunities for staff to speak-up about their concerns. Our Workforce Race Equality Standard (metric 4) that measure the likelihood of ethnic minority staff accessing training compared to White staff is 1.02, indicating they are just as likely to access non-mandatory and CPD-funded training as White staff.

Understanding the lived experience of our staff is key to effecting change. In the autumn of 2025, BME staff will engage with the Trust board representatives, and they will be able to highlight the challenges they face and celebrate what is working well. We currently tailor support for our internationally educated staff and this work will continue and there are plans to introduce a programme for internationally educated Allied Health Professionals (AHPs).

The Trust will also encourage staff to update their demographic information on the electronic staff record system, this will improve the data quality.

Our Medical Workforce Strategy for 2025-26 seeks to improve equity, this includes debiased recruitment processes, consultant mentorship, Scope for Growth career conversations and medical degree apprenticeships. Interview panel members will also receive anti-bias training and there will be EDI representatives on interview panels for senior medical roles. The aim is to improve representation at senior medical levels and support career progression for all doctors.

Workforce Disability Equality Standard

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

The 2024-2025 WDES Report is based on a snapshot of our workforce data as at 31 March 2025. Benchmark data, used for comparison, is based on staff survey results from NHS organisations of a similar size and nationally compiled data.

We deliver a range of initiatives across the year to support disabled staff including access to advice and guidance, health and wellbeing and occupational health services and access to training and development, including the launch of Trust-wide mentoring and Scope for Growth Career Conversations; and the Differently Abled Staff Network Chair represents the voice of disabled staff at key stakeholder meetings and committees. The network continues to engage with our Estates Department to provide insights into improving accessibility to the Trust site and this programme of work is being carefully monitored at the strategic committee that oversees EDI. During 24/25 the Trust developed an action plan in response to the national NHS EDI Improvement Plan six high impact actions. We have highlighted relevant actions that respond to WDES in the table at the end of this section of the report and actions for the next financial year (April 2025 to March 2026).

Disabled Staff Representation

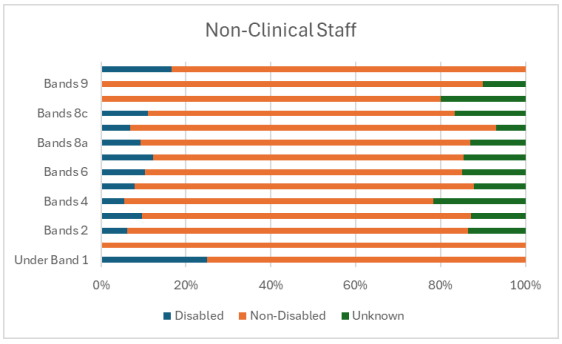
Overall disabled staff representation has increased from 247 (4.14%) in 2023/24 to 327 (5.33%) this year, with a modest increase in disabled staff across most bands. The largest growth being in entry and lower-mid roles (Band 2 to Band 4).

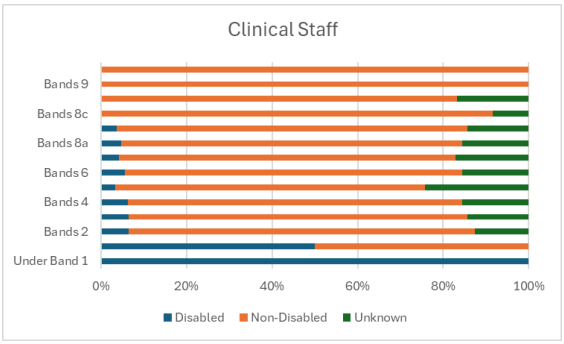
Agenda for Change (AfC) Non-Clinical Disabled Staff – representation across Bands 2 to 4 is relatively the same (6.3%-6.5%), targeted development opportunities for this group of staff could support progression. Reducing the ‘unknown’ status would help to improve data quality – this reaches 14% in some bandings. There are two disabled staff who are 8c and one Very Senior Manager (VSM).

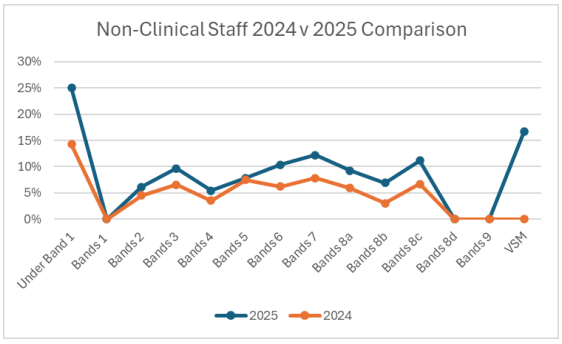
AfC Clinical Disabled Staff – representation is poorer in this group of staff, with no representation above Band 8b. The Trust will continue to offer career development opportunities for all staff and improve its recruitment practices to ensure it is fair and equitable, including the introduction of Inclusion Recruitment Champions (IRCs) in November 2023, the IRCs sit on interview panels for 8b and above roles. We also advertise roles across varied channels which has helped to attract a more diverse candidate pool.

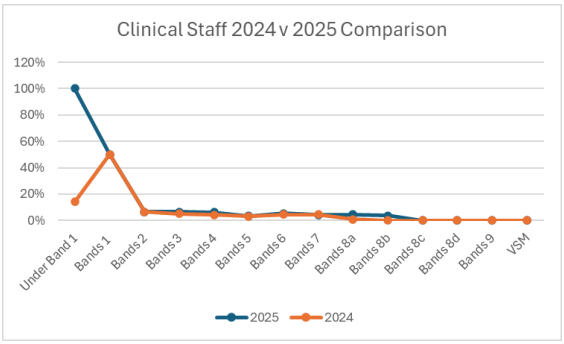
Medical and Dental Roles – there is low representation across all medical and dental consultant, specialists and trainee roles (between 2% to 3%), non-disclosure is high amongst consultant and specialist staff (14% and 11% respectively).

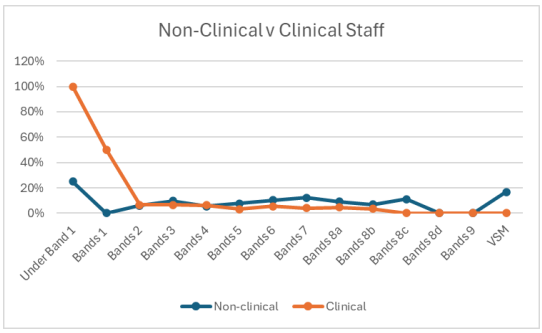
This data will be reviewed with the Trust Board and representatives of the disabled staff network, the Differently Abled Network, during the summer of 2025 to identify any targeted actions.

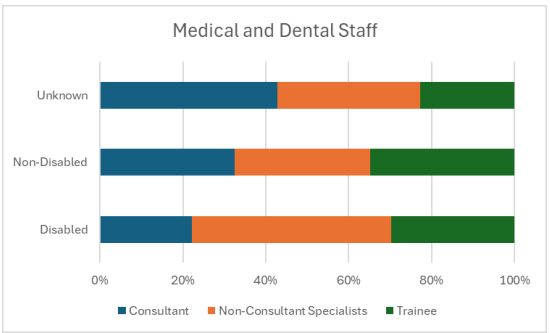












AfC Non-Clinical Staff	Disabled		Non-Disabled		Unknown		Total
AfC Bands <1 to 4	70	8%	702	78%	130	14%	902
AfC bands 5 to 7	28	10%	217	76%	39	14%	284
AfC bands 8a and 8b	7	8%	67	81%	9	11%	83
AfC bands 8c to VSM	3	8%	31	79%	5	13%	39
Total Clinical	108	8%	1017	78%	183	14%	1308

AfC Clinical Staff	Disabled		Non-Disabled		Unknown		Total
AfC Bands <1 to 4	86	7%	1035	79%	184	14%	1305
AfC bands 5 to 7	109	4%	1942	76%	503	20%	2554
AfC bands 8a and 8b	7	4%	126	80%	24	15%	157
AfC bands 8c to VSM	0	0%	21	91%	2	9%	23
Total Clinical	202	5%	3124	77%	713	18%	4039

Non-declaration rates

15.9% of staff have not stated whether they have a disability or not. This has improved since last year, when the rate was 19.1%. We have seen a year-on-year improvement since the Trust commenced measuring this data which was 30% in 2019. When rates of non-declaration are higher than the declaration rate this affects the quality of the data, and adds significant uncertainty to the estimate of disabled staff representation. The actual level of representation could fall anywhere between 5.3% and 21.2%.

WDES Improvements

There has been a small improvement in representation. The percentage of disabled staff and staff with LTC or illness who have experienced harassment, bullying and abuse from patients has reduced by 0.81%, this is 4.51% higher than the benchmark average, and is a continuing downward trend for the third year in a row. The percentage for staff without a disability or LTC or illness remains relatively the same since last year (0.8% higher than the benchmark average).

The WDES Metrics below, indicate where we have made improvements and where the metrics have worsened. Numbers in green indicate an improvement, numbers in red indicate the metric has worsened and numbers in yellow indicate there is relatively little or no change.

The three high priority areas for improvement include bullying and harassment from staff and patients and equal opportunities/progression (metric 4 and 5) are noted in the table at the end of these reports (see section 'high priority areas for improvement'), including actions that we will take in response to this data.

WDES Metrics

Ten metrics in table below, highlighting changes since last year. National data* and the Trust's benchmark data are highlighted in blue.

No	WDES Metric	Bench-mark	2023-2024	2024-2025	Difference	Direction
1	Percentage of staff in each of the AfC Bands 1-9 and VSM	5.7%*	4.1%	5.3%	+1.2%	Improved
2	Relative likelihood of staff being appointed from shortlisting across all posts *A figure below 1:00 indicates that Disabled staff are more likely than Non-disabled staff to be appointed from shortlisting. However, 7.5% of applicants had an unknown status - the number could be closer to parity (i.e. 1:00).*	0.98*	1.46	0.8	-0.66	Similar
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal capability investigation (average rolling two-year period) A figure above 1:00 indicates Disabled staff are more likely than Non-Disabled staff to enter the formal capability process. Number of non-disabled staff reported	2.04*	6.17 (2 disabled staff)	2.01 (1.5 disabled staff)	-4.16	Improved

	increased from 6 to 11 this year.					
4	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from:					
	Patients, their relatives or the public	29.4%	34.7%	33.9%	-0.8	Improved
	Managers	15.1%	12.8%	14.2%	+1.4	Worsened
	Colleagues	25.2%	23.2%	26.8%	+3.6	Worsened
	a) Percentage of staff who reported bullying and harassment	51.8%	45.7%	51.6%	+5.9	Improved
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	51.3%	52.9%	51.6%	-1.3%	Worsened
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	26.8%	27.2%	28.2%	+1.0	Worsened
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	34.7%	34.0%	34.4%	+0.4	Similar
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	74.0%	73.2%	74.2%	+1.0	Improved
9a	a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	6.4	6.4	6.3	-0.1	Similar
	b) Initiatives that support the voice of disabled staff: Executives Sponsor attends disabled staff network meetings; Board engages with staff network leads; EDI Lead supports network chairs; EDI champions programme launched in January 2024; staff network chair represents staff at EDI strategic committee meetings; all staff can engage with Group CEO at monthly open forums; line managers receive training to support health and wellbeing conversations; EDI-related training provided to enable staff to speak-up (e.g. Bystander and Addressing Unprofessional Behaviours workshops).					
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	5%*	N/A (no Board members)	0.55%	N/A	N/A

Board representation

	2024 BOARD MEMBERSHIP					OVERALL WORKFORCE	RATE OF DISABILITY/ LTC* FROM STAFF SURVEY
	Voting	**Non-Voting**	**Executive**	**Non-Executive**	**Total**		

Disabled	1	0	0	1	1	5%	22%
Non-Disabled	11	0	7	4	11	79%	78%
Unknown	4	1	2	3	5	16%	

This data excludes Associate Non-Executive Directors. The Trust currently has two associates, one from a BME background and no Disabled Associates.

Workforce Race Equality Standard

The NHS Workforce Race Equality Standard (WRES) is an initiative aimed at addressing racial inequalities within the NHS workforce. It focuses on ensuring that employees from ethnic minority background have equal access to career opportunities and receive fair treatment in the workplace. The WRES requires NHS organisations to collect, analyse, and publish data on race equality indicators such as recruitment, career progression, and disciplinary actions. By highlighting disparities and holding organizations accountable, the WRES seeks to create a more inclusive and equitable working environment for all NHS staff.

The 2024-2025 WRES Report is based on a snapshot of our workforce data as at 31 March 2025. Benchmark data, used for comparison, is based on staff survey results from NHS organisations of a similar size and nationally complied data.

We have undertaken a range of initiatives across the year in Response to last year's data and we have aligned our plans to the national NHS EDI Improvement Plan six high impact actions. The Trust introduced mentoring in November 2025 and continue to develop its programme of EDI Champions who are trained to respond to unprofessional behaviours and Inclusion Recruitment Champions who support interviews for Band 8B and above staff. Our board have engaged with staff across all protected characteristics to learn more about their lived experience and what we have heard has helped us to address some of the thematic challenges. We recognise that discrimination disproportionately affects staff from ethnic minority backgrounds and we are committed to continue to address this, our Leadership Conference (June 2025) will in part focus on anti-racism and the Trust is currently developing a guide to address racist incidents which will launch in the autumn of 2025.

Ethnic Minority Staff Representation

We continue to improve overall representation of ethnic minority staff in the Trust, an increase of 232 staff, from 1624 (27%) in 2023/24 to 1856 (30%) this year.

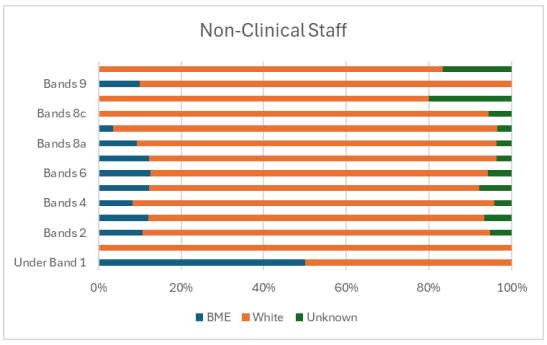
Agenda for Change (AfC) Non-clinical roles – there is less representation of ethnic minority staff in non-clinical roles, 11% compared to 36% in clinical roles. Representation declines sharply at senior non-clinical levels, Band 8a and 8b (7%, 11 out of 157 staff) and Band 8c to VSM (0 out of 8), suggesting a need to improve progression opportunities. When compared to last year, there is relatively no change in representation between Under Band 1 to Band 4, indicating some stagnation. The Trust now has one senior leader at Band 9, in 2024 there were no senior leaders in non-clinical roles between Band 8C and Very Senior Management (VSM) from an ethnic minority background.

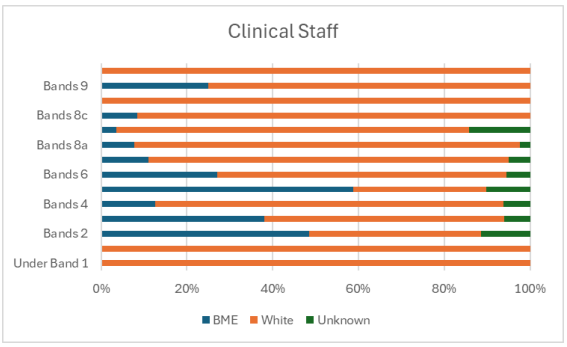
AfC Clinical roles – there is strong representation of ethnic minority staff in clinical roles (38%, 971 out of 2554 staff). Like non-clinical staff, there is a significant drop in representation in senior roles (Band 8a to 8b is 7% BME, 11 out of 157 and Band 8c to VSM is 9% BME, 2 out of 23), despite there being a high presence in operational bands 5 to 7. The higher proportion of staff at mid-level banding indicates a good progression pipeline and the Trust will continue to offer leadership development opportunities for all staff including mentoring, which was re-introduced in November 2025 and improve recruitment practices to ensure they are fair and equitable.

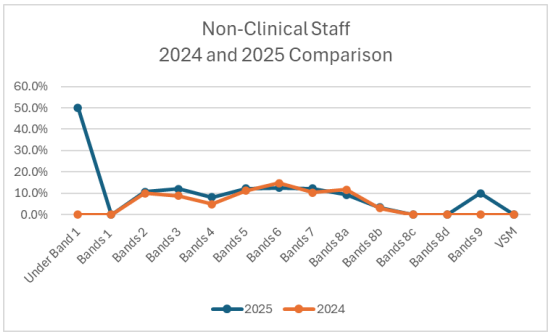
Medical and Dental roles – representation of ethnic minority staff is lowest in the most senior roles, 40% are trainees, 36% are non-consultant specialists and 24% are consultants. Ethnicity is unknown for 11% of medical and dental staff, improving ethnicity data

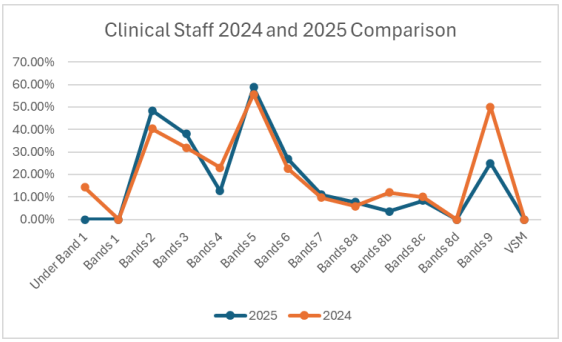
completeness would help to develop more targeted interventions. Staff receive an annual reminder to update their demographic information, which is making improvements over time.

