GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Thursday 4 May 2023, 9.30am to 1.00pm
By Teams

AGENDA

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

		PAPER	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Liam Coleman (Peter Hill to chair meeting), Claire Lehman	Verbal	PH	-	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	PH	-	-
3.	**Minutes of the previous meeting (public)** Peter Hill, Deputy Chair • 2 March 2023	1 - 10	PH	Approve	-
4.	**Outstanding actions of the Board (public)**	11	PH	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	-	-	-	-
6.	**Improving Together Staff Stories** Hayley Moore, Ward Sister Beech Ward, and Alex Harrington, Head of Integrated Podiatry, to present	12 - 19	EB/HM/ AH	Assurance	9.45
7.	**Ockenden Report – GWH Update** Lisa Cheek, Chief Nurse Lisa Marshall, Director of Midwifery & Neonatal Services, and Kat Simpson, Head of Midwifery & Neonatal Services, to present	20 - 42	LM/KS	Assurance	10.15
8.	**Chair's Report** Peter Hill, Deputy Chair	43 - 46	PH	Note	10.30
9.	**Chief Executive's Report** Kevin McNamara, Chief Executive	47 - 57	KM	Note	10.40
10.	**Integrated Performance Report** • Integrated Performance Report – Pillar Metric deep dive and refresh	58 - 111	Executive Directors	Assurance	11.00

	• Performance, Population & Place Committee Board Assurance Report (March & April) – Peter Hill, Non-Executive Director & Committee Chair	112 - 115	PH		
	• Quality & Safety Committee Board Assurance Report (March & April) – Nick Bishop / Claudia Paoloni, Non-Executive Director & Committee Chair	116 - 122	NLB/CP		
	• Finance, Infrastructure & Digital Committee Board Assurance Report (March & April) – Faried Chopdat, Non-Executive Director & Committee Chair	123 - 127	FC		
	• Year End 2022/23 Update	Verbal	SW		
	• People & Culture Committee Assurance Report (April) – Paul Lewis, Non-Executive Director & Committee Chair	Verbal	PL		
11.	**Mental Health Governance Committee Board Assurance Report** Lizzie Abderrahim, Non-Executive Director & Committee Chair	128 - 131	EKA	Assurance	12.15
12.	**Staff Survey Results 2022** Jude Gray, Chief People Officer	132 - 193	JG	Receive	12.25
13.	**Committee Effectiveness Review 2022/23** Caroline Coles, Company Secretary	194 - 242	CC	Approve	12.40
14.	**Annual Review of Trust Constitution** Caroline Coles, Company Secretary	243 - 387	CC	Approve	12.50
	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.**				
15.	**Ratification of Decisions made via Board Circular** Caroline Coles, Company Secretary	Verbal	CC	Note	12.55
16.	**Annual Self Certification – G6/FT4/CoS7** Caroline Coles, Company Secretary	388 - 394	CC	Approve	-
17.	**New Code of Governance for Provider Trusts** Caroline Coles, Company Secretary	395 - 398	CC	Assurance	-
18.	**Register of Interests and Declaration of Interests at Meetings** Caroline Coles, Company Secretary	399 - 401	CC	Approve	-
19.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	PH	Note	-
20.	**Date and Time of next meeting** Thursday 1st June 2023 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	PH	Note	-
21.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	13.00

2023											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Board	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board
			Workforce, Culture & EDI			Patient Voice/Patient Safety Framework			Strategy		

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC IN LECTURE HALL 1, ACADEMY, GREAT WESTERN HOSPITAL SWINDON AND VIA MS TEAMS 2 MARCH 2023 AT 9.30 AM

Present:

Voting Directors

Liam Coleman (LC) (Chair)	Trust Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Nick Bishop (NB)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat	Non-Executive Director
Andy Copestake (AC)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Paul Lewis (PL)	Non-Executive Director
Kevin McNamara (KM)	Chief Executive
Helen Spice (HS)	Non-Executive Director
Felicity Taylor-Drewe (FTD)	Chief Operating Officer
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Chief Medical Officer

In attendance

Maxine Buyanga (MB)*	Deputy Divisional Director of Nursing (agenda item 255/22 only)
Caroline Coles (CC)	Company Secretary
Naginder Dhanoa (ND)	Chief Digital Officer
Tim Edmonds (TE)	Associate Director of Communications & Engagement
Rayna McDonald (RM)*	Deputy Chief Nurse (agenda item 255/22 only)
Claudia Paoloni (CP)	Associate Non-Executive Director
Claire Warner (CW)	Deputy Chief People Officer (Observer)
Sharon Woma (SW)*	Equality, Diversity & Inclusion Lead (agenda item 260/22 only)

Apologies

Peter Hill	Non-Executive Director

Number of members of the Public: 4 members of public* (included 3 Governors: Pauline Cooke, Chris Shepherd, and Mufid Sukkar and 1 member of staff)

*Indicates those members attending virtually by MS Teams.

Matters Open to the Public and Press

Minute	Description	Action
250/22	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public and acknowledged that this was the last Board meeting for Andy Copestake, Non-Executive Director whose term of office comes to an end on 31 March 2023. The Board thanked Andy for his significant contribution during his term of office and wished him well for the future. It was also noted that, following a request from North Bristol NHS Trust, Jude Gray, Chief People Officer, would be working part time for a short period, for North Bristol	

Minute	Description	Action

Trust. Claire Warner, Deputy Chief People Officer would be stepping up to support this wider system working.

Apologies were received as above.

251/22 **Declarations of Interest**
There were no declarations of interest.

252/22 **Minutes**
The minutes of the meeting of the Board held on 2 February 2023 were adopted and signed as a correct record with the following amendments:-

231/22 : Chief Executive's Report : Integrated Front Door - Delete word *'capability'* in 3rd paragraph.

253/22 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list and the following noted:-

- Future action for Improving Together – It was noted that the 'One Year On Report' would be presented at the end of Q1 2023/24 (August 2023 Board meeting).

- Integrated Performance Report Development - the additional meeting for Non-Executive Directors (NEDs) to discuss the Integrated Peformance report would be arranged outside the normal regular NED sessions.

There followed a discussion on the NHS App particularly around the link between this national development and the procurement of a joint BSW Electronic Patient Record system. It was agreed that this would be picked up with the EPR provider and through the provider collaborative.

The Board **noted** the outstanding actions.

254/22 **Questions from the public to the Board relating to the work of the Trust**
There were no questions to report.

255/22 **Care Reflections – Patient Story**
Rayna McDonald, Deputy Chief Nurse and Maxine Buyanga, Deputy Divisional Director of Nursing (Surgery, Women and Children) joined the meeting for this agenda item.

The Board received a reflection of care from another Trust which raised awareness of childhood cancer through 'Sophie's Legacy'.

Due to technical issues the short film was not able to be shown but all Board members were requested to view off line through the link in the Board papers.

The Board considered a presentation which outlined Sophie's legacy, this was in memory of a young child who died from cancer aged 10 who wished to improve the lives of children and their families with cancer through her own experience. The primary objectives were noted as:-

Minute **Description** **Action**

- support parents/guardians and families whose children have been admitted to hospital;
- provide art therapy for children in hospital, as well as in the community;
- raise awareness and be an advocate for childhood cancer – including signs & symptoms of childhood cancer; and,
- improve the quality of children's time in hospital through better food standards and the provision of play.