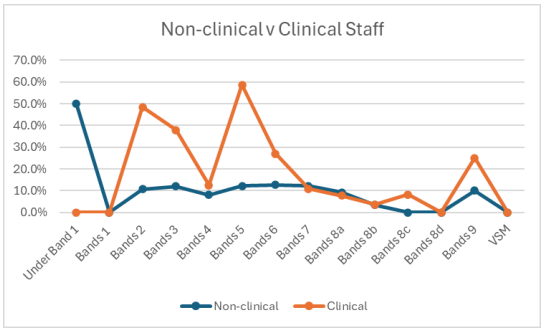
This data will be explored with the Trust Board and representatives of the Race Equality staff network during the summer of 2025

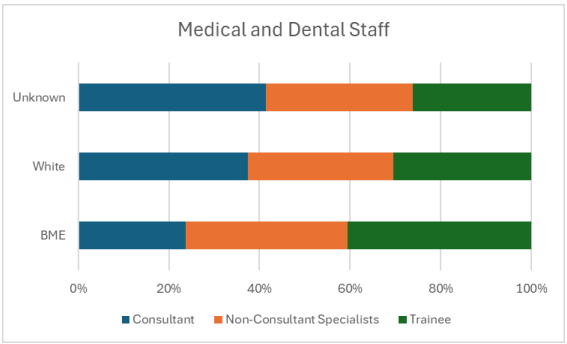












AfC Non-Clinical Staff	BME		White		Unknow n		Total
AfC Bands <1 to 4	100	11%	751	83%	51	6%	902
AfC bands 5 to 7	35	12%	232	82%	17	6%	284
AfC bands 8a and 8b	6	7%	74	89%	3	4%	83
AfC bands 8c to VSM	1	3%	35	90%	3	8%	39
Total Clinical	142	11%	1092	83%	74	6%	1308

AfC Clinical Staff	BME		White		Unknown		Total
AfC Bands <1 to 4	461	35%	750	57%	94	7%	1305
AfC bands 5 to 7	971	38%	1390	54%	193	8%	2554
AfC bands 8a and 8b	11	7%	139	89%	7	4%	157
AfC bands 8c to VSM	2	9%	21	91%	0	0%	23
Total Clinical	1445	36%	2300	57%	294	7%	4039

WRES Improvements

We have continued to see an improvement in overall representation and in ethnic minority staff experiencing harassment, bullying or abuse from colleagues in last 12 months, this has reduced by 1.69% since last year, this is 1.23 percentage points lower than the benchmark

average. There is no significant change for White staff, however, this has worsened by a small increase of 0.47%.

The WRES Metrics below, indicate where we have made improvements and where the metrics have worsened. Numbers in green indicate an improvement, numbers in red indicate the metric has worsened and numbers in yellow indicate there is relatively little or no change.

The three high priority areas for improvement include bullying and harassment from patients, discrimination and equal opportunities/progression (metric 5, 7 and 8) are noted in the table in the next section (high priority areas for improvement), including actions for 25/26 in response to this data. This will include taking steps to understand their perceptions and lived experience around equal opportunities in order to develop appropriate responses. The discrimination metric has improved slightly since last year, however, this remains the Trust's EDI Pillar Metric (Improving Together focus) for the second year in a row, to maintain the momentum on actions underway, particularly as there is a correlation between the types of behaviour experienced through harassment and bullying and discrimination – this number also remains considerably higher than the benchmark.

WRES Metrics

Ten metrics in table below, highlighting changes since last year. National data* and the Trust's benchmark data are highlighted in blue.

No	WRES Metric	Bench-mark	2023-2024	2024-2025	Difference	Direction
1	Percentage and number of staff in the Trust by ethnicity (AfC Bands 1-9 and VSM)	28.6%*	27.2%	30.3%	+4	Improved
2	The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants *A figure above 1:00 indicates that White candidates are more likely to be appointed from shortlisting than BME candidates. The gap could be higher, 18% of candidates have not stated their ethnicity.*	80% of NHS Trusts report White applicants are significantly more likely to be appointed, figure broadly unchanged since the inception of WRES*	1.27	2.01	+0.74	Similar
3	The relative likelihood of BME staff entering the formal disciplinary process compared to white staff *A figure below 1:00 indicates that White staff are more likely than BME staff to enter the formal disciplinary process. The ethnicity status of 8% of staff is unknown.*	1.09*	0.44	0.92	+0.48	Similar
4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff A figure of 1:00 indicates parity.	Range 0.8 – 1.25, except Southwest avg. 0.79*	1.02	0.91	-0.11	Similar
5	Percentage of staff experiencing harassment, bullying or abuse from	28.3%	26.8%	27.9%	+1.1	Worsened

	patients, relatives or the public in last 12 months					
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	24.8%	25.2%	23.5%	-1.7	Improved
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	49.7%	45.6%	44.6%	-1.0	Worsened
8	Percentage of staff experiencing discrimination at work from other staff in the last 12 months	15.7%	19.5%	18.6%	-0.9	Similar
9	The representation of BME people amongst board members	16.5%*	1	1*	0	No change

Board Representation

	2023 BOARD MEMBERSHIP					OVERALL WORKFORCE	RATE OF ETHNICITY FROM STAFF SURVEY
	Voting	**Non-Voting**	**Executive**	**Non-Executive**	**Total**		
Ethnic Minority	1	0	0	1	1	30%	30%
White	14	1	8	7	15	62%	69%
Unknown	1	0	1	0	1	7%	

*This data excludes Associate Non-Executive Directors. The Trust currently has two associates, one from a BME background.

High priority areas for improvements for WDES and WRES

Metric	Description	2024-2025 Actions (reporting year)	2025-2026 Planned Actions
WDES3	Formal disciplinary process (capability)	• Evaluate data by demographic group to identify any disparities and audit via a monthly case work meeting • One-day Expectations of Line Managers workshop, covering all aspects of line management responsibilities • Training to support implementing the Just & Learning 4 step model	• Pilot Cultural Ambassadors to improve the experience of staff involved in formal and informal processes and reduce the imbalance in severity of disciplinary actions against minoritised staff. Current three staff trained in role
WDES4 WRES5	Harassment, bullying and abuse from patients, relatives and visitors	• Launch of Maybo training (reduce risk of behaviours of concern and workplace violence) for priority areas • Introduction of EDI Champions – currently 62 across the Trust • Launch of 'Addressing Unprofessional Behaviours' and 'Bystanders' training • Launch of 'Cultural Competence' training that includes ableism • Staff access Freedom to Speak Up Guardian Service • Staff receive support from disabled staff network and its chair	• Safe to speak engagement: bullying and harassment from patients and visitors • Launch of Never OK campaign in June 2025, including Go & See to wards with police staff • Increase number of EDI Champions • Slice of Life: Board engagement - values-led behaviours: engagement with staff to explore their lived experience • Regular comms to promote available support - EDI Lead to launch drop-in clinic (sessions) for staff to seek advice and guidance
WDES5 WRES7	Equal opportunities for career progression and promotion	• Train Inclusion Recruitment Champions to sit on interview panels 8B+ roles • Leadership and CPD development accessible to all staff. 7% of staff who accessed CPD training stated they had a disability, 30% were BME	• Focus on development of existing staff, due to reduction in recruitment across the NHS: • Increase number of Inclusion Recruitment Champions • Improve demographic data capture for

		• Apprenticeships accessible to all staff, 27% are BME, staff preferred not to share sexual orientation or disability status	Leadership programmes • Promote mentoring through all Staff Networks and extensively across the Trust
WDES4 WRES5 WRES8	Discrimination from other colleagues (which will have a positive impact on metric 6, harassment and bullying)	• Introduction of EDI Champions – 62 across the Trust • Launch of 'Addressing Unprofessional Behaviours' and 'Bystanders' training • Launch of 'Cultural Competence' training that includes racism • Staff access Freedom to Speak Up Guardians (x number) • Staff receive support from Race Equality staff chair and EDI Lead	• Slice of Life: Board engagement - values-led behaviours: engagement with staff to explore their lived experience • Continue with provision of training to address unprofessional behaviours • Continue to recruit, train and deploy EDI Champions who can support colleagues locally
WDES6	Felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	• Line manager training to support health and wellbeing conversations • One-day Expectations of Line Managers workshop, covering all aspects of line management including EDI, health and wellbeing and supporting attendance	• Continue with training offer including Expectation of Line Manager workshops (aiming 90% of Band 6 to 8C who are identified as a supervisor on the Electronic Record System)

These actions will be included in the EDI/HI 2025/2026 Action Plan.

EDI & HI 2025-2026 Action Plan

High Impact Action (HIA)	EDI Objective	Action	Measures of Success
1: Board	Inclusive & Compassionate Leadership	• Board set commitments for 2025-26, including engagement with staff to understand their lived experience and review of all EDI-related data to support shaping and driving actions. The Board will also undertake 'safety visits', which will incorporate discrimination, bullying and harassment and other unprofessional behaviours.	• Increased diversity of Board • Number of events attended by Board • Board appraisals reflect EDI commitments
2: Recruitment	Represented & Supported Workforce	• Improve demographic information – raise awareness of data and encourage staff to share their demographic information to improve data quality. • Increase the number of Inclusion Recruitment Champions and expand their coverage, IRCs currently sit on interviews for Band 8b and above roles, this can be expanded to roles where we need to see more progression. • Deliver programmes that support recruitment from groups that are economically or otherwise disadvantaged – Project Search, Dare 2 programmes, Carer's Charter initiatives.	• Increased representation in senior roles • Reduction in unknown demographic status by 5% • Growth in Inclusion Recruitment Champions by 20% • Maintain participation rates in Dare 2 and Project Search programmes
3: Pay Gaps	Represented & Supported Workforce	• Develop Disability Pay Gap processes and publish in 2026, alongside Gender and Ethnicity Pay Gap reporting. • Promote and deliver leadership and development to all staff. • Continued delivery of Expectation of Line Managers training which helps line managers to support and develop their teams. • Continue the existing Mentoring programme that runs until March 2026 and evaluate.	• Publication of the Trust's first Disability Pay Gap report in 2026 • Attendance and evaluation of leadership training • Expectation of Line Management targets achieved • Completion and evaluation of mentoring pilot in March 2026
4: Workforce Health Inequalities	Better life outcomes	• Improve data dashboards to support tackling workforce health inequalities to support expanded data requirements. In April 2026, the NHS will introduce new Staff Standards that will measure our performance around the provision of nutritious food/drink; reduction in violence, racism and sexism; standards of healthy work/OH support; and flexible working. • Pilot Cultural Ambassadors to improve the experience of staff involved in formal and informal processes. • Our data suggests that staff have equitable access to health and wellbeing and occupational health services, we will continue to monitor access and provide a wide range of support, including 24/7 online support to all staff.	• Improved accessible data dashboards available to key stakeholders • Recording of 3 Cultural Ambassadors utilised in formal and informal processes • Evaluation of access to OH and wellbeing services by demographic group continues to show equitable access • Publish Differently Abled Network Guide to reasonable adjustments
5: Internationally recruited staff	Represented & Supported Workforce	• SIFE Programme – support Internationally educated nurses to acquire their RCN Pin. • Access to leadership programmes for internationally educated staff.	• Staff enrolled on SIFE have successfully attained RCN Pin (target to be set once baseline established) • Internationally educated staff currently enrolled have completed Florence Nightingale programme
6: Addressing bullying, harassment, discrimination	Represented & Supported Workforce Let every voice be heard	• Increase the number of EDI Champions, these are staff who are trained to address unprofessional behaviours in their area of work, their intervention can help to support minoritised staff who are more likely to experience bullying, harassment and discrimination.	• 20% growth in number of EDI Champions • Positive evaluation of the work of EDI Champions • Re-design and launch of re-branded EDI Champion's training

		• Deliver planned EDI Champions training and the rebranding of the EDI Champions training to ensure this is accessed by any staff – thus equipping staff to address any unprofessional behaviours. • To support staff who are unable to attend face-to-face or virtual training, we will explore other learning modalities including self-paced modules (for example revising the EDI mandatory training and exploring the use of AI in EDI training). • Promote Never OK campaign and delivered associated initiatives including Safe to Speak Survey for staff to understand their experience of patient abuse, which will enable targeted initiatives and the launch of 'Addressing racist incidents' guide and training to help staff combat discrimination, there is a Trust-wide target to reduce these incidents. • Working group to form to launch the Trust's behavioural framework, a new set of behaviours, co-designed with staff, that are supportive of the Trust's values. These initiatives will contribute towards HIA4, as they are linked to improving staff health and wellbeing.	• Reduction in WDES and WRES metrics that measure discrimination and bullying and harassment from patients and colleagues
Health Inequalities		• Develop Health Inequalities training to improve staff awareness; including health inequalities training for the Trust Board and Trust Management Committee. • Continue to improve data to expand our data analysis capability and develop data dashboard for staff. • Expand membership to committee who oversee health inequalities (IHISC) to enable increased oversight of Core20Plus5 priorities.	• Lauch of Health Inequalities training; delivery of training to Board and TMC • Improved patient data dashboard • Increase in speciality representation on committee – Inclusion & Health Inequalities Subcommittee

Great Western Hospitals
NHS Foundation Trust

EDI & HI Annual Report Apr 2024 – Mar 2025

People & Culture Committee Presentation

August 2025

Together we are Great

NHS
Great Western Hospitals
NHS Foundation Trust

Public Sector Equality Duty

Meeting our Duty

General Aims:

1. Eliminate discrimination
2. Advance Equality
3. Foster Good Relationships

Specific Duties:

1. Publish Equalities Information to demonstrate compliance with the Duty – due regard to the 3 aims (above), at least annually
2. Publish Objectives, at least every 4 years

2024-2025 Workforce EDI Initiatives

NHS
Great Western Hospitals
NHS Foundation Trust

High Impact Action	EDI Objective	Initiative
1. Board commitments	**Inclusive Leadership:** • Board objectives • Use of data and understand lived experience • Prioritise EDI actions	• Engagement: 6 x Slice of Life events with workforce (Sept 24 to Dec 24) • Engagement: 1 x Change the Narrative event with public (Nov 24) • Increase support and involvement with staff networks • Review how EDI/HI is referenced in Board Papers and agree improvements
2. Recruitment and Talent Management	**Represented & Supported workforce:** • Talent management programme • Widen recruitment opportunities in local communities	• Succession Planning for Executive Team • Moderation Board established • Scope for Growth and Talent Management plans • Recruit, train and deploy additional IRCs and evaluate performance across the year
3. Eliminating Pay Gaps	**Represented & Supported workforce:** • Implement the Mend the Gap review (medical staff) • Pay gaps in place for sex, race and disability • Promote flexible working	• Review Mend the Gap report and identify actions • Include Ethnicity Pay Gap (EPG) in 24/25 report • Flexible working policy already in place
4. Address Workforce health inequalities	**Represented & Supported workforce:** • Line managers and supervisors to have regular effective wellbeing conversations with their teams. • Work in partnership, for example, to support social mobility and improve employment opportunities across healthcare • Implement a plan to address workforce health inequalities	• Wellbeing conversations already embedded in 1-2-1s. Work with system partners to provide opportunities- e,g. Project Search • Map health inequalities data across workforce demographics – improve take up of flu/covid vaccine • Review and sign off Data Quality policy and create new Data Quality Improvement Plan • Joint Network 'Count Me In' awards, funding for small projects to support patient and workforce equity • Address bullying, harassment and discrimination – see HIA5.

2024-2025 Initiatives

Great Western Hospitals NHS Foundation Trust

High Impact Action	EDI Objective	Initiative
5. Induction, onboarding and development programme of internationally recruited staff	**Represented & Supported workforce**: • Support before they join • Comprehensive onboarding programme • Cultural awareness of line managers and teams • Access to development	• Internationally educated staff supported – IENs, AHPs, medical staff • Cohort of IENs participated in Florence Nightingale Foundation (IEN) programme • Deliver SIFE programme to support existing internationally educated staff who wish to progress into obtaining their nursing registration or working towards nursing competency.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	**Represented & Supported workforce/ Voice of staff:** • Review data by protected characteristic on bullying, harassment, discrimination and violence, set targets, and implement plans • Review disciplinary and employee relations processes • Create an environment where staff feel able to speak up and raise concerns, Board should review this data • Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence • Have mechanisms to ensure staff who raise concerns are protected by their organisation	• Deliver EDI/HI related workshops: Cultural Competence, Addressing Unprofessional Behaviours, Introduction to Health Inequalities; and the introduction of AI driven immersive training • Recruit, train and deploy EDI champions who can support staff locally • Trust commissioned Clever Together to evaluate speaking up processes; undertake engagement with staff to develop a behavioural framework that aligns with Trust values • FTSU promoted, service improvements under way • HR monitor data and Just Learning Culture embedded in processes

Impact: Diversity in the Trust

Great Western Hospitals NHS Foundation Trust

The Trust employs **6056 staff** as at 31.03.2025 (increase of 94, from 5962), the gender split (sex) remains the same, 82% female and 18% male. 58% F/T and 42% P/T.

We are supported by **595 Volunteers** (up by 185, from 410) and a further 44 currently in the recruitment process. 75% are women and 25% men.

	Female	Male	BME	White	Disabled	LGB	Hetero-sexual	Religion / Belief (all)
Staff	82%	18%	30%	63%	5%	2%	70%	57%
Volunteers	75%	25%	31%	63%	6%	4%	73%	60%
Patients	54%	46%	17%	76%	N/A*	N/A*	N/A*	47%
Swindon	50%	50%	19%	81%	16%	2%	90%	60%

- More ethnically diverse, a growth of 3%, and 1% increase in disabled staff, with no increase in LGB staff.
- Unknown status improving – but still higher than other demographics 16% not stated if disabled or not; 27% not shared sexual orientation.
- Patient data is improving, but less robust than workforce data – unable to provide data for disabled and LGB patients.

Impact: Disability Equality

2024 Staff Survey Key Metrics

Successes

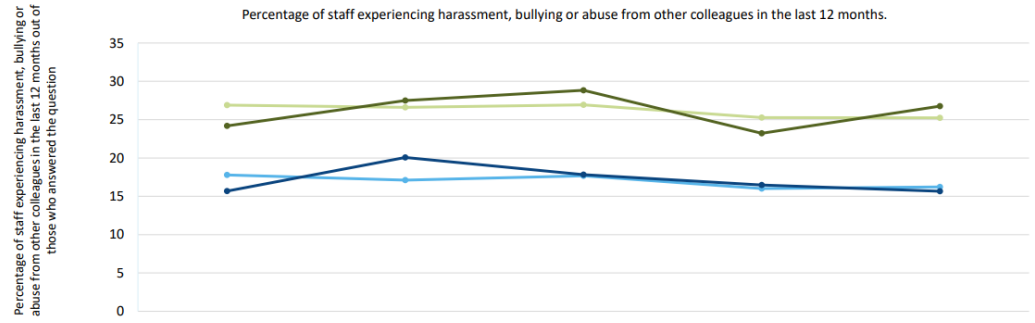
- The percentage of staff with LTC or illness who have experienced **harassment, bullying and abuse from patients has reduced by 0.81%**, this is 4.51% higher than the benchmark average, and is a **continuing downward trend for the third year in a row**. The percentage for staff without LTC or illness remains relatively the same since last year (0.8% higher than the benchmark average).

Areas for improvement

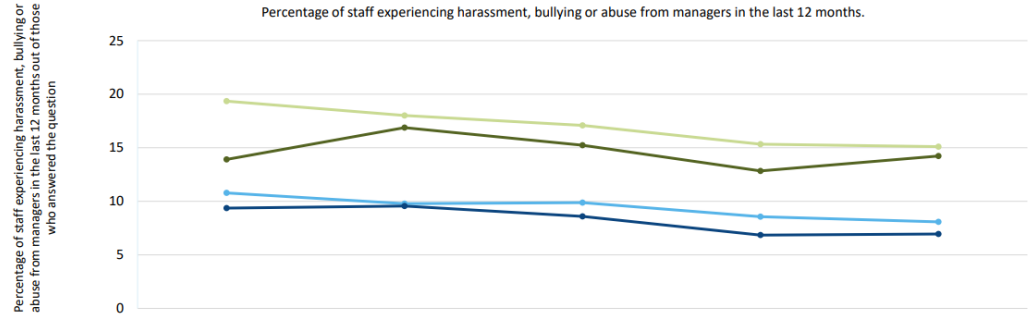
- The percentage of staff with LTC or illness experiencing **harassment, bullying and abuse from a manager has increased by 1.38%** (0.88% lower than the benchmark average), the percentage for staff without LTC or illness remains relatively the same as last year (1.13% lower than the benchmark). Civility & Respect training has been implemented, and Leadership Behaviours were introduced in October 2023, more recently Expectations of a Line Manager training was introduced in November 2024 with further training sessions planned for 2025, the impact of this will be measured over the coming months. EDI Champions include disabled staff, and the Differently Abled Network were instrumental in shaping the programme and oversight in its delivery.

- The percentage of staff with LTC or illness experiencing **harassment, bullying or abuse from colleagues in the last 12 months has increased by 3.54%,** in contrast to having reduced by 5.61% the year before. This is higher than the benchmark average by 1.52%. The percentage of staff without LTC or illness who have experienced harassment, bullying or abuse has decreased by 0.81%. This is slightly better than the national average. However, the number of staff with LTC who went on to report it has improved by 5.93% indicating staff are more likely to speak up.

- The percentage of staff with LTC or illness who believe the organisation provides **equal opportunities for career progression or promotion has reduced by 1.33%,** similar to the benchmark average. The disparity between this group and staff without LTC and illness is 4.69% (the non-LTC/illness group is 1.29% lower than the benchmark average). Inclusion and Recruitment Champions sit on interview panels for 8B and above roles and the Board engaged with disabled staff in December 2024 to understand their lived experiences. The feedback from these listening events were reviewed at a People Services Workshop to identify actions and a 'you said, we did' document will be published in new financial year.



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	24.18%	27.49%	28.83%	23.22%	26.76%
Staff without a LTC or illness: Your org	15.68%	20.07%	17.83%	16.47%	15.66%
Staff with a LTC or illness: Average	26.89%	26.60%	26.93%	25.26%	25.24%
Staff without a LTC or illness: Average	17.79%	17.11%	17.67%	16.01%	16.22%
Staff with a LTC or illness: Responses	153	553	711	857	908
Staff without a LTC or illness: Responses	491	1804	2373	2951	3193



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	13.91%	16.88%	15.23%	12.84%	14.22%
Staff without a LTC or illness: Your org	9.37%	9.56%	8.58%	6.84%	6.95%
Staff with a LTC or illness: Average	19.35%	18.00%	17.09%	15.33%	15.10%
Staff without a LTC or illness: Average	10.78%	9.77%	9.88%	8.56%	8.08%
Staff with a LTC or illness: Responses	151	557	709	857	907
Staff without a LTC or illness: Responses	491	1810	2388	2952	3193

Impact: Race Equality

Great Western Hospitals NHS Foundation Trust

2024 Staff Survey Key Metrics

Successes

- We have continued to see an improvement in BME staff experiencing **harassment, bullying or abuse from colleagues in last 12 months**, this has reduced by 1.69% since last year, this is 1.23 percentage points lower than the benchmark average. There is no significant change for White staff, however, this has worsened by a small increase of 0.47%.

Areas for improvement

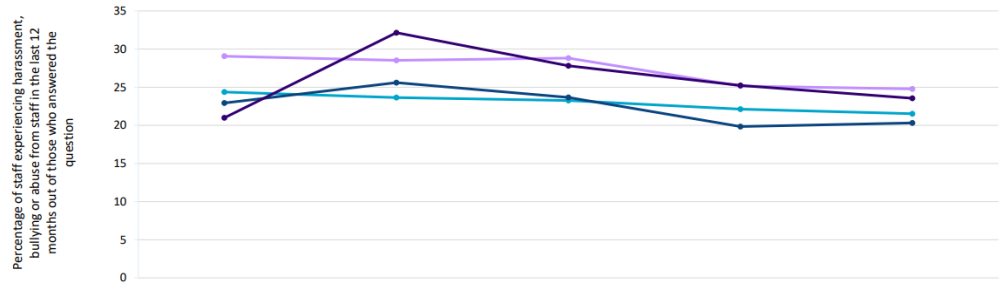
- BME staff believing that the organisation provides **equal opportunities for career progression or promotion has worsened by 0.85%**, notably 5 percentage points lower than the benchmark average, whilst the rate for White staff has stayed relatively the same as last year (0.32% improved) and is 1.42% better than the benchmark average. Inclusion and Recruitment Champions were introduced in November 2023 for band 8B and above. Leadership Skills training has also been delivered including interview skills for ethnic minority and internationally educated staff. Focus for 2025 will be to assess the impact measurement and the Board will engage with Staff Networks including Race Equality Network to review data in the Summer of 2025.

- BME staff experiencing **harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months has increased slightly by 1.18%,** this is marginally lower than the benchmark average (0.32% lower). There was no significant change for White staff, a reduction of 0.22% since 2023. EDI conference in November 2024 focused on allyship and included Bystander training, we will better understand the impact of this in 2025. A guide is currently being developed to support staff to address racism which will be launched during Black History Month.

- Although BME staff experiencing **discrimination from a manager or colleague in the last 12 months has reduced by 0.98% to 18.57%, this remains higher than the benchmark average by 2.85** percentage points. The percentage of White staff experiencing discrimination is relatively the same as 2023 (0.15 percentage points lower) and is the same as the benchmark. The disparity between BME and white staff is 11.88% (down by 0.83%), the Trust Pillar Metric target is 9.4% (the national disparity worsened from 8.3%).

- To support EDI pillar metric question 16B, Divisional Working Groups are taking local action and over 60 EDI champions are supporting local actions and addressing unprofessional behaviours. The Cultural Ambassador has recently been introduced and will be piloted in our Conduct Management Policy to support staff that feel they are being treated unfavourably. This is in the early stages and dependent on the impact, may be extended to other Trust policies.

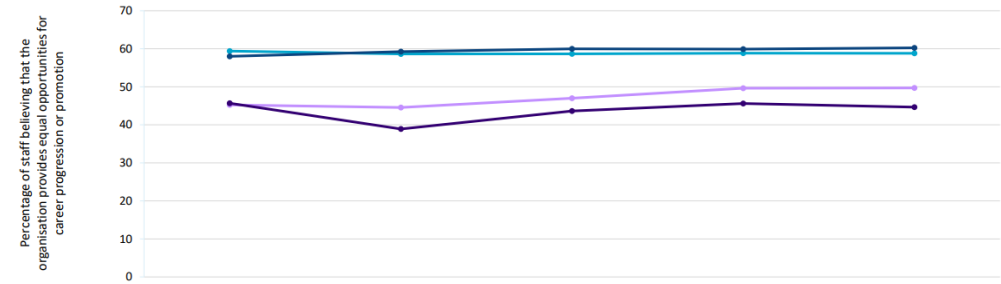
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months



	2020	2021	2022	2023	2024
White staff: Your org	22.94%	25.61%	23.67%	19.84%	20.31%
All other ethnic groups*: Your org	20.99%	32.15%	27.82%	25.24%	23.55%
White staff: Average	24.37%	23.65%	23.25%	22.12%	21.53%
All other ethnic groups*: Average	29.07%	28.53%	28.81%	25.16%	24.78%
White staff: Responses	558	2023	2455	2837	2856
All other ethnic groups*: Responses	81	367	647	1030	1295

*Staff from all other ethnic groups combined

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.



	2020	2021	2022	2023	2024
White staff: Your org	58.01%	59.25%	59.96%	59.92%	60.24%
All other ethnic groups*: Your org	45.68%	38.90%	43.63%	45.60%	44.65%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%
White staff: Responses	562	2032	2455	2824	2842
All other ethnic groups*: Responses	81	365	644	1022	1290

*Staff from all other ethnic groups combined

Impact: Equality Delivery System

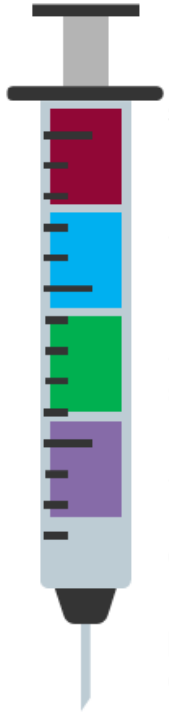
Domain 2 (workforce health and wellbeing) and Domain 3 (Inclusive Leadership)

Great Western Hospitals NHS Foundation Trust

Improved from 'Developing Activity' (a score of 7, up from 5 last year) to 'Improving Activity' (a score of 6 up from 4) for the Domains scored to date. Domain 1 to be included to determine overall EDS rating.

Successes:

- Introduction of Cultural Competence training, Addressing Unprofessional Behaviours and other bespoke training
- Introduction of EDI Champions and Inclusion Recruitment Champions
- Divisional working groups (staff survey working groups, including Q16B)
- Increased leadership presence supporting EDI
- Board commitments (EDI Improvement Plan - High Improve Actions)
- EDI and Leadership Conferences
- Improving Together implemented into EDI
- Leadership programmes – Expectation of Line Managers, Aspiring Leaders etc
- Health & Wellbeing and OH services
- EDI budget has enabled more innovation (AI) and increased engagement
- Joint network formation (inaugural project 'Count Me In' awards)



EDS Ratings

score under 8= Undeveloped

Score between 8 and 21 = Developing

Score between 22 and 32 = Achieving

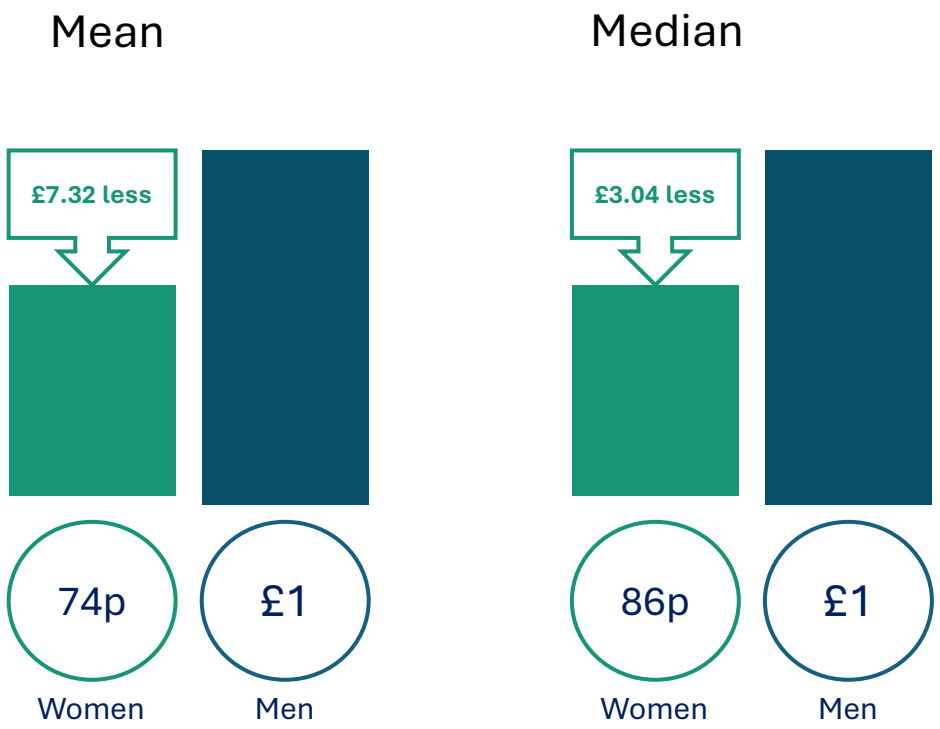
Score 33 = Excelling

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

Domain 1: Patient and Provider Services scored at system level, awaiting final outcomes to determine overall score for the Trust.

Impact: Gender Pay Gap

Great Western Hospitals NHS Foundation Trust



The Trust has a:

All staff: Mean gender pay gap in favour of male staff: £7.32 (26.03%)

Cause of the mean gender pay gap:

- Driven mostly by medical staff
- Mean Pay gap is a result of over-representation of male staff in senior roles and under-representation of males in Bands1-5 (41% of male staff), thus earning more per hour on average.
- In contrast female staff are similarly distributed in 3 quartiles (lower, lower and upper middle), but under-resented in the top quartile.
- The increase in female consultants and females in the middle grades have helped

All staff: Median gender pay gap in favour of male staff: £3.04 (13.76%)

Cause of the median gender pay gap:
Driven by medical staff – male staff are disproportionately represented in higher paid roles

The median for non-clinical staff is in favour of female staff.

- Growth in female staff in the middle bandings AfC roles (90) has helped, there was a smaller increase of male staff in this banding (43)
- Male staff are under-represented in middle banding

Impact: Gender Bonus Pay Gaps

Great Western Hospitals NHS Foundation Trust

Mean bonus pay gap for all staff is 30.76%, in favour of male staff

Cause of the mean gender bonus pay gap:
Mean gap is impacted by the size of the bonuses and is more sensitive to extreme values

- More male staff have received high value awards.