The Board noted the improvements the Trust had introduced particularly in play specialists, better food for children and provisions for parents/carers. Jon Westbrook, Chief Medical Officer added that the number of acute child cases within the Trust were relatively small and their stay at the hospital was for a short time, however it was recognised that the role of play specilists was varied and adopted across the hospital to meet the variety of needs in other departments.

Sophie's mum had been invited to the Trust to discuss improvements and the Board looked forward to hearing the reflections through the Quality & Safety Committee Board Assurance Report in due course.

There followed a discussion on further opportunities to explore within the Trust which included Serco and Costa, local businesses, patient feedback, and charitable funds.

The Board were grateful in being able to hear and discuss Sophie's Legacy in memory of a remarkable young girl and the Chair apologised for not being able to show the film but again encouraged all Board members to watch the video.

The Board **noted** the care reflection.

256/22 **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 and the following noted:-

- The Non-Executive Director recruitment had been completed and was going through the appropriate governance route.
- Informaiton on Board Safety Walks was a attached as a summary of the discussions captured through the Quality & Safety Committee.

In addition it was noted that the BSW Acute Hospital Alliance, which the Trust was part of, had successfully been chosen as the first wave of a new Provider Collaborative Innovators Scheme.

The Board **noted** the report.

257/22 **Chief Executive's Report**

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

Vaccination Programme - The Trust'c covid/flu vaccination programme had come to an end and the Trust, for the 3rd year running, had been in the top 10 position in the country thanks to the hard work of the vaccination team.

Minute **Description** **Action**

Operational Pressures - A trend of around 30 patients with covid had generally been seen since January 2023. Operational pressures, although remained a challenge, were more manageable as the impact of cross system working was taking effect. The Trust was also performing comparatively well in respect of activity recovery.

Andy Copestake, Non-Executive Director asked if there was a relationship between the performance of activity to the number of Non-criteria to Reside (NCTR) patients. Kevin McNamara, Chief Executive replied that this was regularly discussed at ICS level to try and better understand if there was a correlation, however, there were a number of elements within the system that were dependent on the reduction of NCTR. Felicity Taylor-Drewe, Chief Operating Officer added that activity performance was certainly linked to bed occupancy however it was important to focus on the patient experience.

Nick Bishop, Non-Executive Director recognised that the Navigation Hub was a contributor to the reduction in NCTR and asked if there were other areas that could help to reduce this further. Felicity Taylor-Drewe, Chief Operating Officer responded that there were other areas to drive improvement and any new structures would come through the Performance, Population & Place Committee and future Board meetings through patient and staff stories particularly around the virtual ward.

Industrial Action – The Royal College of Nursing held industrial action at the Trust on 6 & 7 February 2023 and a small number of clinics had been cancelled as a result of the action. The industrial action due on 1 – 3 March had been postponed pending national talks however further strike action was planned by Junor Doctors.

CQC 1/4ly Engagement Visit – The Trust held its regular quarterly engagement meeting with CQC representatives on 21 February 2023. The team had extended their visit to spend the day at the Trust looking at some of our services. This had been a successful day with good discussions and positive feedback.

Way Forward Programme – Integrated Front Door (IFD) – A short ground-breaking ceremony had taken place on 21 February 2023 as the start of the urgent and emergency care developement.

In addition the Chief Executive acknowledged the announcement of the Chief Executive of Swindon Borough Council (SBC), Suzie Kemp, stepping down from the role and wished to recognise Suzie's part as a strong and positive partner within the system and wished her well for the future.

Faried Chopdat, Non-Executive Director asked if there would be any impact on the Co-ordination Centre as a result of changes in Chief Executive at the SBC and what were the next steps. Kevin McNamara, Chief Executive replied that the Trust had a positive working relationship at all levels within the Swindon Borough Council and the next step was for the development of a business case for a system wide Co-ordination Centre which may result in some local elements elevated to system level.

Lizzie Abderrahim, Non-Executive Director highlighted the Trust's support in Race Equality Week in particular the pledge to explore setting up safe space. Kevin McNamara, Chief Executive added that the next Board workshop in April 2023 was on equality, diversity & inclusion (ED&I) with an external facilitor to explore this and other elements of ED&I.

Minute	Description	Action

The Board **noted** the report.

258/22 **Integrated Performance Report**

The Board received and considered the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in December 2022 and January 2023.

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) around the IPR at its meeting on 22 February 2023 and the following highlighted:-

- Paul Lewis chaired the meeting and presented the report in the absence of Peter Hill.
- The assurance ratings remained the same as the previous month.
- The excellent progress in the reduction of NCTR due to the good work not only with partners but within the community.
- There had been some progress in cancer performance however there continued to be hotspots in Dermatology and Plastics.
- The annual Emergency Preparedness Resilience & Response report was presented and it was noted that the Trust was compliant in 62 core standards with further work required in 6.
- Both the draft BSW Integrated Place Partnership Strategy and Swindon Joint Health & Wellbeing Strategy were noted by the Committee.
- The Committee referred a concern to the Finance, Infrastructure & Digital Committee around coding.

Liam Coleman, Chair asked for clarification on the coding issue. Simon Wade, Chief Financial Officer replied that coding had a quality aspect as well as a financial impact. Additional temporary resourcing was being put in to manage the backlog in the next month to ensure a correct footing going into a new financial regime in 2023/24 and would be monitored through the Finance, Infrastructure & Digital Committee.

Claudia Paoloni, Associate Non-Executive Director asked if the Trust were exploring automated clinical coding. Felicity Tayor-Drew, Chief Operating Officer replied that the Trust had introduced elective Bluespier however there were more opportunities to explore.

Liam Coleman, Chair echoed the concerns of PPPC with regard to Referral to Treatment Time (RTT) performance. The chair of PPPC confirmed that the level of challenge and questioning around the performance had been robust at the meeting and there would be a more in-depth analysis at the next meeting and once the modelling and actions were known then the Committee would decide whether this remained an amber or red assurance rating.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (Q&SC) around the quality element of the IPR at the meeting held on 16 February 2023 and the following highlighted:-

Minute **Description** **Action**

Pillar Metric - There had been a reduction in harm mainly due to decreased covid rates.

Family & Friends Test (FFT) – Although some improvement in this area the red risk rating reflected patient experience as a whole.

There followed a discussion on the use of the FFT in relation to building evidential data to demonstrate any funding invested to improve patient experience actually worked and was value for money. The Chief Nurse explained that FFT was one of a number of tools used to measure patient experience. A Patient Experience Report was presented to Quality & Safety Committee which brought all these elements together and the impact to patient experience.

Nick Bishop, Non-Executive Director asked if children were asked about their experience. Lisa Cheek, Chief Nurse replied that the Trust obtained feedback using our "Tops and Pants" board where younger children can tell us what they think about their stay.

Pressure Ulcers - Pressure harms had decreased slightly within hospital but had increased within community. Of particular note was the lower degree of harm from pressure ulcers coming through.

Falls - Performance had improved slightly.

Maternity - Overall performance was good.

Mortality – The Committee noted that the position regarding low coding numbers influenced much of the data presented. However, the results were generally reassuring with the proviso that the latest data was dated September 2022. The issue around coding was being addressed by additional resource.

Governance during Operational Pressures – A comprehensive and concise report was considered by the Committee which outlined all the actions that had been put in place in response to unprecedented operational pressures during the Winter period. This report would act as a template for future operations under similar circumstances.