Median bonus pay gap for all staff is 62.44%, in favour of male staff

Cause of the median gender bonus pay gap:

- Female staff have received far less than the typical male staff, 66 payments went to female staff, but this represented 28% of the total available awards, compared to 19 payments to male staff, 72% of the total available awards.

In contrast, for medical staff only, the mean bonus pay gap was in favour of female staff and the median was 0% because a large percentage of female staff received mid-level awards.

Impact: Ethnicity Pay Gap

Great Western Hospitals NHS Foundation Trust

Mean

Median

The Trust is reporting this pay gap information for the first time.

All staff: Mean ethnicity pay gap in favour of White staff: £0.79 (3.6%).

- This is because White staff on average earn more per hour.
- White staff are over-represented in the Upper Quartile (76% of this group is White, compared to 23% BME) - mean is affected by extreme values.

All staff: Median ethnicity pay gap in favour of BME staff: £0.28 (1.45%)

Due to the proportion of BME staff being employed in AfC middle grades, with less representation in the Lower and Upper quartiles.

When Medical only staff are analysed, the mean and median pay gaps are in favour of White staff. There is an under-representation of BME staff in senior clinical

Impact: Ethnicity Bonus Pay Gaps

Great Western Hospitals NHS Foundation Trust

Mean Ethnicity bonus gap for all staff is 8.24%, in favour of White staff.

Cause of the mean gap:
Mean gap is impacted by the size of the bonuses and is more sensitive to extreme values

- On average more White staff received more awards than BME staff, a few White staff received high value awards pulling the mean in their favour.

Median Ethnicity bonus pay gap for all staff is 35.81%, in favour of BME staff.

Cause of the median gap:
The Median gap is the middle value; it reflects the typical bonus received and is less affected by outliers

- White staff received more payments, including a lot of low value awards, which would affect the distribution and positioning of the median (middle) value for this group, effectively lowering it.

In contrast for medical staff the median is in favour of White staff:

- More White staff received a bonus and typically bonus payments were higher for White staff – the top award to BME staff was £20K received by one staff, compared to 6 White staff receiving £20K and over, with the top award being £47K, the middle value being higher.

Highlighting Health Inequalities

NHS
Great Western Hospitals
NHS Foundation Trust

- Anchor Institution – Project Search; Pathway to the Future; and Dare 2 programmes (Doctor, AHP, Nurse, Midwife, Care)
- Engagement with local population, 19 events hosted by Patient Experience and Engagement Lead; Board engagement in October 2024
- Embedding Improving Together ethos into patient engagement
- Improved data – analysis of waiting list to detect inequalities in most challenged areas and improved demographic data (split by key indicators such as ethnicity, deprivation, age and gender)
- Key dashboards developed with specific stratification and segmentation by demographic areas to enabled targeted actions
- Sustainability – reducing our carbon footprint. Climate Change Risk Assessment undertaken and Adaptation plan with BSW Hospital Group

Priorities for 2025-26

Great Western Hospitals NHS Foundation Trust

EDI Improvement Plan – six High Impact Actions

- Q16B Addressing discrimination and addressing harassment, bullying and abuse – maintain momentum (EDI Champions, supporting networks, Divisional/Staff Survey Working Group role)
- Developing staff/Equal Opportunities – continue with EoLM, access to Leadership training across bands, access to Mentoring and Coaching, Scope for Growth, EDI training
- HWB and OH support – workforce health inequalities
- Supporting internationally educated nurses to progress, including SIFE; Florence Nightingale programme to develop leadership course which can be accessed by internationally educated AHPs
- Board commitments and leadership accountability
- Supporting staff to address harassment and abuse from patients – Never OK campaign

Health Inequalities (HI)

- Increase staff awareness of HI and implement training
- Continue to improve data
- Review membership to IHISC to enable increased oversight of Core20Plus5 priorities
- TMC and Board HI workshops to help inform 3-year HI action plan

Group working opportunities

To be explored in year.

Discussion

- Observations
- Revisions/Recommendations
- Seeking approval to publish report

Report Title	**Health, Safety, Fire and Security Annual report 2024/25**				
Meeting	**Trust Board**				
Date	**11/09/2025**	**Part 1 - Public**	✓	**Part 2 - Private**	☐
Accountable Lead	Simon Wade, Chief Financial Officer				
Report Author	Sue Morgan, Associate Director of Health, Safety, Fire & Security				
Appendices	Appendix 1- Summary of Quarter 4 (Q4) incidents Appendix 2 - Health, Safety, Fire and Security Strategy Appendix 3- All GWH incidents reported under RIDDOR 2024/25 Appendix 4 - Health, Safety, Fire and Security audits, FRA's and training Appendix 5 - Violence and aggression incidents Appendix 6 - Summary of HSE enforcement action against NHS Trusts				

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 H&S team on site audit commenced in 2024/25 providing the Trust with assurance that it is complying with key aspects of the Plan, Do, Check, Act model as defined in the HSE publication 'Managing for health and safety' (HSG65). This audit enables an in-depth check of department / ward compliance led by a member of the H&S team with recommendations given to improve compliance.

Year two of the health, safety, fire and security strategy is now operational to provide in-depth scrutiny into key risks identified across the health, safety, fire and security workstreams. A

summary of these workstreams and actions completed in 2024/25 are detailed in Appendix 2. There are however gaps, and these are recorded and managed via the GWH risk register.

Report

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

This report is to provide a summary of key health, safety, fire and security incidents that have taken place in 2024/25. Key messages:

- Year one of the three-year Health, Safety, Fire and Security strategy has now ended and updates on the workstreams are provided in appendix 2.
- There was a total of 524 staff related incidents reported in 2024/25 with 383 reported under the categories of violence and aggression
- A total of 15 RIDDORs were reported in 2024/25. These include 4 reports following patient falls with a specified injury, nine staff over 7-day absence (due to injuries), one staff specified injury (fracture) and one staff dangerous occurrence incident (blood borne virus).
- The new H&S team training sessions are proving popular with good attendance
- The new H&S team audit is making good progress with a further forty-four departments audited in Q4. A total of 79 have been completed since the audit programme started in July 2024.
- An in-depth study of lone working has now started with a report due in the next financial year
- There were four confirmed fires in 2024/25 and a total of fifty-two false alarms, of these the Fire and Rescue Service were called to attend fifteen incidents
- There have been 10 unacceptable behaviour letters issued during this reporting year and one 'Banning' letter preventing a patient from accessing a specific service in the community for a period of twelve months.

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)	ID 1300 Fire Risk Assessments ID 1301 the limited support available for staff who have been victims of violence and abuse ID 1202 Patient Moving and Handling training	8H 8H 9H
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Health & Safety Group (23Jun25) Trust Management Committee (19Jun25) Finance, Infrastructure and Digital Committee (28Jul25) Audit, Risk and Assurance Committee (planned4Sept25)	
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:

1. Approve the report, and note the good progress made during the 2024/25 year.
2. Note that the format of the final report will be subject to review by the Comms Team

Accountable Lead Signature	Rupert Turk
Date	**16/07/2025**

1. Health, Safety, Fire and Security Strategy

The Health, Safety, Fire and Security Strategy commenced this year with good progress being made on the H&S and Fire workstreams primarily. The security related workstreams will be developed in 2025/26 and details of all the 2025/26 workstreams can be found in appendix 2.

Fire Safety – there were three initial workstreams for fire safety. Progress was made on the changes to be made for the Fire Safety Policy and Protocol including the recruitment of an Authorised Engineer (Fire) and the Policy will be updated in 2025/26. The fire risk assessment programme was developed with the intention now of continuing to carry out the fire risk assessments in 2025/26. The fire safety training programme was developed with classroom-based fire safety training being brought back into the new starter induction and the development of new ward fire tabletop training.

Health and Safety – the Display Screen Equipment (DSE) workstream was fully completed with a new Trustwide referral process to support staff with DSE assessments now in place. The H&S team audit programme was developed and again this workstream was completed with a team KPI developed. Work is continuing with the workstreams to update the manual handling policy once the refresher training programmes are established and a new Training Needs Analysis is underway now that new training courses have been written and implemented.

2. Health, Safety, Fire and Security Key Performance Indicators (KPI's)

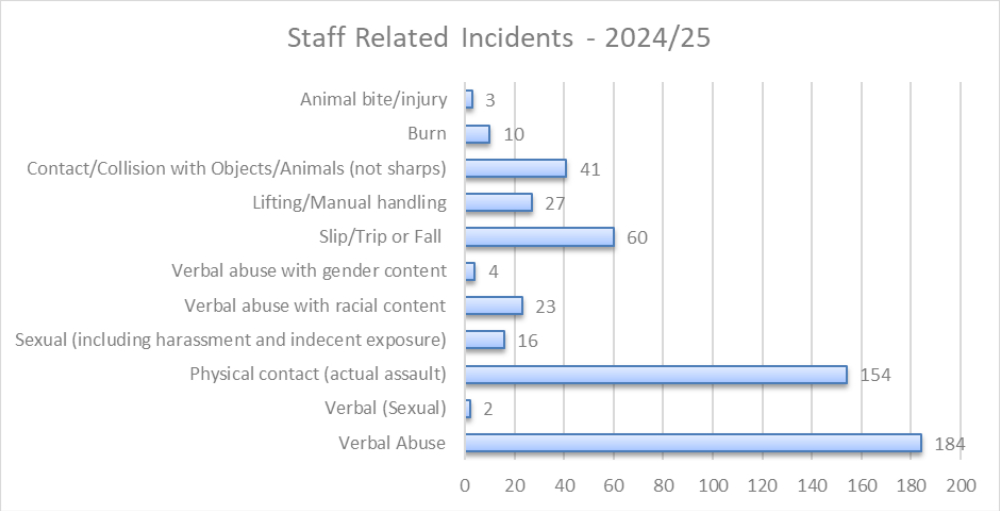
Key Performance Indicator	Target	Actual
1. Complete Health and Safety Team Audits	76	79
2. Health and Safety Short Courses	32	31
3. Completed Fire Risk Assessments (commenced Q4)	15	15

One short course was cancelled due to insufficient people booked on, the team will continue to promote courses with low numbers

3. Health and Safety

Health and Safety incidents reported 2024/25

There was a total of 524 staff related health, safety and security incidents in 2024/25. In summary, these include 3 animal bite/ injuries, 10 burns, 41 collisions, 60 falls and 27 manual handling injuries. In relation to violence and aggression there were 16 incidents reported as sexual, 154 physical assaults, 23 verbal abuse with racial content, 4 verbal abuse with gender content, 2 verbal (sexual) and 184 categorised as general verbal abuse. The breakdown is illustrated in the graph on page 4.



RIDDOR reportable incidents

In total there were fifteen incidents reported under RIDDOR. These include 4 reports following patient falls with a specified injury, nine staff over 7-day absence (due to injuries), one staff specified injury (fracture) and one staff dangerous occurrence incident (blood borne virus). The full details of all incidents reported under RIDDOR in 2024 /25 are in appendix 3.

Health and Safety Audit

The H&S Team Audit commenced in Q2 where a total of 7 audits were completed. The KPI for Q3 was 28 and this was achieved. The KPI was adjusted in Q4 to 42 to meet the expected numbers identified by the H&S Managers self-assessment audit (153 audits) and to allow for any additional audits of identified departments. However, the H&S team have worked with (and continue to work with) department managers to streamline the audit process and this has seen a number of audits combine. The KPI has been reduced to 36 per quarter from 25/26 as this number will give a more realistic programme to complete the departments each year.

2024/25 total	Red (0-70%)	Amber (71-94%)	Green (95%- 100%)
79	20	46	13

This is an excellent start for a new audit programme and support is offered to all departments to achieve a high level of compliance.

This level of audit will ensure that the Trust can evidence its requirement to undertake actions as part of the Check section of the Plan, Do, Check. Act H&S management process (HSG65). A list of all departments audited by quarter is included in appendix 4.

H&S Managers self-assessment audit

The H&S Managers self-assessment audit was issued 01 May 2024 and closed 30 June 2024. 153 audit requests were sent to departments and 133 were returned. The 20 not returned were scored as 0. In summary: 26 scored less than 70%, 56 were scored between 70% and

94% and 71 scored 95% or more. This audit is now fully archived as it has been replaced by the H&S team led audit.

Health and Safety Training

- Health and Safety short courses (one hour)

In total for 2024/25 there were 32 short courses delivered with 153 staff trained. It should be noted that the Trust had received enforcement action previously from the HSE which included the requirement to provide training for staff who write risk assessments. To date there were eight specific courses for writing risk assessments and 43 staff were trained.

- Department H&S representative course (2 day external)

A-plus are an external training provider who deliver the two-day H&S representative course. Over 2024/25 7 courses were offered and one was cancelled due to a lack of attendees. This gave 72 available seats for training (6x12) and of these 46 staff were trained.

The Health and Safety team are working with NEBOSH to establish the NEBOSH Health and Safety Award (3 day) course this year. This training will be delivered by the H&S team.

- Fire Warden Training (1/2 day external) summary for 2024/25

A-plus also currently provide the training for the Trust Fire Warden programme. In 2024/25 18 courses were offered with three cancelled due to low numbers booked. 128 fire wardens were trained.

Health and Safety Meetings

The terms of reference for the H&S Group and its two subgroups the H&S Working Group and the Security Assurance Group were reviewed in 2024/25. The two subgroups have been moved in the annual calendar to align with the H&S Group. Attendance at the H&S Group was discussed at the Trust Management Committee and the Divisions have been asked to provide representation going forward. A new reporting template for Divisions will be put forward in 2025/26.

4. Manual Handling

Risk register entry
Risk ID1202 – Inadequate Manual Handling Training
There is a risk of injury to both patients and staff due to a lack of classroom based manual handling training within the Trust.

The Patient Handling Training on the new staff induction programme commenced 5 August 2024. There was still insufficient resource with trainers and training facilities to commence the Patient Handling classroom-based training for existing GWH staff in 2024/25. This equates to approximately 2,500 staff who require this training. The clinical training lead for the Academy

has drafted a plan to bring back this training and a further train the trainer course was completed in Q4. The Academy plan to commence the classroom-based training for existing staff in July 2025. This remains a significant Trust risk.

5. Fire Safety

Risk ID 1182 – now closed

There is a risk of non-compliance with RRFSO 2005 which requires the organisation's responsible person to appoint competent persons to assist in undertaking preventive and protective measures in relation to fire safety. The HTM 05-01 provides further clarification and requires NHS organisations to have an Authoring Engineer (Fire) (AE).

GWH were part of a joint procurement process with Bath and Salisbury Trusts to recruit an AE (Fire) across BSW. Fire Safety Partnership (FSP) were successful in this process, they had met with SW as the Executive responsible for Fire Safety however there was a delay with the procurement process. The Trust signed the formal appointment letter 06 January 2025. The EFM Board confirmed agreement to close this risk and this was recorded in the H&S Group.

Risk ID 1300

There is a risk that the Trust is non-compliant with the requirements of HTM 0501 which requires the responsible person to undertake a suitable and sufficient assessment of fire risk. This is because there is insufficient resource within the fire safety team to undertake all the required Secondary Fire Risk Assessments. This could result in an increased risk of fires leading to injury or loss, enforcement action and reputational damage. Current score 4C x 2L = 8H

This was a new risk added in Q3 to focus on the completion of fire risk assessments and primarily the Secondary Fire Risk Assessments required for individual wards and departments. Work has been completed to identify these areas and create a programme for carrying out the FRAs however this will take a significant amount of time to complete these initial risk assessments. In Q4 the Trust recruited Fire Safety Partnership to undertake fire risk assessments and thirteen were completed before the end of the financial year. The completion of fire risk assessments remains a KPI for the fire safety team going into 2025/26.

Fire Safety Training

A new classroom-based fire safety training programme for the new starter induction programme commenced in Q2. The fire safety training programme for wards and clinical departments is now in place and all wards and clinical departments are now offered fire evacuation tabletop training. In Q4 there were fourteen fire tabletop training sessions held in departments with 92 staff trained. Details of this training can be found in appendix 4.

Summary of Fire incidents for 2024/25

There were four fires recorded in 2024/25:

1. Bin fire (external) the Fire and Rescue Service were not called.
2. Unattended toaster on Forest ward, SWICC, the Fire and Rescue service attended.
3. Unattended toaster SWICC staff room. The Fire and Rescue Service were not called.

4. Bin fire (external). Fire and Rescue Service were not called.

There was a total of fifty-two false alarms, of these the Fire and Rescue Service were called to attend fifteen incidents.

6. Security

Risk register
ID1301
There is a risk that the Trust will not provide sufficient support to staff who are victims of Violence and Abuse or to establish a more effective violence and abuse prevention strategy due to a lack of resource within the Health, Safety, Fire and Security Team. There is a risk of injury/ loss, enforcement action and reputational damage

This was a new risk added in Q3 to focus on the provision of Security Management Specialist Services following the departure earlier in 2024 of the contracted provider SAFE. The Trust Associate Director for Health, Safety, Fire and Security is a Security Management Specialist and can provide a level of assurance for the Trust. There is limited operational capacity to support staff or the prevention programme as described in the risk.

Physical Assaults

In total for 2024/25 there were 154 reported incidents of physical assaults on staff by patients. Work has commenced on identifying trends in incidents with the aim to offer targeted support for wards/ departments going forward. A further breakdown by ward / department can be found in appendix 5.

Lone working
A review of lone working was carried out in February to April. This included a small staff survey, review of datix incidents and interviews with managers of lone workers. A final report will be prepared by the end of Q2 2025 and a plan for staff training will be implemented.

Sanctions
The current GWH Unacceptable Behaviour Letter's (UBL) template was reviewed and a new letter template giving less specific detail was drafted and sent to our legal team for comment. This template was also sent to our Police Liaison Officer for comment and a final version of the letter will be agreed in 2025/26. A new monthly meeting has also been set up with our police liaison officer, Serco security and our Emergency department colleagues (primarily but this will be extended to other departments as required) to review the sanctions.

There have been 10 unacceptable behaviour letters issued during this reporting year and one 'Banning' letter preventing a patient from accessing a specific service in the community for a period of twelve months.

7. Enforcement Authority Action

Unwanted fire signals leading to fire and rescue services attendance

Dorset and Wiltshire Fire and Rescue Services (DWFRS) initially wrote to the Trust on the 19th of March 2024 advising a new investigation was being carried out on recent unwanted fire signals at GWH. Their initial investigation had identified that in the previous 12 months the DWFRS had crews in attendance 34 times to site, with 30 of those being due to false alarms. The fire safety team have reviewed the fire team response protocol and increased the time to confirm a fire from 5 to 10 minutes to allow time for a more thorough check of an area where there is no obvious reason for the fire detector activation. On 13 January 2025 DWFRS confirmed the Trust was no longer under investigation and advised we are 'now actively in the good books' and described this as a positive engagement story.

Health and Safety Executive

The HSE wrote to GWH 31 July 2024 to advise that a concern had been raised that risk assessments were not in place for lone workers. A response was sent 04.08.24. There has been no further correspondence.

Summary of HSE enforcement of other NHS organisations reported 2024/25

The recording of enforcement notices on the HSE public register can be delayed so for the purposes of this report the information will be for entries recorded during 24/25. The purpose of adding this information is to ensure learning from other NHS organisational H&S failings.

There was one prosecution for failures relating to patient falls. A prohibition notice was served to stop the use of a containment level 3 laboratory. These are detailed in Appendix 6.
Thirteen Improvement Notices were served:

- 3 x failures in relation to CL3 facilities
- 4 x Failures in relation to violence and aggression risks
- 1 x failure in relation to manual handling
- 1 x failure in relation to ionising radiation
- 2 x failure in relation to ligature risks
- 2 x failures in relation to sharps

8. Conclusions / Recommendations

As the report illustrates there has been and continues to be a significant amount of work carried out to progress the Health and Safety agenda at the Trust and increase the profile of the H&S team activity. To continue the improvements full engagement is needed at the relevant Trust groups at all levels to ensure the messages are disseminated effectively across all Divisions.

The Group is asked to approve the content of the report, and the good progress made during the 2024/25 year.

Appendix 1 Summary of Quarter 4

The Health and Safety team introduced a new quarterly update report in 2024/25 and this is a summary of Q4 specific information.

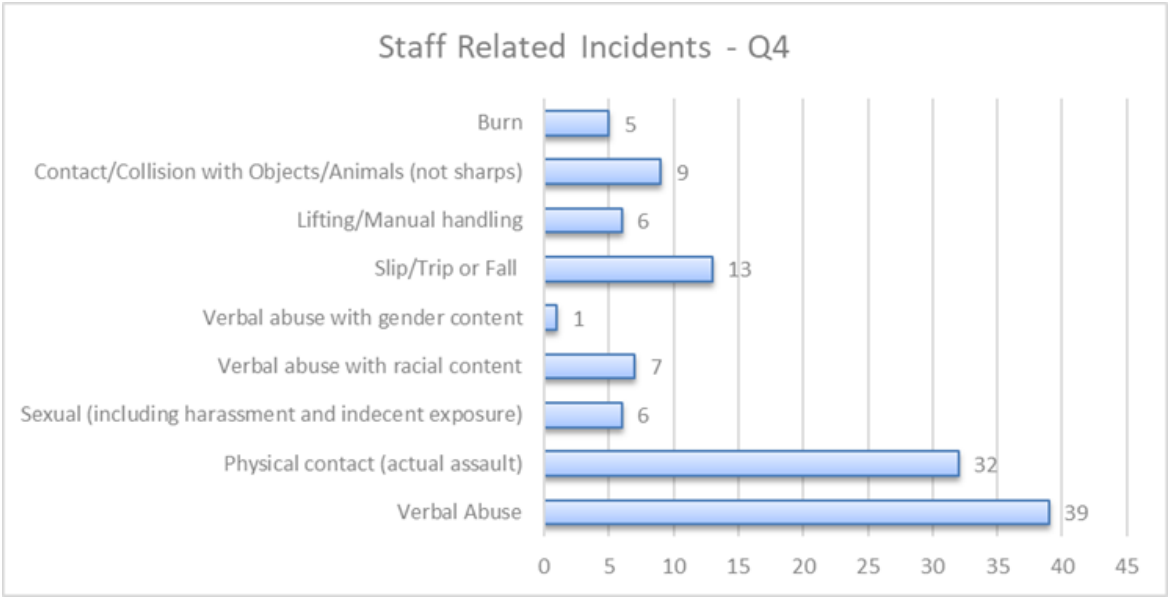
Health and Safety Team Key Performance Indicators for Q4

Key Performance Indicator	Target	Actual
1. Complete Health and Safety Team Audits	42	44
2. Health and Safety Short Courses	12	11
3. Completed Fire Risk Assessments	15	15

1. Completed
2. One short course was cancelled due to insufficient people booked on, the team will continue to promote courses with low numbers and going forward we will add an additional course per quarter to allow for any short notice cancellations
3. This was an initial KPI and may not be achievable by the current team, the bulk of these were completed by an external company. This will be reviewed for the new financial year KPI. The limitations for the fire team to complete fire risk assessments is recorded on the risk register (ID1300)

Health and Safety Incidents in Q4

There was a total of 118 staff related health, safety and security incidents in Q4 in comparison to 141 in Q3, 105 in Q2 and 160 in Q1. In summary, these include 5 burns, 9 collisions, 13 falls and 6 manual handling injuries. In relation to violence and aggression there were 6 incidents reported as sexual abuse, 32 physical assaults, 7 verbal abuse with racial content, 1 verbal abuse with gender content and 39 categorised as general verbal abuse. The breakdown is illustrated in the graph below.



Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents in Q4

There were two incidents reported under RIDDOR in Q4. This included one staff incident where the staff member had saline solution contaminated with blood containing a BBV (high viral load) splashed into their eyes (reported as a dangerous occurrence). The second report was following a patient fall with fracture.

H&S team audit – Q4 totals

Q4 total	Red (0-70%)	Amber (71-94%)	Green (95%- 100%)
44	10	25	9

Health and Safety short courses

The H&S team introduced 4 new short courses in 2024/25. These courses cover specialist subjects including the Control of Substances Hazardous to Health (COSHH), How to write a Risk Assessment, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and a general H&S Managers Awareness course. In Q4 the team delivered eleven of these courses with a total of fifty-five staff trained. (Further detail is included in appendix 4)

Physical Assaults

In Q4 (2024/25) there were a total of 32 reported incidents of physical assaults on staff by patients. In comparison in Q3 there were 35, Q2 there were also 35 and Q1 where there were 49. Work has commenced on identifying trends in incidents with the aim to offer targeted support for wards/ departments going forward. A further breakdown by ward / department can be found in appendix 5.

HSE enforcement of other NHS organisations in Q4.

- Forth Valley Health Board 12.12.24

12.12.24 An Improvement Notice was served against Forth Valley Health Board for failing to put in place arrangements to reduce the risks posed to patients by ligature points particularly windows and doors that had been assessed by the Health Board as very high risk.

- Betsi Cadwaladr University Health Board 01.04.25

The Health Board was fined £250,000 following failures relating to patient falls in its hospitals. Three elderly patients sustained falls in 2022 and 2023 and they all sadly died. The cause of death of two of them was identified as being as a direct result of falling. Betsi Cadwaladr University Health Board pleaded guilty to breaching Section 3 (1) of the Health and Safety at work Act 1974 and were fined £250,000 and ordered to pay costs of £11,766.

Appendix 2- Health, Safety, Fire and Security Strategy 2024/25 update

Fire Safety

Fire safety management provision of an appropriate policy and supporting documents

Initial actions are to ensure the recruitment of an AE (Fire) and to engage a fire safety consultant to support with the Primary FRA as a new requirement for NHS organisations. M10 were commissioned to provide the Primary FRA however this was not received so the Trust will need to review this again in 2025/26. The Secondary FRA programme has commenced with Fire Safety Partnership completing thirteen FRA's. GWH joined Bath and Salisbury in the successful recruitment process for an AE(Fire). A review of fire safety management has been carried out and a report provided to the Executive Director responsible for fire safety. The Fire Safety Policy and Protocol will now be reviewed in 2025/26.

Provide an inclusive fire safety training programme

A new classroom-based fire safety training programme for the new starter induction programme commenced in Q2. The fire safety training programme for wards and clinical departments was developed and all wards and clinical departments are now offered fire evacuation 'tabletop' training. A Fire Safety Training Needs Analysis (TNA) is under development as part of an Improving Together project. This will form part of the wider H&S TNA due for completion in 2025/26.

Deliver a comprehensive programme for the completion of Fire Safety Risk Assessments (FRAs)

The Trust fire risk assessment programme has been drafted however the Trust remains at risk of non-compliance as there are limited FRA's completed by a trained fire risk assessor, the current programme is for managers to complete a FRA template for their department. There is insufficient resource within the current GWH fire team to move this programme forward at pace and therefore a risk entry has been added to reflect the resource limitations as well as the new qualification requirement. Funding for an external fire risk assessor was identified in Q4 and 13 fire risk assessments were completed.

Health and Safety

Develop a comprehensive programme for H&S training

The H&S team have written / updated 4 new short courses. This short course programme is now established and measured as a team key performance indicator. The team are working with NEBOSH to deliver the NEBOSH Health and Safety at Work Award course in 2025/26 and also to deliver training for the safety of lone workers.

Provide a robust and appropriate Manual Handling policy

The team sourced Patient Handling Train the Trainer training and this took place in July 2024 training nine staff. Classroom based training is now taking place for new staff attending the induction day sessions. There remains the risk that this is not yet available for existing staff

and the Academy arranged for a further Train the Trainer course in Q4. There is a schedule to commence training for existing staff in July.

Review the Display Screen Equipment referral process to ensure it is fit for purpose and supports the staff agile working programme

Extensive requests were being made for the H&S team to support with DSE assessments. Many of these could be supported with simple training which is available on ESR. A new referral process was agreed and a newsletter detailing this was circulated in Q2 and is sent out as initial advice in response to all DSE requests. This workstream is now closed.

Develop and implement a new comprehensive health, safety fire and security audit to be completed with managers on site

The new H&S Team Audit commenced with a trial period in August and September to enable training for the H&S advisors and to ensure a robust booking and management system was in place. This programme is working well and monitored through the team KPI's. This workstream has now closed.

The three security workstreams have been carried over into 2025/26 strategy.

New workstreams for 2025/26:

Health Safety, Fire and Security
1. Provide a comprehensive training needs analysis to ensure that Health Safety, Fire and Security training is appropriate across the Trust
Security
2. Develop the GWH Violence Prevention and Reduction Standard
3. Create a streamlined process for the operational management of the GWH door access system
Fire
4. Update the fire safety policy and protocol
5. Deliver a comprehensive programme for the completion of Fire Safety Risk Assessments
Health and Safety
6. Provide a robust and appropriate Manual Handling policy and associated guidance documents
7. Review the staff hybrid working programme in relation to Display Screen Equipment use and the use of handheld devices
8. To identify and ensure a robust system is in place for the identification and control of the risks relating to the use of vibrating / percussive equipment
9. To identify all areas using Local Exhaust Ventilation and to provide assurance that adequate testing and maintenance is being undertaken by the department

Appendix 3 – RIDDOR reportable incidents by quarter in 2024/25

RIDDOR reportable incidents

Quarter 1 April – June 2024

There were five incidents reported under RIDDOR in Q1. This included two patient falls with specified injury (fractures) and three staff over 7-day injuries

ID24949 (Trauma Unit) Patient fell when trying to stand up from the toilet, the seat on the commode was not attached correctly

ID24961 (Trauma Unit) Over 7-day injury following an assault from a patient when the staff member was providing close support care. The staff member sustained an injury to their upper limb.

ID26340 (Linnet Ward) Over 7-day injury (manual handling) following a supported patient fall. The staff member sustained injury to their neck, shoulder and back

ID27220 (Shalbourne Ward) Over 7-day injury after the staff member slipped and fell on water on the floor from a leaking pipe from the ice machine on the ward. The staff member sustained an injury to their back.

ID28460 (Neptune Ward) the Patient was found on the floor following an unwitnessed, the falls risk assessment had not been completed in line with Trust policy.

Quarter 2 July – September 2024

There were five incidents reported under RIDDOR in Q2. This included five staff over 7 day injuries

ID27775 (Woodpecker Ward) Over 7-day injury sustained after a member of staff was punched to the side of their chest. The staff member sustained bruising and possibly a fracture however an x-ray was not considered beneficial

ID 29475 (Theatres) Over 7-day injury sustained after a member of staff was checking theatre instrument trays and two of the trays fell on their hand in the Treatment Centre Pack Room in Theatres. The staff member sustained a fracture to their finger

ID29623 (White Horse Birthing Centre) Over 7-day injury sustained when the staff member was supporting a patient in an emergency procedure in the White Horse Birthing Centre. The staff member sustained a muscular injury to their back.

ID30727 (Delivery suite) Over 7-day injury following a delivery bed running over the staff members foot in the Delivery Suite, Delivery room 9 corridor. The staff member sustained bruising to their foot.

ID31123 (Kingfisher Ward – SAU) Over 7-day injury following an assault from a patient when the staff member was assisting the patient with personal care. The staff member was hit on the noise and was diagnosed with concussion by their GP.

Quarter 3 October – December 2024

There were three incidents reported under RIDDOR in Q3. This included one patient fall with specified injury (fracture), one staff member with a specified injury (fracture) and one over 7 day injury.

ID32549 (Ampney Ward) The patient had an unwitnessed fall that led to a fracture of the lower limb. The falls prevention checks/ paperwork had not been completed until after the fall which was their second fall.

ID33038 (Children's Unit) The staff member went to open the left-hand door at the entrance to the unit (the right was already open), this was to allow a bed through. As they did this the right door closed very quickly catching the staff members wrist in the process leading to a fracture.

ID36382 (Theatre 5) The staff member was walking from theatre 5 to the lay-up room, they used the flat of their hand to open the door but as they entered their hand twisted and the door closed quickly trapping the staff members finger between the door and the frame causing a fracture. This has been reported as the staff member was off work/ unable to perform normal duties for more than seven days.

Quarter 4 January – March 2025

There were two incidents reported under RIDDOR in Q4. This include one patient fall with specified injury (fracture) and one staff related dangerous occurrence:

ID38394 (Mercury Ward) The patient had a second unwitnessed inpatient fall. Following the first fall the patients fall assessment was updated to include line of sight supervision, this was not provided. The bedrail assessment also documented that raised bed rails were not recommended for this patient but these were raised at the time of the fall.

ID38724 (ND) the staff member was splashed with the contents of a syringe containing saline solution and patient's blood, the patient is known to have a blood borne virus with a high viral load.