CQC Preparedness - The Committee was assured that the the only 'Must Do' action relating to Safeguarding Children Level 3 training would be completed by the end of Q1 2023/24.

Use of Resource
Finance, Infrastructure & Digital Committee Overview
The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee around the Use of Resource element of the IPR at the meeting held 20 February 2023 and the following was highlighted:-

Month 10 Position - The latest forecast position was breakeven with no material movements in forecast position. The assurance rating of green reflected this however it was noted that as the Trust moved into the new financial year this would certainly move to red.

Risk – The Committee were assured with the managing of the financial, digital and estates and facilities risks.

Minute **Description** **Action**

BSW Consolidated Finance Report - The Committee received an update on the overall financial position of the BSW ICB, including key risks, mitigations, and delivery of efficiencies. Whilst the Committee was satisfied with the management engagement and response of the Trust with the ICB, the Committee challenged the overall finance governance arrangements at BSW level.

Capital Plan - Captial expenditure was below plan due to slippage however additional governance had been put in place to ensure funding was spent by year-end.

Simon Wade, Chief Financial Officer added that the capital expenditure was not behind on major construction but an aggregate of a lot of smaller works. Purchase orders had been raised for the majority of the spend and the Trust was just waiting on the goods therefore this was more a timing issue.

CIP Programme Update - The year to date forecast position was of 70% of the plan. No further opportunities had been identified due to the increased focus on 2023/24 planning. It was anticipated that this risk would move to a red/red rating given that the shortfall would be carried into the next financial year.

Businesss Planing Update - An updated paper was noted on the business planning for 2023/24, summarising the national update, progress to date, and anticipated outcomes. The Committee noted that the national planning guidance had been gradually released since December 2022, and there still remained several unknowns and therefore an initial view of the proposed deficit and the requirement for difficult decisions and trade-offs would result in a challenging budget for 2023/24. FIDC would consider the whole plan at an Extraordinary FIDC meeting planned for week commencing 20th March 2023.

Shared EPR Risks - A robust governance structure had been put in place however this was rated as red due to the lack of benefits to support the full business case (FBC), including estimated increased costs, resourcing challenges, and the risk that the FBC needed to be approved.

Our People
People & Culture Committee Chair Overview
The Board received an overview of the detailed discussions held at People & Culture Committee around the workforce element of the IPR at the meeting held 21 February 2023 and the following was highlighted:-

- The only red assurance rating was workforce planning due to the on-going position with industrial action, but the Committee were provided with further assurance about plans in place to mitigate and manage this as effectively as possible.
- There had been one assurance rating change from green to amber as the plans to improve the appraisals process and documentation had been delayed and would be covered at the next meeting.
- The workforce planning elements of the Integrated Performance Report were considered in detail and noted the on-going plans with recruitment, sickness/abence rates, 1st year attrition and ‘time to hire’ to further improve the position.
- The Committee received an update about Health & Wellbeing, which covered the framework, a summary of findings and revised improvement actions. It was agreed

Minute **Description** **Action**

that progress had been encouraging and it was good to see that feedback from staff forums and networks have been taken into consideration.

- The Committee received an update about the Secure Appraisal Revalidation Database (SARD) implementation which was the deployment of an electronic workforce system for medical staff covering revalidation, appraisal and job planning. It was agreed that excellent progress had been made and noted the first cycle of electronic job planning was due in July 2023 when the appraisal process would also commence to help improve the quality of appraisals.

Andy Copestake, Non-Executive Director asked if the nurses had a similar system to SARD. Lisa Cheek, Chief Nurse replied that revalidation for nurses and midwives was through the Nursing & Midwifery Council every 3 years to renew their registration and not linked to the appraisal process.

Lizzie Abderrahim, Non-Executive Director asked what lessons could be taken from the SARD process and applied to the nurses appraisals. Jon Westbrook, Medical Director responded that SARD had simplified the process with a greater focus on health and wellbeing, together with less evidencing and more engaging and improved templates. Revalidation was also linked to completion of appraisals, together with qualifying for the Clinical Excellence Awards.

The Board **noted** the Integrated Performance Report.

259/22 **Charitable Funds Committee Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee at the meeting held on 1 February 2023 and the following highlighted:-

- The risk rating on fundraising remained red due to the continued risks and uncertainty with cost-of-living implications. Action plans were in place to mitigate this, but the external risk factors remained very concerning.
- The Finance position was well controlled and there was no longer a deficit expected within the financial forecast at the end of the year due to the changes agreed to make 'agreements in principle' for Cases of Need to ensure that funds were made available only when monies were available to avoid a deficit materialising. In addition, the Committee agreed to set a minimum threshold level for the General Fund which would also mitigate future risks and the amount and approach would be agreed at the next meeting in May 2023.
- The Cases of Need process was working well, but there was still a need to further improve the Divisional Director's levels of understanding and ownership. This would be reviewed again after the Divisions present their 2023 Charitable Funds plans at the next meeting in May 2023.
- The Finance Strategy plan, which would be based upon a 'low risk' investment approach with the scope to maximise shorter term interest rates would be presented at the next meeting.

Lizzie Abderrahim, Non-Executive Director asked what actions were in place to mitigate if the charity was not able to raise appropriate amounts of funds. Paul Lewis, Chair of Charitable Funds replied that events were still planned for the the year but the charity were also looking at other avenues to raise funds which included opportunities with local businesses and legacies.

Minute **Description** **Action**

The Board **noted** the report.

260/22 **Gender Pay Gap Report 2021/22**

The Board received and considered the Gender Pay Gap report for 2021/22 and noted the following:-

- The report had been considered in detail at Trust Management Committee & Performance, Population & Place Committee were it had been approved and recommended for rafitication by the Board.
- The overall findings showed there had been a small deterioration in the mean hourly rates, but it was broadly the same as it was last year with the national pay scheme.
- The gaps included an increase in males at band 8a and above and also within the bonus pay gap which was largely down to more male consultants employed. It was noted that the national Clinical Excellence Awards were in line to be reviewed nationally.
- The Trust level agenda pay gap mean was 30% and median at 20%. Without medical and dental staff this reduced to 7% and 6% respectively and therefore the area of improvement was medical and dental but as the NHS worked within a national pay system there was limited scope to change the situation. It also takes longer for females to progress due to breaks in careers.
- The report included a high level action plan with a more detailed one to follow.

Andy Copestake, Non-Executive Director made the comment that the table on page 11 of the report showed a percentage mean gap ordinary hourly rate of pay for the Non-Executive Directors which was skewed by the Trust Chair's pay being higher than other Non-Executive Directors. Jude Gray, Chief People Officer replied that as this was a national template it was not possible to alter the format.

Lizzie Abderrahim, Non-Executive Director commented that inclusive recruitment practice was relevant to gender as well and asked what actions in this area were being undertaken. Jude Gray, Chief People Officer replied that there were a number of actions being explored which included licence to hire training, values recruitment and cultural embassadors. Felicity Taylor-Drewe, Chief Operating Officer added that the Trust had recently launched a Womens' Network and would invite feedback from this group on this particularly topic.

RESOLVED

to ratify the Gender Pay Gap Report for publication on 30 March 2023.

Consent Items

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

261/22 **Ratification of Decisions made via Board Circular**

None.