Appendix 4 – Health and safety audits and training

Health and Safety Audits completed in 2024/25

Date	Quarter	Department	Division
26/07/24	2	Microbiology	Medicine
21/08/24	2	Car Parking Management	Corporate
09/09/24	2	Discharge Lounge	Medicine
11/09/24	2	Elective Emissions	SW&C
17/09/24	2	General Surgery and Urology Administration	SW&C
19/09/24	2	Integrated Discharge Team/ Patient	Corporate
26/09/24	2	Marketing and Communications	Corporate
01/10/24	3	Hazel Ward & Delivery, Birthing Centre & Digital Maternity Team	SW&C
07/10/24	3	Heart Function and Arrhythmia Specialist Nursing Team	Medicine
11/10/24	3	Orthopaedic OPD Fracture Clinic	SW&C
15/10/24	3	Critical Care Outreach	SW&C
17/10/24	3	Therapies Acute Physio	ICC
22/10/24	3	Health Records	Corporate
24/10/24	3	Rheumatology Specialist Nursing	Medicine
31/10/24	3	Perinatal QSA team	SW&C
01/11/24	3	Trust HQ	Corporate
04/11/24	3	Acute Stroke unit	Medicine
05/11/24	3	Dome medical staff (DOPS) Including Dome & Neuro Admin	Medicine
07/11/24	3	Anticoagulant Service	ICC
11/11/24	3	Cancer Services	ICC
11/11/24	3	Acute Wards Therapy OT	ICC
13/11/24	3	Adult Oncology	ICC
13/11/24	3	Audiology	SW&C
15/11/24	3	Cardiac Cath Lab	Medicine
18/11/24	3	Aldbourne Phase 3	SW&C
19/11/24	3	Breast Centre	Medicine
19/11/24	3	Tissue Viability Nurses	Corporate
20/11/24	3	Biomed Electronics	ICC
20/11/24	3	Academy	Corporate
27/11/24	3	Ampney Ward - Urology	SW&C
27/11/24	3	Acute Cardiac Unit	Medicine
29/11/24	3	Blood Sciences, Haematology, Specimen Reception, Chemical Pathology, Pathology Administration	Medicine
03/12/24	3	Community Diabetes Service	ICC
09/12/24	3	Beech & EPU Phase 3	SW&C
11/12/24	3	Dermatology medical Staff	Medicine
06/01/25	4	End of Life Nursing	ICC
06/01/25	4	Cardiac Rehabilitation	Medicine

08/01/25	4	Cardiology Medical staff, Respiratory Admin, Respiratory Medical staff	Medicine
09/01/25	4	Insight & Learning (prev Clinical Risk & Quality)	Corporate
10/01/25	4	Theatres	SW&C
13/01/25	4	Children's Unit & PAU	SW&C
14/01/25	4	Gastro Admin	Medicine
15/01/25	4	Children's Outreach Nursing services, Community Healthcare for Children	SW&C
16/01/25	4	Community Nursing Team, Night Nursing and Community Phlebotomy Team	ICC
17/01/25	4	Serco	Serco
20/01/25	4	Clinical Coding	Corporate
23/01/25	4	Infection Control	Corporate
06/02/25	4	Orthopaedic Medical Staff	SW&C
06/02/25	4	Rheumatology Services	Medicine
07/02/25	4	RTT - Referral to Treatment Team	Corporate
10/02/25	4	Medical Speciality Services	Medicine
11/02/25	4	Rapid Response Nursing	ICC
11/02/25	4	Pharmacy	Medicine
12/02/25	4	Diabetes & Endocrine Medical Staff	Medicine
13/02/25	4	Clinical Audit	Corporate
20/02/25	4	Daisy Ward / Day Surgery Unit	SW&C
24/02/25	4	Eye Services - Optical	SW&C
25/02/25	4	Meldon Ward	SW&C
26/02/25	4	Orthopaedic Administration	SW&C
27/02/25	4	Sterile Services	SW&C
27/02/25	4	Occupational Health and Wellbeing	Corporate
28/02/25	4	Cellular Pathology	Medicine
04/03/25	4	Diabetes Nursing	ICC
05/03/25	4	Dietetics (AKA Dietetics & Nutrition)	ICC
06/03/25	4	IT Technical Services	Corporate
11/03/25	4	Cardiology OPD Nursing	Medicine
11/03/25	4	Imaging (Radiologists / Radiography Administration / Radiography / MRI / Ultrasound)	Medicine
11/03/25	4	Outpatients Appointments Booking	ICC
13/03/25	4	R&D	Corporate
14/03/25	4	Laundry/Linen	Corporate
24/03/25	4	Estates & Facilities	Corporate
25/03/25	4	Surgical Assessment Unit (SAU)	SW&C
25/03/25	4	Jupiter Ward	Medicine
25/03/25	4	Neptune Ward	Medicine
26/03/25	4	Finance	Corporate
26/03/25	4	PALS	Corporate
27/03/25	4	People Operations	Corporate

27/03/25	4	Trust Equipment	ICC
31/03/25	4	Mercury Ward	Medicine

Health and Safety short courses delivered 2024/25

Quarter	Course	Attendance
1	Health & Safety for Managers	2
2	RIDDOR	7
2	Health & Safety for Managers	2
2	Risk Assessment	5
2	COSHH	2
2	RIDDOR	7
2	Health & Safety for Managers	6
2	Risk Assessment	8
2	COSHH	8
3	Health & Safety for Managers	3
3	Risk Assessment	4
3	COSHH	5
3	RIDDOR	8
3	Health & Safety for Managers	3
3	Health & Safety for Managers	1
3	Risk Assessment	6
3	COSHH	4
3	RIDDOR	9
3	Health & Safety for Managers	1
3	Risk Assessment	2
3	COSHH	5
4	RIDDOR	9
4	Health & Safety for Managers	3
4	Risk Assessment	4
4	COSHH	4
4	RIDDOR	8
4	Health & Safety for Managers	2
4	Risk Assessment	7
4	COSHH	4
4	RIDDOR	3
4	Health & Safety for Managers	4
4	Risk Assessment	7

Fire safety tabletop training sessions delivered in 2024/25

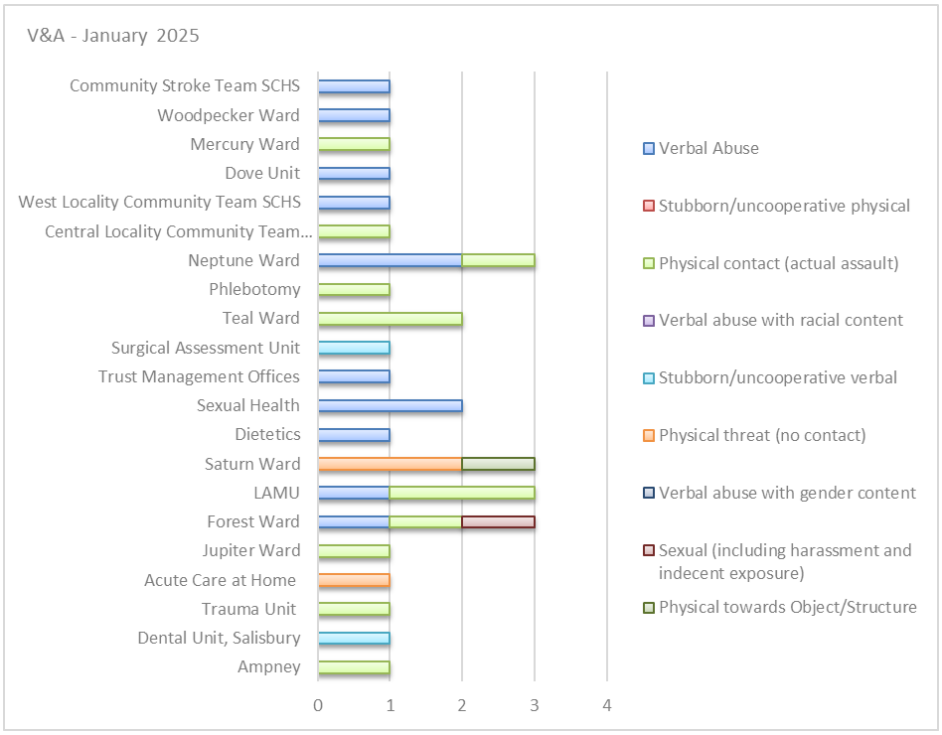
Date	Quarter	Department	Attendance
11/04/24	1	Theatres 1-10	43
20/05/24	1	Aldbourne Ward	18
12/06/24	1	Orchard Ward SWICC	16
13/06/24	1	Forest Ward SWICC	19
17/07/24	2	Wren Ward	12
05/08/24	2	Microbiology (x2)	15
06/08/24	2	Renal Ward	12
29/08/24	2	Saturn Ward	26
04/09/24	2	Orbital	6
09/09/24	2	Teal Ward	6
12/09/24	2	Breast Centre (x2)	19
12/09/24	2	Pre-op assessment	14
18/09/24	2	UTC	8
25/09/24	2	Linnet Ward	15
25/09/24	2	West Swindon Health Centre	4
31/10/24	3	Radiology	2
11/11/24	3	W.Swindon H.Centre (Cardiology)	3
31/10/24	3	Radiology	4
14/11/24	3	Endoscopy	23
19/11/24	3	Library	3
07/11/24	3	Liden Site managers	17
26/11/24	3	The Academy	35
03/12/24	3	Radiology x2 sessions	32
11/12/24	3	Radiology x2 sessions	20
17/12/24	3	W.swindon Dental Team	19
20/01/25	4	CCU	5
21/01/25	4	Radiology	6
04/02/25	4	UTC	7
04/02/25	4	Pharmacy	9
12/02/25	4	Birthing centre/white horse	
18/02/25	4	Discharge Lounge	4
24/02/25	4	Kingfisher	8
25/02/25	4	Dove / Falcon	7
25/02/25	4	womens out patients	5
20/02/25	4	Discharge Lounge	4
03/03/25	4	Woodpecker	8
12/03/25	4	BTC Theatres	16
25/03/25	4	MAU	7
12.03.25	4	Neptune	6

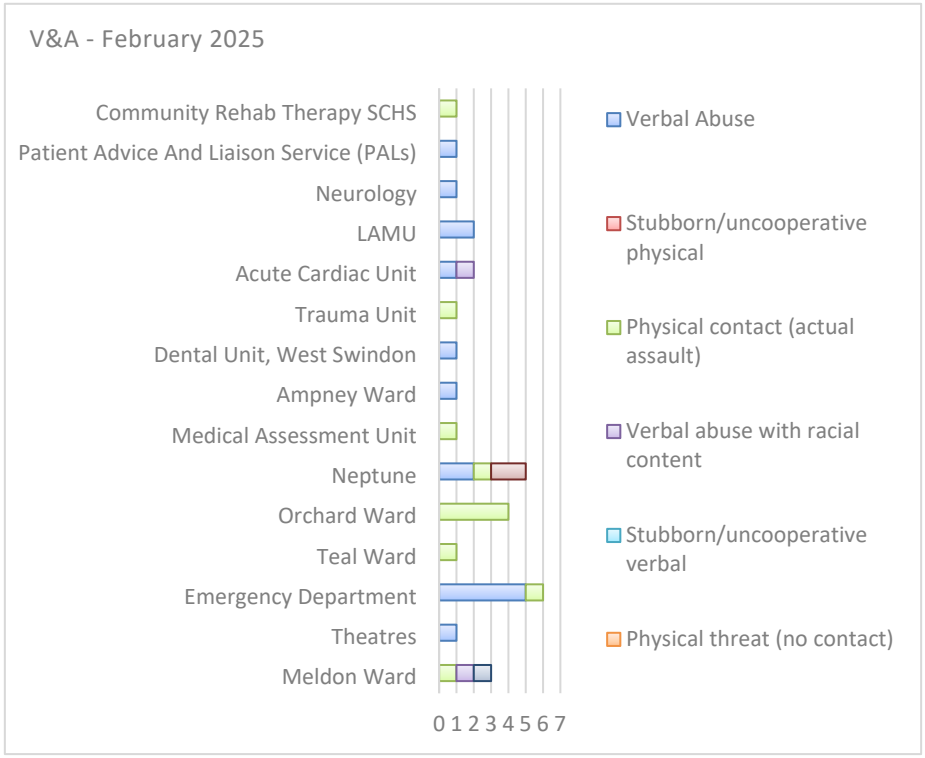
Fire risk assessments completed in Q4

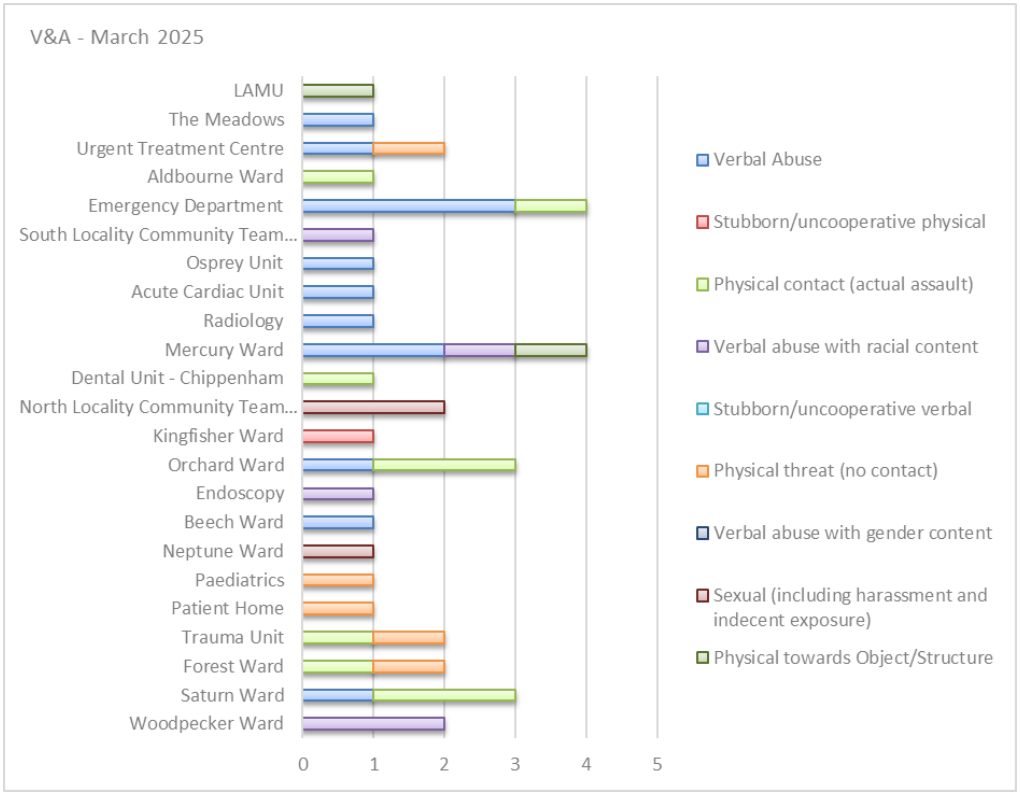
21/01/25	4	Linnet
27/01/25	4	Kingfisher
03/02/25	4	Dove
03/02/25	4	Falcon
04/02/25	4	Teal & TOPSSU
17/02/25	4	Woodpecker
17/02/25	4	Wren
24/02/25	4	ENT and Audiology
24/02/25	4	Osprey
01/11/24	3	SWICC
03/03/25	4	2nd Floor GWH-Streets
04/03/25	4	GWH Theatres 1-10
04/03/25	4	BTC Theatres 11 -15
18/03/25	4	Pharmacy
31/03/25	4	Imaging

Appendix 5 - Violence and Aggression Incidents by ward/ department

Quarter 4 incidents







Violence and Abuse ranked highest 3 areas per month based on the number of incidents reported

	TOP 3		
	1	2	3
Jan-25	Neptune Ward	LAMU	Saturn Ward Forest Ward
Feb-25	Emergency Department	Neptune Ward	Orchard Ward
Mar-25	Emergency Department	Mercury Ward	Saturn Ward Orchard Ward

Appendix 6 Summary of HSE enforcement action reported on the HSE website in 2024/25

Prosecution

Betsi Cadwaladr University Health Board 01.04.25

The Health Board was fined £250,000 following failures relating to patient falls in its hospitals. Three elderly patients sustained falls in 2022 and 2023 and they all sadly died. The cause of death of two of them was identified as being as a direct result of falling. Betsi Cadwaladr University Health Board pleaded guilty to breaching Section 3 (1) of the Health and Safety at work Act 1974 and were fined £250,000 and ordered to pay costs of £11,766.

Prohibition Notice(s)

University hospitals Sussex NHS Foundation Trust 13.03.24

Immediate prohibition notice to stop use of the containment level 3 laboratory as it is not sealable to permit disinfection by gaseous Formaldehyde.

Improvement Notice(s)

Royal Cornwall Hospitals NHS Trust 25.01.24

Improvement Notice received for failing to minimise the risk of exposure to employees of hazard group 3 biological agents in a CL3 Facility

Cumbria, Northumberland, Tyne and Wear NHS Foundaton Trust 09.02.24

Improvement notice received for failing to make and give effect to such arrangements as are appropriate, having regard to the nature of your activities and the size of your undertaking, for the effective planning, organisation, control, monitoring and review of the preventative and protective measures for violence and aggression risks, that will so far as is reasonably practicable, ensure the health, safety and welfare at work of your employees and persons not in your employment.

Milton Keynes University Hospital 13.02.24 (two improvement notices)

Improvement notice received as the Trust have not ensured that the number of appointed manual handling competent persons have the time available for them to fulfil their functions and the means at their disposal are not adequate having regard to the size of your undertaking, the risks to which your employees are exposed and the distribution of those risks throughout your undertaking.

A second improvement notice was received for failing to ensure that the number of appointed competent persons for violence and aggression risk have the time available for them to fulfil their functions and the means at their disposal are not adequate having regard to the size of your undertaking, the risks to which your employees are exposed and the distribution of those risks throughout your undertaking

Greater Glasgow and Clyde NHS Trust 21.02.24

Improvement notice received for failing to designate as classified persons all employees who are likely to receive an effective dose greater than 6 mSv per year, or an equivalent dose greater than 15 mSv per year to the lens of the eye, or greater than 150 mSv per year for the skin or extremities

University hospitals Sussex NHS Foundation Trust 20.03.24

Improvement notice received for failure to put in place arrangements that are suitable to ensure the ongoing sealability status of the containment level (CL) 3 laboratory. A prohibition notice was issued for the containment level 3 laboratory as it was not sealable to permit disinfection by gaseous Formaldehyde.