Minute	Description	Action

262/22 **Fit & Proper Persons Test Policy Update**
The Board received a paper that contained an updated Fit & Proper Persons Test Policy. The regulations had not changed since the last policy and therefore no significant changes to the policy document. One minor change was noted which was the governance process would now be via People & Culture Committee.

RESOLVED

to approve the Fit & Proper Persons Test Policy.

263/22 **Urgent Public Business (if any)**
None.

264/22 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 4 May 2023 at 9.30 am, at the Double Tree by Hilton, Swindon.

265/22 **Exclusion of the Public and Press**

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.

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – May 2023				
PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
		No actions		

Future Actions				
2-Feb-23	231/22	**Chief Executive's Report : Improving Together** 'One-year on' reflection report on Improving Together to include next steps	Chief Officer for Improvement & Partnerships	Q2
2-Feb-23	232/22	**IPR : Board Assurance Reports** Relook at format of Board Assurance Reports to ensure consistency of rag ratings across all committees	Company Secretary	End Q1 2023

Report Title	**Improving Together Staff Stories**						
Meeting	**Trust Board**						
Date	**4th May 2023**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]		Agenda Item [Added after submission]	
Accountable Lead	Claire Thompson, Chief Officer for Improvement & Partnerships						
Report Author	Emily Beardshall, Deputy Director of Improvement & Partnership						
Appendices	Metric refresh presentation recommendations from TMC						

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

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Process							
Significant		**Acceptable**	x	**Partial**		**No Assurance**	
High-level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

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

Two staff will attend Trust Board to share their reflections on being part of Cohort 3 of the Improving Together training.

The staff members are

- Hayley Moore – Ward Sister Beech Ward
- Alex Harrington – Head of Integrated Podiatry

The attached slides give a short overview of the Improving Together deployment and an overview of reflections from staff on the current cohort which has finished during April 23.

Cohort 4 training will begin in May and we are keen to build on reflections of staff to improve and refine our approach.

Links to Strategic Pillars & Strategic Risks – select one or more	★			
	x	x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)				**Risk Score**
	Improving Together is a key part of mitigation to BAFS1 – Outstanding Patient Care			/
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Improving Together Steering Group, Improvement Sub-Committee, Trust Management Committee			
Next Steps	• strategy. Process to begin in July 23.			

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?		X	
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	X		
Explanation of above analysis: The focus of Improving Together pillar metric 8 provides some assurance on the promotion of EDI within the trust.			

Recommendation / Action Required The Board 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	27/04/23

Great Western Hospitals
NHS Foundation Trust

Improving Together Staff Stories

Trust Board 4th May 23

Improving
together

What is Improving Together?

NHS
Great Western Hospitals
NHS Foundation Trust

Overview

- Improving Together is our Trust-wide approach to change, innovation and continuous improvement, introducing a consistent methodology across the organisation. It is based on the Catalysis Operational Excellence model and fulfils all the 5 components of the recommendation of the *NHS delivery and continuous improvement review* (published April 2023).
- 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.
- 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.

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"*

Strategic Framework

Great Western Hospitals NHS Foundation Trust

Our Vision

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

Outstanding care and a focus on quality improvement in all that we do	Staff & volunteers feeling valued and involved in helping improve quality of care	Improving quality of care by joining up acute and community services in Swindon and through partnerships with other providers	Using our funding wisely to give us a stronger foundation to support improvements in quality
1 Reducing Harm	6 Staff Retention	9 Emergency Attendances	11 Sustainability / Carbon footprint
2 Friends & Family Test	7 Staff Survey – % Recommend	10 No Criteria to Reside	12 GWH Financial Control Total
3 Waiting List > 65 weeks	8 Equality, Diversity & Inclusion		
4 Cancer Waiting Times			
5 Time in Emergency Dept			

Four strategic pillars

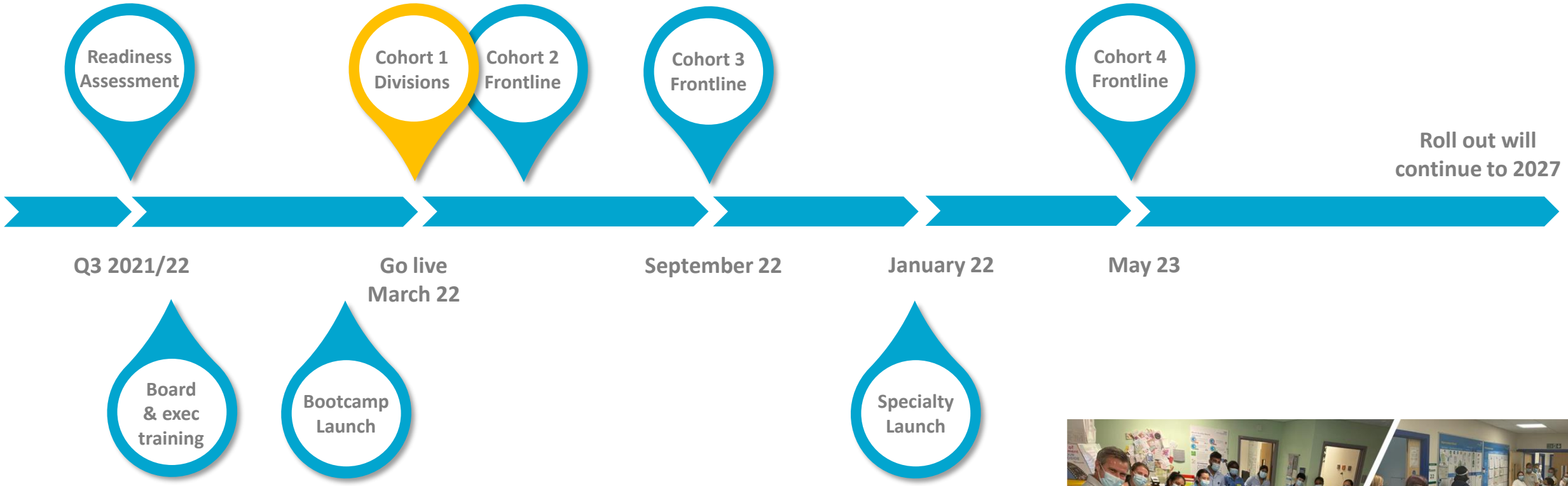
Pillar Metrics

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

Where are we in the improvement journey?

Great Western Hospitals NHS Foundation Trust

Implementation timeline



Staff Stories

Barbara

Cohort: 3

Frontline team: Beech Ward (Gynaecology Ward)

Role: Lead Divisional Pharmacist WC & SH

Barbara is the pharmacist who supports Beech ward. She has talked about the difference Improving Together training has made to the team.

Some challenges included

- It took time to get the team to focus on changes they could make rather than focus on the barriers to change and the things beyond our control.
- People in more senior roles making the shift from feeling like they had to make all the decisions and solve all the problems to leading a team to find the solutions that are right for them
- Taking the time out for coaching sessions during winter pressures

Early benefits

- The focus on the mindset shift for the whole team has made a difference to how we work together and solve problems
- Leadership behaviours being clear early on helped develop our approach and underpinned all we do throughout the team, giving all team members a voice and common language
- Helped the team prioritise ideas and build consensus as a team for changes they wanted to make

Quick wins are important at the beginning to help people engage

I am really glad to have been part of the programme it has helped to develop me alongside my educational supervisor training

Regular improvement huddles really cemented our understanding

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

Staff Stories

Alex

Cohort: 3

Specialty Team: Community Tissue Viability

Role: Head of Integrated Podiatry

Focusing on frontline teams leading change that is meaningful for them and their patients

Improving Together has given us a common language for improvement across all levels of the organisation helping us to support and challenge more effectively

Alex leads our Integrated Podiatry team and joined Improving Together cohort 3 as part of the community tissue viability specialty which was brought together for the training to support the community frontline teams.