Pennine Care NHS Foundation Trust 01.05.24

Improvement notice received for failing to give effect to appropriate arrangements for the prevention of violence and aggression risks on a ward.

Devon Partnership NHS Trust 31.07.24

An Improvement Notice served for failing to make a suitable and sufficient assessment of the risk of violence to staff and others exposed on a specific ward and a failure to identify measures to control the risks.

NHS Highland 15.08.24

An Improvement Notice served for failing to reduce as far as reasonably practicable the risk posed to patients, specifically those who report suicidal ideations, from ligature anchor points.

Dartford and Gravesham NHS Trust 25.10.24

An Improvement Notice served for having inadequate arrangements to minimise the risk of exposure to hazardous biological agents in the CL3 laboratory as they had failed to provide a system that is suitable and effective to ensure an appropriate level of senior management oversight of the work and the application of relevant biosafety standards.

Worcestershire Acute Hospitals NHS Trust 28.10.24

Two Improvement Notices served for failing to put in effective preventative and protective measure for staff at risk of serious injury from blood borne viruses when using medical sharps. The second improvement notice was for line managers failing to carry out a suitable investigation encompassing the circumstances of an injury caused by a medical sharps device.

Forth Valley Health Board 12.12.24

12.12.24 An Improvement Notice was served against Forth Valley Health Board for failing to put in place arrangements to reduce the risks posed to patients by ligature points particularly windows and doors that had been assessed by the Health Board as very high risk

Report Title	**Responsible Officer Annual Report**				
Meeting	**Board of Directors**				
Date	**11/09/2025**	**Part 1 - Public**	✓	**Part 2 - Private**	☐
Accountable Lead	Dr Stephen Haig – Acting Chief Medical Officer				
Report Author	Amy Smith, Medical Revalidation & Job Planning Specialist & Dr Stephen Haig, Acting Chief Medical Officer				
Appendices	Appendix 1: Annex A – Professional Standards framework for quality assurance and improvement 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:

Report

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

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

Revalidation, Appraisal and Job Planning are both now implemented utilising SARD and operating as business as usual with a full cycle of job planning covering 2024/25 complete with 2025/26 well underway. Processes are more robust and improved with strengthened oversight for the organisation and support for doctors with a small, dedicated team and intuitive system in place. This is evidenced by consistent appraisal compliance and much-improved compliance of job plans.

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	Appraisals and revalidations are reviewed monthly at the Medical Staff Support Group (Professional Standards).	
Next Steps		

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

Accountable Lead Signature	
Date	**13/08/2025**

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of

can confirm that:

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

Action from last year:	To ensure the acting Deputy Chief Medical Officer completes appropriate CPD training for the role.
Comments:	Acting Chief Medical Officer (Dr Steve Haig) has already completed Responsible Officer Training and now supports appraisal and revalidation procedures. The Interim Deputy Chief Medical Officer has undertaken and attended the relevant courses for the role.
Action for next year:	The Trust has appointed a new Chief Medical Officer to start in October 2025. To ensure the new Chief Medical Officer completes appropriate CPD training for the role.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Continue to embed and deliver a high-level service with a focus on quality outcomes.
Comments:	Revalidation, Appraisal, and Job Planning are both now implemented and operating as business as usual with the Revalidation and Job Planning Specialist and CMO office continually developing the much strengthened and robust revalidation, appraisal and job planning processes. This is evidenced by consistent appraisal compliance and much-improved compliance of job plans.
Action for next year:	Continue to embed and deliver a high-level service with improving on quality outcomes.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

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

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

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

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

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Continue with attendance and support with facilitating future meetings.
Comments:	A BSW ICA quarterly meeting has been taking place, whereby leads across Revalidation and Appraisal share learning, information, ideas and any challenges. Attendance at the newly formed National Revalidation and Appraisal Managers Network was set up in 2023 whereby managers and specialists can come together as a forum to share approaches, processes, ideas, information and learning within medical revalidation and appraisal. These are currently held by a neighbouring trust online with a view to rotate the chair of the network meetings.
Action for next year:	Continue with attendance and collaboration at future meetings .

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Continue to support locum and short-term placement doctors while they are working at GWH.
Comments:	There has always been an induction for all locum staff when they start with the Trust. The Medical Revalidation & Job Planning Specialist works closely with Recruitment and Temporary Staffing Teams at the trust to ensure locum doctors are supported and follow the trust appraisal process where necessary, or Transfer of Information Forms are completed if required by the trust or by other organisations that the doctor works at.
Action for next year	Continue to support locum and short-term placement doctors while they are working at GWH.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Continue to monitor and quality assure the information that is included on 'other practice forms and quality of appraisals on newly launched template to ensure that there is robust information.
Comments:	The SARD appraisal module at the trust is reflective of the medical appraisal template (2022) including the revised and rebalanced approach to medical appraisal developed in line with the Good Medical Practice Guide 2024. This now includes the continued focus on doctors' professional development and wellbeing as well as including an area to reflect if you are an educational supervisor or clinical supervisor or both. The Good Medical Practice (GMC) domains are included with the post appraisal forms. Doctors that work in other organisations are required to complete an 'Other Practice Form'. This allows for evidence of any complaints or incidents to be shared with GWH. Monthly quality assurance checks take place with SARD with support from CMO office. Please see Appendix A reflecting consistent compliance.
Action for next year:	Continue to monitor and quality assure the information that is included on 'other practice forms and quality of appraisals on newly launched template to ensure that there is robust information.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

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

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

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

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

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	To continue to embed and maintain the trust appraiser allocation process and development of in-house refresher training.
Comments:	The trust currently has an appropriate number of trained appraiser's vs appraisees as per trust policy. The trust appraiser allocation process has been embedded since January 2023 to support with the completion of timely appraisals which is evident through consistent appraisal compliance. The trust held New Appraiser Training in March 2025 whereby 15 new medics undertook training along with continued In House Refresher Appraiser Training Education Event took place with the last session in May 2025. These are well attended with a range of topics and speakers attending and future dates being arranged. These take place about 2 yearly.
Action for next year:	To continue to embed and maintain the trust appraiser allocation process and continue to offer and develop In House Appraiser Refresher Training.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Continue to embed the ASPAT tool across the trust to all appraisers and support and identify areas where additional training/support may be required.
Comments:	Appraisee's provide appraiser feedback, which is collated into a report in SARD and is shared with the appraiser yearly and uploaded to their own appraisal for reflection. The use of the ASPAT tool is business as usual which helps to provide feedback to appraisers on summary outputs which can be reflected upon in their own appraisal and as part of a development.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	For 2024/25 90% of appraisers scored 75% and above (Good) which is an improvement on 2023/24. Well attended In House Refresher Appraiser Education Events take place twice yearly with a range of topics and speakers. New Appraiser Training took place in March 2025 with 15 new medics trained.
Action for next year:	Continue to embed the ASPAT tool across the trust to all appraisers and support and identify areas where additional training/support may be required which can be covered at In House Appraiser Refresher Training Education Events.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Continue to monitor via MSSG
Comments:	Quality assurance is maintained and shared at monthly MSSG meetings. These are attended by the Interim Chief Medical Officer, Chief People Officer, Trust Appraisal Lead, Medical Job Planning and Revalidation Specialist and the Interim Deputy CMO for Medical Workforce. The committee regularly review quality assurance and create actions on an ad hoc basis as required.
Action for next year:	Continue to monitor via MSSG

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Continue to engage with the GMC ELA.
Comments:	The RO has monthly meetings with the GMC ELA to discuss all investigations that are on-going and any concerns about engagement in the appraisal process. The GMC ELA is involved in any conversations about deferrals or Failures to Engage and this has helped to avoid the need to reach formal process.
Action for next year:	Continue to engage and work with the GMC ELA.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	Continue with the current policy and monitor impact of SARD.
Comments:	The Medical Revalidation & Job Planning Specialist supports the CMO Office with revalidation compliance and this is monitored at MSSG on a monthly basis. Where a deferral has been made, the RO will write to the doctor involved to explain the reasoning behind the decision. If appropriate the Clinical Lead and HR Business Partner are included so that they are able to support the doctor. The most common reason remains the lack of evidence of colleague or patient feedback.
Action for next year:	Continue with the current policy and monitor impact of SARD.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Continue with embedding and delivering effective clinical governance for doctors across the trust.
Comments:	Quality assurance and governance of the appraisal and revalidation process is maintained by monthly MSSG meetings. These are attended by the Interim Chief Medical Officer, Chief People Officer, Trust Appraisal Lead, Medical Job Planning and Revalidation Specialist and the Interim Deputy CMO for Medical Workforce. The committee regularly review quality assurance and create actions on an ad hoc basis as required. Medical Job Planning is now business as usual and all job plans are reviewed, monitored and agreed monthly via Medical Working, Consistency and Advisory Group. The last audit undertaken by KPMG in May 2024 reported that the trust has good and effective governance and controls in place.
Action for next year:	Continue to embed and deliver effective clinical governance for doctors across the trust.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	To embed the skills gained during the recent Case Investigator training and continuing to ensure individuals are treated consistently and fairly and in a Just and Learning approach.

Comments:	MSSG is set up to better triangulate disparate areas of medical performance so that concerns around performance, conduct, health complaints etc can be seen as one offering, resulting in the opportunity to better support doctors in difficulty and for earlier intervention if concerns are evolving
Action for next year:	To continue to embed the skills gained during Case Investigator training and ensure individuals are treated consistently and fairly and in a Just and Learning approach.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Continue to embed and deliver a high-level service with readily accessible information and support with a focus on quality outcomes for medical appraisals.
Comments:	The Trust has a well embedded electronic system (SARD) and processes are managed and administrated by the Medical Revalidation & Job Planning Specialist ensuring up to date information is accessible in an appropriate and usable format for their appraisals. The Trusts Medical Revalidation & Job Planning Specialist along with the CMO office continue to ensure that all information provided to doctors is in an accessible, convenient and up to date format to doctors. The team continue to evolve and administrate the system to support the doctors with revalidation and their appraisals
Action for next year:	Continue to embed and deliver a high-level service with readily accessible information and support with a focus on quality outcomes for medical appraisals.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Where appropriate ensure de-brief sessions take place following case investigations to allow for any learning to be identified.
Comments:	This is covered in the Medical and Dental Revalidation and Appraisal Policy, reviewing investigations to ensure that the investigation followed policy and if there is any learning for change.
Action for next year:	Continue to review investigations upon completion, ensuring the correct process has been followed and ensure de-brief sessions take place following case investigations to allow for any learning to be identified.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	To continue triangulating data sources e.g. complaints, feedback and identified capability and conduct issues to allow for appropriate actions to be taken
Comments:	The interim Chief Medical Officer and Senior People Partner for medical meet regularly to discuss any on-going investigations or concerns. The Interim Chief Medical Officer meets as required with the nominated Non-Executive Director to discuss on-going investigations to ensure that the correct process is being followed. A monthly report is presented to Board with anonymous data on current investigations and exclusions or restrictions in practice.
Action for next year:	Continue to triangulate data sources e.g. complaints, feedback and identified capability and conduct issues to allow for appropriate actions to be taken

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Continuation of the established process between RO's and other appropriate counterparts.
Comments:	The RO continues to communicate with any other RO relevant to the practice of an individual doctor. There is a embedded process of sharing of information (MPIT forms) of doctors who join the organisation and leave the organisation The GPs working in the GWH Primary Care Network are not connected to GWH but to NHS England. This relationship has strengthened over the past 12 months with a more robust system for raising and discussing concerns. The RO is in direct communication with the counterpart at the local private hospital to ensure concerns are shared between the two organisations should these arise.
Action for next year:	Continuation of the established process between RO's and other appropriate counterparts

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	Continue to develop the MSSG meeting to ensure robust oversight.
Comments:	The MSSG is diverse and includes the Trust lead for Equality, Inclusion and Diversity to minimise the risk of unconscious bias impacting on case management and decision making. MSSG also has SAS representative as part of core membership. All members of MSSG are up to date with Equality and Diversity training.
Action for next year:	Ensure the MSSG meeting continues to have robust oversight.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	N/A
Comments:	National databases are monitored and alerts are received and acted on. This year we have had mortality alerts from the National Hip Fracture Database and the joint replacement database. We have looked into the issues and responded to them, and improved on our performance. We engage with the CQC and other national bodies. We received concerns from the CQC and the deanery on standards within Paediatrics and Neonates, and the Acting CMO convened and ran an executive led oversight group to ensure the concerns were responded to and that improvements were made. We have developed more robust learning from deaths policies and procedures this year and action the learning from SHMI data as well as engaging with regional teams.
Action for next year:	Continue to engage with national level groups to ensure that learning is used obtained and acted upon.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	n/a
Comments:	The Acting CMO ensures that the CEO and the CPO are informed of all MHPS investigations and any serious concerns or complaints. The CEO runs a regular briefing session for the CMO, Chief Nurse, and CPO where significant cases are discussed. The CMO and CNO meet regularly and discussions are had about professional standards. The 4 step process from the just and learning culture is embedded in the processes across all staff groups. The GWH has developed behavioural

	standards which are applicable to all staff groups. The CMO and CNO have been instrumental in launching these.
Action for next year:	Continue to work with colleagues across professional groups to ensure equity of response to concerns.

1E – Employment Checks

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

Action from last year:	Continue to monitor the pre-employment checks**.**
Comments:	The trust has the TRAC recruitment system, and all processes and checks are monitored throughout the year in conjunction with the general recruitment team to standardise processes. Pre-employment checks include GMC check, national insurance number, right to work checks (Passport/Visa), DBS check, an occupational health check, forms including Confidentiality, Data Protection & Caldicott Statement and Self Declaration
Action for next year:	Continue to monitor the pre-employment checks**.**

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	n/a
Comments:	Revalidation, appraisal and regulation are well embedded in all processes in the GWH. The CMO ensures that data from these is presented to the trust regularly, especially to the medical staff. Learning from cases is presented and discussed.
Action for next year:	Continue to develop learning from cases and development opportunities.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	The Trusts ongoing focus is to provide innovative and inclusive ways to support leadership and development at all levels. Promote and drive compassionate leadership and reduce barriers tom education, training and career development. Continue to develop an inclusive and diverse workforce and create an environment that embraces diversity. Establish strong staff networks to shape future strategies and help address inequalities. Continue to improve patient information that meets the needs of a diverse population and involve people with protected characteristics opportunities to get involved and influence our work.
Comments:	Individuals will not be disadvantaged by any condition or requirement relating to employment that is not justifiable, nor suffer any detriment for exercising this right. The trust actively promotes a culture of equal opportunities for staff, patients and clients through strategies relating to equality of access to patient services, physical access to facilities, all aspects of service delivery, employment practices and cultural/disability awareness raising. The trust has also recruited EDI Champions in the last year who are members of staff who voluntary lead on promoting equality, diversity and inclusion in their area.
Action for next year:	The Trust continues to build a workplace where everyone feels welcome, involved and has the same opportunities. The trust's diversity is a strength, and the people reflect the multicultural communities they care for. The trust continues to build to promote an equal opportunity through strategies relating to equality of access, inclusive recruitment practices, special events and celebrations, Staff Networks and learning opportunities for all staff.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	A framework is being developed to support learning from incidents, including supporting staff, how to debrief effectively, and to provide governance and validation mechanisms to improve the safety and experience of the people we serve and our colleagues, so that risks are addressed, and learning is maximised. Overall, we aim to create a safe, kind, and compassionate environment. The Trust's journey will include us looking in partnership for alternative solutions to Trust procedures where appropriate. Alongside our Freedom to Speak Up Guardians, our civility champions, our People Operations Team and our Staff-side colleagues, the Trust is developing training plans to implement a framework to embed a just and learning culture.

Comments:	The trust is committed to creating an environment where all staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed, and it is important that as a trust we learn from each other, or from mistakes and put safeguards in place to ensure they do not occur again.
Action for next year:	To continue to build on a framework to support learning from incidents, including how to support staff and debrief effectively. Ensure governance and validation mechanisms are in place to improve the safety and experience of the people the trusts serve, as well as staff so risks are addressed and learning maximised, Promotion of Freedom to Speak up Training to all staff as well as accessibility of the Trust's Freedom to Speak up Guardians.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	n/a
Comments:	There is well developed policy and process for concerns to be raised. We have a new FTSU guardian who is developing this route for raising concerns at the GWH. We have had an external company (Clever Together) review our speaking up policies and processes, and we have redesigned these from the bottom up.
Action for next year:	Continue to embed these processes

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	n/a
Comments:	We monitor our level of parity using data from the PPA and from GMC connect. The characteristics of practitioners discussed with the PPA is in line with the characteristics of our employed medical staff. We have implemented more support for IMGs who are starting work in the GWH including a longer supernumerary time.
Action for next year	Continue to monitor this and develop more processes to support IMGs into work in the GWH.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Continue to attend meetings and engage with peer review programmes.
Comments:	The trusts Interim Chief Medical Officer attends regular meetings with the regional HLRO. The Trust Appraisal Lead attends regular regional and national Network meetings and both ensure professional standards processes are aligned with other organisations with sharing and revieing of local processes and policies.
Action for next year:	Continue to attend meetings and engage with peer review programmes.