Reflections

- Bringing teams together and supporting them to learn to work together is really important; putting organisational development at the front of the training helps. We need to support organic changes
- We need to manage expectations of teams that are starting out on their journey as some parts of the organisation are further ahead
- We need to be able to maintain our approach even during times of pressure
- Community services interact differently and we have had to operationalise Improving Together slightly differently; Coach House were great at facilitating this and working with the team

Hayley

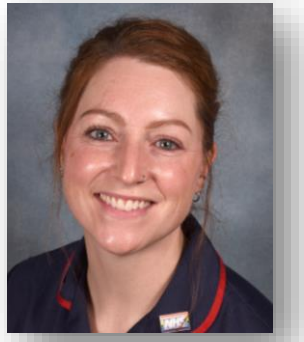
Cohort: 3

Frontline team: Beech Ward (Gynaecology Ward)

Role: Ward Sister

People sometimes found it hard to see how the training was relevant to them but it all started to make sense when we started improvement huddles on the ward

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



Hayley is the ward sister on Beech ward and has played a key leadership role in the team training during cohort 3.

Reflections

- There is a big responsibility for the ward manager and other team leaders, we need to think through how we support them
- Sometimes the routines feel “on top of” our day to day work and we hope this will change over time.
- The approach has helped us have space for improvements during our day and a chance for all staff to get involved in the discussion
- Medical engagement has been low within the team, not helped by the range of specialties that have patients on the ward
- Our improvement board is a focal point and something the team are proud of

Report Title	**Ockenden Report – GWH Update**				
Meeting	**Trust Board**				
Date	**4th May 2023**	Part 1 (Public) [Added after submission]	X	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek (Chief Nurse)				
Report Author	Lisa Marshall, Kat Simpson & Laura Little				
Appendices	None				

Purpose

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

Assurance Level

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

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

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

Report

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

A progress update on the Immediate & Essential Actions (IEAs) outlined in the full Ockenden Report including key highlights for celebration and continued key risks. A SWOT analysis on GWH Ockenden RED Immediate & Essential Actions.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	X	X	X	X	X
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	X		X	X	X
Key Risks – risk number & description (Link to BAF / Risk Register)	ID: 572				**Risk Score**
	There is a risk that mothers and babies are at risk of potential harm in the event of not achieving all 15 immediate and essential actions as outlined in the full Ockenden Report (published March 2022) Risk has been reviewed and is in date.				9
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps					

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

Explanation of above analysis:

None of the Immediate and Essential Actions (IEAs) focus on historically under-represented groups and therefore is not directly referenced in the content. The perinatal team ensure that all improvement workstreams prioritise equality, diversity, and inclusion for all service users.

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ **Understand the progress against the Immediate and Essential Actions and their impact on the development of the perinatal strategy for access to safe maternity care and potential risks of non-compliance.**	
Accountable Lead Signature	
Date	27th April 2023

Ockenden Report – GWH Update

Lisa Marshall — Director of Midwifery and Neonatal Services
Kat Simpson — Head of Midwifery and Neonatal Services
Laura Little — Project Co-ordinator

Background of Ockenden Report & GWH Timeline

Great Western Hospitals NHS Foundation Trust

March 2021 — Phase One Report published

June 2021 — Phase One Report evidence submitted

February 2022 — Ockenden One Year On update to Trust Board

March 2022 — Full Report published

July 2022 — Self Assessment of Full Report presented to board inc. identification of risks & investment requirements

October 2022 — Successful national funding submission obtained

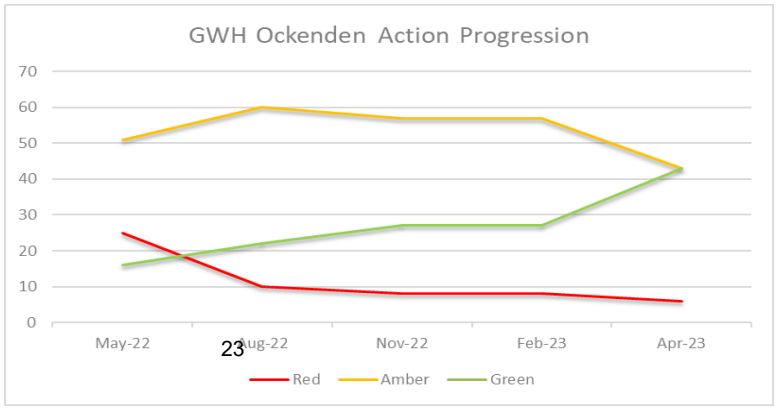
April 2023 — Submitted business case to support future compliance of CNST & Ockenden

May 2023 — Ockenden Full Report One Year On update to Trust Board

GWH Ockenden Progress Summary:

- Significant increase in 'green' Immediate and Essential actions following a deep dive into the 'amber' actions.
- This has been influenced by associated progress achieved against the Clinical Incentive Scheme for Trusts (CNST) and compliance with local audits initiated following publication of the Ockenden report in March 2022
- Funding secured to support expansion of bereavement services, consultant job planning to support patient safety agenda and support worker development
- Next steps include further workforce planning to support full compliance

	RED	AMBER	GREEN
May 2022	25	51	16
Nov 2022	8	57	27
April 2023	6 ↓	43 ↓	43 ↑



Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 1: Workforce Planning & Sustainability

Financing a safe maternity workforce. The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented

Training. We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented

GWH Self Assessment (April 2023)

2	7	2

Immediate & Essential Action Detail (IEA 1 : Workforce Planning & Sustainability) - Financing a safe maternity workforce The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
1. The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England	AMBER	AMBER	
2. Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	AMBER	AMBER	
3. Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	AMBER	AMBER	
4. The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	AMBER	AMBER	

Key Highlight for Celebration:

- Engagement with workforce planning across Local Maternity & Neonatal System (LMNS)
- Inclusion of increased headroom for education & training in business planning

Continued Key Risks:

- Establishment of safe staffing levels in line with local acuity
- A validated safe staffing tool is essential for workforce planning

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 1: Workforce Planning & Sustainability

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GWH Self Assessment (April 2023)		
2	7	2

Immediate & Essential Action Detail (IEA 1 : Workforce Planning & Sustainability) - Training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	GWH RAG (01.06.2022)	GWH RAG (31.042023)	KEY IMMEDIATE ACTIONS
5. All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this	AMBER	AMBER	Successful bid for funding to support preceptorship period.
6. All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	AMBER	GREEN	
7. All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	RED	RED	Engagement with UWE & LMNS to establish nationally recognised education module to be included in ongoing Maternity Education Programme
8. All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development	AMBER	AMBER	
9. All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	AMBER	AMBER	
10. All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience	RED	RED	Engagement in National Head of Midwifery network and use of Royal College of Midwives (RCM) Toolkit to undertake succession planning
11. The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	AMBER	GREEN	

Key Highlight for Celebration:

- Funded education package to enable staff to access a High Dependency module to ensure 24/7 provision by suitably skilled staff
- Inclusion of increased headroom for education & training in business planning
- Scoping of succession planning programme for Senior Managers and Clinical posts underway
- Committed engagement in establishment of regional Maternal Medicine Networks
- Operational planning to ensure no Newly Qualified Midwives (NQM) are allocated to the Community setting during their first year post qualification

Continued Key Risks:

- Informal strategy in place supporting staff with career progression. Strategies to be formalised by 1st July 2023.
- Availability of nationally recognised Labour Ward Coordinator education module

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 2: Safe Staffing

All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.