Section 2 – metrics

Year covered by this report and statement: 1April - 31March .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	504

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	609
Total number of appraisals approved missed	60
Total number of unapproved missed	20

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	53

Total number of late recommendations	0
Total number of positive recommendations	53
Total number of deferrals made	11
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	**38**
Total number of trained case managers	**23**
Total number of new concerns registered	**11**
Total number of concerns processes completed	**9**
Longest duration of concerns process of those open on 31 March	**1.5 years**
Median duration of concerns processes closed	**4 months**
Total number of doctors excluded/suspended	**4**
Total number of doctors referred to GMC	**1**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	315
Number of new employment checks completed before commencement of employment	315

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	N/a
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	N/a

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
During 2024 the Workforce Insights, Systems & Planning team have worked closely with SARD in supporting the development and launch of an improved and enhanced dashboard and platform for appraisal and revalidation which has included improved navigation and accessibility from a mobile device. This has allowed the user to be able to alternate and scroll seamlessly across their platforms as well as include progress bars providing increased and clearer visibility. In October 2024 and in line with the Good Medical Practice Guide 2024 the Trust launched a rebalanced and improved approach to medical appraisal. This includes the continued focus on doctors' professional development and wellbeing as well as including an area to reflect if you are an educational supervisor or clinical supervisor or both. The Trust introduced the Appraisal Summary and PDP Tool (ASPAT) which was developed by doctors to quality assure appraisal outputs and is used nationally in early 2024. The team assess and score the quality of appraisals and can feedback to appraisers which can be used and reflected on as part of a development process and improve the process and quality of appraisals. The sharing of this feedback is in its 2nd year, and we are seeing an improvement of the quality of outcome summaries. In April 2024 we launched a newly designed In House Appraiser Education Event as part of Clinical Governance Study Days. We hold at least two a year as part of Appraiser Refresher Training and include topics suggested by the appraisers as well as guidance and support provided by the Trust Appraisal Lead and Medical Revalidation and Job Planning Specialist along with guest speakers. Some topics covered already in the two sessions delivered since April 2024 are, ASPAT & the Appraisal Summary, Occupational Health & Well Being Support, PGME - Training Offer for medics, SARD Questions and Answers on using and utilising the system, what is the Consultant Leadership Programme, SAS Doctor Advocate Introduction. This approach has proved successful through the number of attendees and feedback as well as cost savings to the Trust
Actions still outstanding
Continue to support locum and short-term placement doctors while they are working at GWH. Continue with attendance and support with facilitating future National Revalidation & Appraisal Managers meetings, as well as BSW AHA meetings.
Current issues
No current issues The Trust is committed to continue to embed and deliver a high-level service with a focus on quality outcomes.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Continue to support locum and short-term placement doctors while they are working at GWH. Continue with attendance and support with facilitating future National Revalidation & Appraisal Managers meetings, as well as BSW AHA meetings.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
SARD has been fully implemented throughout the Trust across Revalidation and Job Planning. Following its second year as business as usual there will be further work undertaken to align reporting inputs and outputs across all workforce management systems, notably standardising activity language within SARD and the rostering system to enable meaningful analysis of planned vs actual activity Trust Appraiser Training has been organised for 2025 and 2026 in association with Doctors Training. This is due to changes in roles and responsibilities and a decrease in Trust trained appraisers during 2024. This will support and contribute towards the continued level of compliance across medical appraisal as well as develops the medic to help maintain high standards of professional responsibility. We will continue to build positive working relationships with SARD whereby we create autonomy in being able to develop and improve a system that is fit for purpose, having wider visibility with a holistic approach and ensure we utilise the system in the best possible way.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

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

Official name of the designated body:	Great Western Hospitals NHSFT

Name:	
Role:	
Signed:	
Date:	

Report Title	**Committee Effectiveness Review 2024**				
Meeting	**Trust Board**				
Date	**11/09/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Remuneration Committee Terms of Reference Appendix 2 – Charitable Funds 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):

Following the report in the July 2025 Board meeting, this report provides the committee effective reviews for the remaining Board committees (except for TMC which will be undertake following the commencement of the new Managing Director on 1 Sept-25) Charitable Funds Committee and Remuneration Committee.

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.

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	***Charitable Funds Committee*** ***Remuneration 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:-

- ***Charitable Funds Committee***
- ***Remuneration Committee***

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	**15/08/2025**

REMUNERATION COMMITTEE
TERMS OF REFERENCE 2025/26

Purpose
To fulfil the Committee's statutory role in the appointment and removal of Executive Directors including the Chief Executive in line with the NHS Act 2006 and code of governance, and, to determine levels of remuneration and terms of conditions of service for Executive Directors.

1. AUTHORITY

1.1 The Remuneration 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.

ROLE / PURPOSE

2.1 The Committee is required to put in place formal, rigorous and transparent procedure for the appointment of the Chief Executive and other Executive Directors , ensure plans are in place for orderly succession to the board and oversee the development of a diverse pipeline for succession, and to develop, maintain and implement a remuneration policy that will enable the Trust to attract and retain the best candidates.

2.2 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).

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

2.4 The Committee will take into consideration the Trust's '*Guiding Principles for Executive Directors Remuneration*' (Sept-23) when considering Executive Director's remuneration.

3. MEMBERSHIP

3.1 The membership will comprise all Non-Executive Directors including the Chair of the Trust.

3.2 The Chief Executive shall be a voting member of the Committee for the appointments or removal of Executive Directors only.

3.3 The Committee will be chaired by the Trust Chair. In the absence of the Chair of the Committee, the remaining members present shall elect one of their number to chair the meeting.

3.4 *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. ATTENDANCE

4.1 The Chief Executive will normally attend meetings, withdrawing as appropriate when matters relating to their own performance and remuneration are discussed.

4.2 The Chief People Officer will support the Committee with appropriate papers and proposals for consideration and be in attendance as and when appropriate and necessary.

4.3 *Substitutes / deputies* – There is no provision for substitutes on this Committee.

4.4 *External advisors* - The Committee may invite external advisors to attend for all or part of any meeting.

5. QUORUM

5.1 The quorum for meetings of the Committee shall be three members (3 Non-Executive Directors).

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet at least twice a year with additional meetings being called at such other times as may be required.

6.2 The Committee on occasions may be required to meet as a Committees-in-Common to consider Group roles.

7. DUTIES

7.1 To keep under review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.

7.2 To approve the procedure and documentation for the appointment of Executive Directors and Chief Executive posts.

7.3 To approve the appointment of Executive Directors, including the Chief Executive

7.4 Additionally, for the appointment of the Chief Executive the Committee will keep the Council of Governors informed of progress of a campaign and report the appointment of the Chief Executive to the Council of Governors for approval.

7.5 To consider and agree any matter relating to the continuation in office of any Board Executive Director including removal from office, suspension or termination of employment by the Trust.

7.6 The Committee shall adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract and retain Executive Directors.

7.7 To set on an annual basis individual remuneration arrangements for the Chief Executive, other Executive Directors in accordance with policy and having regard to individual performance.

7.8 To ensure that in the event of loss of office and/or termination of employment of the Chief Executive or any Executive Director the contractual terms and any payments made, are appropriate and consistent with all relevant Government guidelines.

7.9 To monitor and evaluate the performance of individual Executive Directors.

7.10 To engage the services of or take advice from any suitably qualified third party or advisers to assist with any aspects of its responsibilities provided that the financial and other implications of seeking outside advisers have been discussed and agreed by the Chief Executive.

7.11 Ensure plans are in place for orderly succession to the Board and oversee the development of a diverse pipeline for succession, taking into account the challenges and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.

7.12 Where appropriate, authorise any severance payments including redundancy payments, non-contractual settlements and compromise agreements as determined within current NHS rules, ensuring that they are fair to both the individual and the organisation.

8. REPORTING RESPONSIBILITIES

8.1 This Committee is accountable to the Trust Board. The Chair of the Committee will provide a brief verbal summary after each meeting to the Board on the work of the Committee.

8.2. Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee. Minutes will be retained by the Company Secretary.

8.3 Minutes of meetings of this Committee will not be made available to Executive Directors, with the exception of the Chief Executive and Chief People Officer (on a need to know basis).

8.4 The Committee shall make a statement in the annual report as required.

9. MEETING ADMINISTRATION

9.1 The Company Secretary will provide administrative support to the Committee.

9.2. 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. REVIEW

10.1 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.

10.2. 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 annual review	June 2022	Remuneration Committee	2.1 & 7.12 reference to succession planning and diversity
V2.0	Annual Review	May 2023	Company Secretary	Amendments to job titles Added 7.3 Deleted 7.10
V2.0	Approved	June 2023	Board	As above
V3.0	Annual Review	May-24	Remuneration Committee	Added 2.3 and 2.4 Changed Chair of meeting to Trust Chair Appendix 1 – changed name of Chair of Committee Appendix 2 – Updated
V3.1	Updated	Aug-24	Board Meeting	Added 3.4 voting in the event of equality of votes.
V4.0	Annual Review	July-25	Company Secretary	Added: 6.2 reference to meeting as a Committees-in-Common for consideration of Group roles 7.12 reference to redundancies authorisation in line with NHSE guidance

Appendix 1 - Summary

Committee	Remuneration Committee
Chair Lead EDs	Liam Coleman, Trust Chair Jude Gray, Chief People Officer
Frequency	At least twice a year
Membership	All Non-Executive Directors
Quorum	3 x NEDs
Remit	Recruitment and appointment of Executive Directors Develop, maintain and implement Remuneration Policy Ensure orderly succession plans Receive reports on Chief Executive and other Executive Directors performance against objectives To agree annual remuneration of Chief Executive and other Executive Directors

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE
2025/26

Purpose
On behalf of the Corporate Trustee, the purpose of the Committee is to manage the routine affairs of the charity, in accordance with the Scheme of Delegation.

1. AUTHORITY

1.1 Great Western Hospitals NHS Foundation Trust Board, acting as a Corporate Trustee for Great Western Hospital (GWH) Charitable Fund (Charity Registration Number 1050892) has established a Charitable Funds Committee (the Committee).

1.2 The Committee is administered and managed by the Trustees who are responsible for the overall management of the Charitable Funds. This is a non-statutory Committee that reports to the Trust Board and has no powers other than those specifically delegated in these terms of reference.

2. ROLE

2.1 The purpose of this Committee is to oversee the management of Charitable Funds.

2.2 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).

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

3. MEMBERSHIP

3.1 The membership of the Committee shall consist of:

- Three Non-Executive Directors
- Two Executive Directors; the Chief Financial Officer and one other.

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

3.3 In the absence of the Chair, a Non-Executive Committee member will perform this role.

4. ATTENDANCE

4.1 Other attendees will include but are not limited to:

Chief Executive
Associate Director of Fundraising & Voluntary Services
Head of Financial Control
Financial Accountant (or nominated Deputy)
Divisional Directors
Executive Assistant to Chief Financial Officer (administrative support)

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 The Trust Chair may attend meetings of the Committee (but not if specifically excluded by the Chair of the Committee), but may not chair meetings nor contribute to the quorum.

4.6 *Advisors* – External advisors may attend as necessary at the request of members to include any departments who have an interest in the current meeting, i.e. fundraising, finance, and any department submitting a case of need or external investment advisors.

4.7 *Administration of Committee* – The Executive Assistant to the Chief Financial Officer shall provide appropriate administrative support and guidance to the Chair and Committee members.

5. QUORUM

5.1 The quorum for meetings of the Committee shall be three members to include two Non-Executive Director and one Executive or Non-Voting Board Director.

6. FREQUENCY OF MEETINGS

6.1 The Trustees shall normally meet four times per year and at such other times as the Trust shall require.

7. DUTIES

7.1 Ensure that best practice is followed in terms of guidance from the Charity Commission, Audit Commission, National Audit Office, Department of Health and other relevant organisations.

7.2 Ensure that the appropriate policies and procedures are in place to support the Charitable Funds Strategy and to advise Fund Managers on income and expenditure and that this is reviewed at regular intervals.

7.3 Ensure that fund objectives and spending plans are in line with Charitable objectives, spending criteria and priorities set by donors.

7.4 Ensure that all funds are correctly allocated as restricted or unrestricted and are accounted for accordingly. The number of funds should be reviewed on an annual basis to identify whether a programme of rationalisation is required.

7.5 Develop and review the Trust's Charitable Funds Strategy and Trustees' terms of reference on an annual basis and agree changes where appropriate.

7.6 Develop and review the Scheme of Delegation for charitable funds on a regular basis and recommend changes where appropriate.

7.7 Ensure that a separate register of interests is compiled for both Trustees and Fund Managers, and that this is reviewed and updated on a regular basis.

7.8 Review and approve fundraising policies in conjunction with the Director of Finance, ensuring that statutory requirements are complied with.

7.9 On an annual basis, review and approve summary level income and expenditure plans from Fund Managers, ensuring that they complement the strategy.

7.10 Ensure an effective mechanism exists whereby equipment needs are identified and satisfied (within resource constraints) through an equitable bidding process underpinned by business plans. (All equipment purchased by charitable funds will be recorded in a separate register.)

7.11 Oversee the management of investments. Where an investment broker is used, the Trustees will ensure the investment strategy has been appropriately communicated, the information required is specified and received in a timely manner, and that the service is market tested at regular intervals.

7.12 Ensure that all research monies paid into charitable funds meet the criteria for charitable status as specified by the Charity Commission.

7.13 Review and discuss all Audit Reports on Charitable Funds and recommend action to Trustees.

7.14 Review the Charity Annual Accounts and Trustee Annual Report and comment/recommend approval to the Trustees as appropriate.

7.15 Approve any request to set up new funds and cost centres (Charitable Funds only).

7.16 Agree and approve the bases of apportionment for investment income and administration costs, respectively.

7.17 Recommend to the Board any major fund raising appeals and plans, including any material changes to those plans already approved by the Board.

7.18 The charity also holds funds on behalf of ~~Wiltshire Health & Care LLP~~ HCRG Care Group who have their own approval process, which is then ratified by the GWH Charitable Funds Committee subject to funds being available

8. REPORTING RESPONSIBILITIES

8.1 The Trustees are accountable to the Charity Commission for the proper use of the charitable funds and to the public as a beneficiary of those funds.

8.2. Minutes will be prepared after each meeting of this Committee and circulated to members of the Committee and others as necessary. Once the Committee has approved the full minutes, a copy will be available, for information, to the Board at its next meeting.

8.3 The key issues of the Committee will be included in the Board of Directors agenda and papers as directed by the Chair of the Charitable Funds Committee and accepted by the Chairman of the Trust.

8.4 The Chair of the Committee shall draw to the attention of Trust Board any issues that require disclosure to the full Board, or require Executive action.

8.5 The Committee will report to the Trust Board annually on the matters of business it has carried out.

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.

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

10. REVIEW

10.1 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.

10.2. 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	For review	Nov-21	Charitable Funds Committee	- Membership to reflect NED to be in majority - Divisional Directors to be included in the attendee list
V1.1	For review	Apr-22	Committee Effectiveness Review	- Include Wiltshire Health & Care in duties. Other amendments include:- - New format - Added deputies for Executive Directors - Link to the Strategic Framework - Summary table of meeting remit
V2.0	For annual review	May-23	Company Secretary	- Change of job titles
V2.0	Approved	Jun-23	Board	As above
V3.0	For annual review	May-24	Charitable Funds Committee	- 2.3 added - the Committee will demonstrably consider the equality, diversity and inclusive implications of decisions they make. - 4.1 job title change - Appendix 1 – Chair name change - Appendix 2 – updated - 5.1 and append 1 amended quoracy requirements for voting purposes to align with 3.4 (For voting purposes there must be a majority of Non-Executive Directors)
V4.0	Annual Review	June-25	Charitable Funds Committee	- Delete reference to voting as not required within this Committee as any major approval is for Trustees.
V5	Annual Review	Aug-25	Charitable Funds Committee	- Change name and job title in appendix 1 - 7.8 – change WH&C to HCRG

Appendix 1 - Summary

Committee	Charitable Funds Committee
Chair Lead EDs	Julian Duxfield, Non-Executive Director Simon Wade, Chief Financial Officer One other Executive Director (tbc)
Frequency	At least 4 times per year
Membership	3 x NEDs 2 x EDs
Quorum	2 x NEDs 1 x ED
Remit	Charitable Funds Performance Charitable Funds Strategy Funding Policies Management of Funds