GWH Self Assessment (April 2023)		
1	5	4

Immediate & Essential Action Detail (IEA 2 : Safe Staffing)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS s
12. When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	AMBER	AMBER	Operational review of escalation policy in progress
13. In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	RED	RED	Complete Risk Assessment and Improvement Plan
14. All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	GREEN	GREEN	
15. All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	AMBER	GREEN	Impact of Maternity Continuity of Carer on staffing levels monitored via 6 monthly Safer staffing paper
16. The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	AMBER	GREEN	
17. The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	AMBER	AMBER	
18. All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	RED	AMBER	Inclusion of additional roles within Business Planning. Undertaking associated recruitment process
19. Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	AMBER	GREEN	
20. All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	AMBER	AMBER	
21. All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction	AMBER	AMBER	

Key Highlights for Celebration:

- Implementation of an effective mentorship and coaching programme for senior midwives to support leadership and management
- Continued work on Escalation Policy to include the visibility of staffing concerns and communication channels with Local Maternity & Neonatal System (LMNS)
- Continued provision of one Continuity of Carer team focussing on the geographical area with the demographic of highest index of multiple deprivation
- Inclusion in business planning of supernumerary Clinical Skills Facilitators across all settings

Continued Key Risks:

- Full review of the Obstetric and Gynaecology workforce and provision of clear escalation policy for periods of competing workload may be delayed without publication of RCOG guidance

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS

Immediate & Essential Action 3: Escalation and Accountability

Staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.

GWH Self Assessment (April 2023)		
0	2	3

Immediate & Essential Action Detail (IEA 3 : Escalation & Accountability)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
22. All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	GREEN	GREEN	
23. When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	RED	AMBER	
24. Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	AMBER	AMBER	To be undertaken as part of review & improvement planning for Obstetric & Gynaecology workforce
25. There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit	AMBER	GREEN	
26. There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	AMBER	GREEN	

Key Highlights for Celebration:

- Further development of Escalation Policy to include clear guidelines for assurance process on staff competency levels
- Established system for audit of Consultant attendance for mandated emergency situations and escalation
- Updated guidance to ensure clarity on when consultant attendance is required. Monitoring process introduced to identify future areas of learning and improvement
- Obstetric Consultant job planning for 2023/24 has been undertaken with consideration of Ockenden requirements

Continued Key Risks:

- Full review of the Obstetric and Gynaecology workforce and provision of clear escalation policy for periods of competing workload may be delayed without publication of RCOG guidance

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 4: Clinical Governance (Leadership)

Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.

GWH Self Assessment (April 2023)		
0	4	3

Immediate & Essential Action Detail (IEA 4 : Clinical Governance - Leadership)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
27. Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans	GREEN	GREEN	
28. All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	AMBER	AMBER	
29. Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	AMBER	GREEN	
30. All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	AMBER	GREEN	
31. All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	RED	AMBER	Formal orientation program to be implemented
32. All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	AMBER	AMBER	Increased consultant PA time included in job planning- to commence July 2023
33. All maternity services must ensure they have midwifery and obstetric co-leads for audits.	AMBER	AMBER	Increased consultant PA time included in job planning- to commence July 2023

Key Highlights for Celebration:

- Further development of in house training to ensure continual focus on “Human Factors”
- Funding obtained to support the identification of Obstetric Co-Lead for development of guidelines and audits
- Continued work on implementation of National Maternity Self Assessment Tool
- Review of Risk and Governance Team roles and responsibilities to align with Patient Safety Incident Response Framework (PSIRF)

Continued Key Risks:

- No risks identified

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals

Immediate & Essential Action 5: Clinical Governance (Incident Investigation & Complaints)
Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner

GWH Self Assessment (April 2023)		
0	3	4

Immediate & Essential Action Detail (IEA 5 : Clinical Governance - Incident Investigation & Complaints)	GWH RAG (01.06.2022)	GWH RAG (31.04.2023)	KEY IMMEDIATE ACTIONS
34. All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	AMBER	GREEN	
35. Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	AMBER	GREEN	
36. Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred	AMBER	GREEN	
37. Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	AMBER	AMBER	Assurance trackers in place to monitor progress
38. All trusts must ensure that complaints which meet SI threshold must be investigated as such.	AMBER	GREEN	
39. All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	AMBER	AMBER	Formal pathway to be developed with MVP
40. Complaints themes and trends must be monitored by the maternity governance team.	AMBER	AMBER	Patient experience co-ordinator role included within business planning for CNST rebate

Key Highlights for Celebration:

- Further strengthening of learning from events within local training provision
- Introduction of Maternity specific Complaints Manager role to be based within the Maternity Governance team
- Inclusion of Patient Experience Co-ordinator role in business planning
- Robust audit programme to monitor changes in practice following learning from incidents

Continued Key Risks:

- Seeking assurance that local action plans from serious incidents meet Ockenden criteria for completion within six months

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 6: Learning From Maternal Deaths

Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.

GWH Self Assessment (April 2023)

0	0	3

Immediate & Essential Action Detail (IEA 6 : Learning from Maternal Deaths)	GWH RAG (01.06.2022)	GWH RAG (31.04.2023)	KEY IMMEDIATE ACTIONS
41. NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.	AMBER	GREEN	
42. This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	GREEN	GREEN	
43. Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	AMBER	GREEN	

Key Highlights for Celebration:

- Alignment of local policies across the Local Maternity and Neonatal system to ensure alignment with revised National standard
- Learning from regional and national maternal deaths is reviewed when available. The provides an opportunity for a Trust level self-assessment and implementation of changes in practice where applicable

Continued Key Risks:

- No risks identified

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 7: Multidisciplinary Training

Staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.

GWH Self Assessment (April 2023)		
0	1	6

Immediate & Essential Action Detail (IEA 7 : Multidisciplinary Training)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
44. All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	RED	GREEN	
45. Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	GREEN	GREEN	
46. All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	AMBER	GREEN	
47. There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	GREEN	GREEN	
48. There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	AMBER	GREEN	
49. Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	GREEN	GREEN	
50. Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	AMBER	AMBER	**Full compliance anticipated in May 2023 following completion of current PROMPT program**

Key Highlights for Celebration:

- Effective workforce planning enables multi-disciplinary attendance opportunity at Perinatal Learning Forum
- Established training database supports full compliance with maternity specific mandatory training
- Formalisation of debriefing processes for staff to provide psychological & wellbeing support
- Development & implementation of stand alone human factors training for all maternity staff
- Inclusion of increased headroom for education & training in business planning

Continued Key Risks:

- No risks identified

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 8: Complex Antenatal Care

Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy

GWH Self Assessment (April 2023)		
0	4	1

Immediate & Essential Action Detail (IEA 8 : Complex Antenatal Care)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
51. Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	RED	AMBER	
52. Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	AMBER	AMBER	
53. NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes	AMBER	AMBER	Ratification of local audit program with associated improvement plans where indicated
54. When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	AMBER	AMBER	
55. Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	GREEN	GREEN	

Key Highlights for Celebration:

- Established referral pathway for women with pre-existing medical conditions.
- Continued work with wider public health bodies & our Maternity Voice Partnership for improved access to maternity healthcare & communication to our service users
- Co-production with Maternity Voices Partnership (MVP) of a tool for documentation of evidence-based advice & decision making in partnership with women

Continued Key Risks:

- Antenatal clinic capacity
- Engagement with National agencies to understand the requirements for a specialist midwifery team for multifetal pregnancies

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 9: Preterm Birth
The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)

GWH Self Assessment (April 2023)

0	0	4

Immediate & Essential Action Detail (IEA 9 : Preterm Birth)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
56. Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	GREEN	GREEN	
57. Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	GREEN	GREEN	
58. Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	GREEN	GREEN	
59. There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	GREEN	GREEN	

Key Highlights for Celebration:

- Continue learning from excellence locally, regionally and Nationally
- Implementation of recommendations from National audits to ensure appropriate birth setting
- Perinatal team nominated for regional award celebrating implementation of nationally recognised PERI-prem pathway

Continued Key Risks:

- No risks identified

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 10: Labour and Birth

Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units

GWH Self Assessment (April 2023)		
0	4	2

Immediate & Essential Action Detail (IEA 10 : Labour and Birth)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
60. All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	AMBER	AMBER	On-going audit in place to monitor
61. Midwifery-led units must complete yearly operational risk assessments	AMBER	AMBER	
62. Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	GREEN	GREEN	
63. It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	RED	AMBER	Audit of newly introduced documentation to ensure practice embedded
64. Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	AMBER	AMBER	Operational review of escalation policy in progress
65. Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	AMBER	GREEN	

Key Highlights for Celebration:

- Development of clear pathway in close collaboration with South West Ambulance Service Trust to ensure access to transfer times and potential delay are minimised, and where unavoidable this information is available to women birthing in the community
- Implementation of funded central CTG monitoring system (launched February 2023)

Continued Key Risks:

- No risks identified

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

NHS Great Western Hospitals

Immediate & Essential Action 11: Obstetric Anaesthesia

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed

GWH Self Assessment (April 2023)

1	4	3

Immediate & Essential Action Detail (IEA 11 : Obstetric Anaesthesia)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
66. Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	GREEN	GREEN	
67. Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	AMBER	AMBER	
68. All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	AMBER	AMBER	
69. Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance	RED	RED	Engagement with national professional bodies to ensure local core data sets are in line with national standards
Obstetric anaesthesia staffing guidance to include: 70. The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	GREEN	GREEN	
Obstetric anaesthesia staffing guidance to include: 71. The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity	AMBER	AMBER	
Obstetric anaesthesia staffing guidance to include: 72. The competency required for consultant staff who cover obstetric services out-ofhours, but who have no regular obstetric commitments	GREEN	GREEN	
Obstetric anaesthesia staffing guidance to include: 73. Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report	AMBER	AMBER	

Key Highlights for Celebration:

- Audit of pathways to explore opportunities for further improvements to patient experience
- Active role in obstetric ward rounds

Continued Key Risks:

- A lack of national alignment in anaesthetic core dataset may negatively impact learning from anaesthetic events

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS

Immediate & Essential Action 12: Postnatal Care

Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times

GWH Self Assessment (April 2023)		
0	3	1

Immediate & Essential Action Detail (IEA 12 : Postnatal Care)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
74. All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward.	AMBER	AMBER	Audit of compliance to be undertaken
75. Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	AMBER	AMBER	Audit of compliance to be undertaken
76. Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	AMBER	AMBER	Audit of compliance to be undertaken
77. Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	AMBER	GREEN	

Key Highlights for Celebration:

- Local escalation policy enables effective monitoring of staffing levels on post natal ward

Continued Key Risks:

- Lack of timely and effective care in postnatal period may result in poor patient outcomes
- Potential increase in obstetric consultant workforce may require future investment over the next 2-3 years

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 13: Bereavement Care

Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.

GWH Self Assessment (April 2023)		
0	1	3

Immediate & Essential Action Detail (IEA 13 : Bereavement Care)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
78. Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday	AMBER	GREEN	
79. All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	AMBER	AMBER	**Newly introduced bereavement role to enable increased training for undertaking post-mortem consent**
80. All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	GREEN	GREEN	
81. Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	GREEN	GREEN	

Key Highlights for Celebration:

- Funding secured for expansion of Maternity and Paediatric Support Service
- Increasing access to training opportunities for staff
- Successful national funding bid achieved with money allocated (£67,720 non recurrent payment) to support:
- Development of Bereavement Champion roles to ensure 24/7 access to service
- Obstetric consultant governance PA
- Development of Maternity Support Worker (MSW) workforce

Continued Key Risks:

- No risks identified

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 14: Neonatal Care

There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.

GWH Self Assessment (April 2023)		
2	2	4

Immediate & Essential Action Detail (IEA 14 : Neonatal Care)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
82. Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	GREEN	GREEN	
83. Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly	GREEN	GREEN	
84. Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	GREEN	GREEN	
85. Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	RED	RED	Engagement with Neonatal Operational Delivery Network to establish Regional enhanced experience programme.
86. Each network must report to commissioners annually what measures are in place to prevent units from working in isolation	RED	RED	Engagement with Neonatal Operational Delivery Network to establish Regional enhanced experience programme.
87. Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	AMBER	AMBER	
88. Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	GREEN	GREEN	
89. Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	AMBER	AMBER	

Key Highlights for Celebration:

- Engagement with GIRFT neonatology deep dive with improvement plan developing
- Full recruitment in to the advance neonatal nurse practitioner (ANNP) pathway

Continued Key Risks:

- Lack of shared learning and experiences may reduce the skills and development in the Neonatal workforce
- Potential risk of increasing backfill costs to support rotation of staff attending other provider Trusts within Network. A model for rotation will be developed with the Operational Delivery Network for Neonatal Care

Summary of Immediate and Essential Action Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Immediate & Essential Action 15: Supporting Families

Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care

GWH Self Assessment (April 2023)

0	3	0

Immediate & Essential Action Detail (IEA 15 : Supporting Families)	GWH RAG (01.06.2022)	GWH RAG (30.04.2023)	KEY IMMEDIATE ACTIONS
90. There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	RED	AMBER	Anticipated green following evaluation of the OCEANS service
91. Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences	AMBER	AMBER	Anticipated green following evaluation of the OCEANS service
92. Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	AMBER	AMBER	Training funded and scheduled for 2023/24

Key Highlights for Celebration:

- Launch of the OCEANS psychological support service
- Division wide train the trainer program in order to ensure effective recognition of psychological distress scheduled for 2023/24

Continued Key Risks:

- No risks identified

SWOT Analysis on Ockenden RED Immediate & Essential Actions

Great Western Hospitals NHS

IEA Detail	Strengths	Weaknesses	Opportunities	Threats	Anticipated Timescale for Improvement
• Implementation of nationally accredited education module for Labour Ward Coordinators	Existing experienced team of coordinators who are sharing learning via team meetings Local away days for team facilitated focusing on the role and responsibilities including sessions on psychological safety, civility, and courageous conversations.	Local provision cannot be benchmarked due to lack of available National guidance or education provision for coordinators	Influence content of national program via engagement with higher education institutions	Delays in implementation due to lack of availability of educational module Release of staff from clinical duties; this will be directly impacted by the length of the course	1st September 2023
• Succession planning programme and development of ongoing leadership opportunities	Recruitment and retention of senior team within maternity Recent recruitment has demonstrated engagement and enthusiasm for career progression resulting in a high level of internal applications	No local documented strategy for succession planning	Development of a Maternity and Neonatal Strategy to complement the Trust pillars including staff and volunteers feeling valued	Alignment to revised Trust strategy for publication 2024 may impacted on timescale for achievement	Gap analysis of leadership role to be completed by 1st July 2023 Published strategy April 2024
• Risk assessment of competing workloads for combined consultant rotas for Obstetrics and Gynaecology	Increase in consultant availability following preliminary Ockenden report which has been sustained No patient safety incidents relating to lack of available consultant availability	Change in clinical leadership has impacted on timescale for completion	Publication of National workforce assessment tool by the Royal College of Obstetricians and Gynaecologists (RCOG) (publication date not released correct 28th March 2023)	Report may be delayed without publication of RCOG guidance	1st October 2023

SWOT Analysis on Ockenden RED Immediate & Essential Actions (cont'd)

Great Western Hospitals NHS Foundation Trust

IEA Detail	Strengths	Weaknesses	Opportunities	Threats	Anticipated Timescale for Improvement
• Establishment of national quality metrics for monitoring anaesthetic indicators to maximise engagement and compliance	Engagement of local anaesthetic consultant with National and regional team Recent Anaesthesia Clinical Services Accreditation (Royal College of Anaesthetists) quality assurance visit provided the Trust with positive feedback on standards of documentation	National resources not yet available	Local engagement and influence on National standards	Delays in benchmarking due to lack of availability of national resources	1st September 2023
• Regional rotational opportunities for Neonatal staff to prevent units working in isolation • Establishment of annual reporting of these opportunities to commissioners	Good local and regional representation at regional meetings and events including Engagement Meeting and bi-annual Education Forum, which provide widespread dissemination of emerging and best practice across all staff groups and grades. Education Working Group well embedded. Regional Foundation Education Programme launched in November 2022.	Operational challenges with cross site working and contracts	Clinical exposure across unit levels, being planned through Medical Workforce Working Group and will include ANNP and Nursing staff groups Operational Delivery Network to develop annual report for commissioners on the measures being undertaken (timescale not confirmed)	Operational complexity due to network size and geographical orientation	1st September 2023

Ockenden Report (2022)

NHS
Great Western Hospitals
NHS Foundation Trust

Enabling safer maternity care

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**4 May 2023**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

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

Assurance Level

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

Process

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

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

Report

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

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

The report provides information in respect of:-

- Council of Governors
- Non-Executive Directors
- Strengthening Board Oversight
- Local Update
- Key Meeting Dates.

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	17 April 2023

Chair's Board Report

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust and externally during February 2023.

1. Trust Update - NHS New Provider Licence

1.1 On 27 March 2023, NHS England launched the new NHS provider licence, which forms part of the oversight arrangements for all NHS providers, such as our Trust.

1.2 The provider licence serves as the legal mechanism for any formal regulatory intervention and underpins mandated support for the most challenged providers.

1.3 A need to change the licence has arisen from changes to the statutory and operating environment, including a shift of emphasis from economic regulation and competition to system working and collaboration. The changes will bring the licence up to date, reflecting the new legislation and supporting providers to work effectively as part of integrated care systems (ICSs).

1.4 The new provider licence aims to support effective system working, enhance the oversight of key services provided by the independent sector, address climate change and make a number of necessary technical amendments.

2. Council of Governors

2.1 Working Groups – The governors held 2 working groups during March & April; Engagement & Membership and People's Experience & Quality working groups. They also held a face-to-face get together, the first post covid, on 24 March 2023 which was well attended.

2.2 Public Health Talk – A very successful health talk, hosted by the governors, was held on 28 March 2023 on the Menopause, and we thank David Griffiths, Consultant Gynaecologist for taking the time to present this very well attended talk.

2.3 Council of Governors Meeting – The next Council of Governors meeting will take place on 10 May 2023 at 5.00pm and will be held virtually. Further details will be found on the Trust's website in due course.

2.4 Monthly Meeting with Lead Governors - The regular monthly meetings were held with the Lead Governors.

3. Non-Executive Directors

3.1 Appointments - Welcome to the newly appointed Non-Executive Directors Dr Claudia Paoloni, Will Smart, Bernie Morley and Associate Non-Executive Directors Dr Rommel Ravanan and Dr Claire Lehman. Julian Duxfield has joined as a Non-Executive Director Designate and will attend all future Board meetings.

3.2 Quality & Safety Committee - Claudie Paoloni, Non-Executive Director has taken over as Chair of the Quality & Safety Committee from Nick Bishop who will be on hand to give any advice as his tenure as Non-Executive Director comes to an at the end of June. On behalf of the Board, I would like to thank Nick for his significant contribution as chair of the Quality & Safety Committee over many years. Nick will remain as Senior Independent Director (SID), as well as his other roles as Board's FTSU representative and NED responsible for oversite of Maintaining High Professional Standards (MHPS) until the end of his tenure and I will commence the process to appoint a new SID from 1 July 2023.

4 Strengthening Board Oversight

4.1 Board Seminar – A Board seminar was held last month, April 2023, in line with the agreed Board timetable, and the focus was on the Board's role in leading and developing an inclusive and compassionate culture. The day was split into two parts with the morning session focussed on the importance of cultural intelligence in developing an equitable culture and the second session on restorative Just Culture. Both sessions were externally facilitated and we thank both Northumbria University and Mersey Care NHS FT and Above Difference for an informative day.

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

Date	Area	Board Member
16 March 2023	UTC	Lisa Cheek, Chief Nurse Paul Lewis, Non-Executive Director
20 March 2023	Beech Ward	Lisa Cheek, Chief Nurse Liam Coleman, Chair
26 April 2023	Linnet Ward	Jon Westbrook, Chief Medical Officer Claudia Paoloni, Non-Executive Director

5. Key Meetings during March and April 2023

Meetings	Purpose
Bi-monthly meeting with Chair/Deputy Chair/ Senior Independent Director	Regular meeting to update and discuss any topical issues
Bi-monthly meeting with Non-Executive Directors/Associate Non-Executive Directors	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
EPR Update	Monthly update meeting

Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
BSW Chairs catch up	Regular meeting bringing together healthcare providers within the BSW ICS
Board Development session for Non-Executive Directors/Associate Non-Executive Directors with Francis Stickland, Bluegrain	Board development session which included the some of the new Non-Executive Directors
South West Wellbeing Guardian Network	Regional network to provide an opportunity to provide feedback on emerging health and wellbeing topics and influence both regional and national health and wellbeing strategy.
HWB Oversight Committee	Attendee of committee
BSW AHA Programme Directors 2023 meeting	Attendee
AHA CIC/ICB Leads Away Day	Development session
AHA Committees in Common	Regular meeting
BSW AHA 6-weekly check in call	Regular meeting
Mental Health Governance Committee	Attendee of committee
Finance, Infrastructure & Digital Committee	Attended Board Committee as observer
Extraordinary Finance, Infrastructure & Digital Committee	Attended Board Committee as observer
Performance, Population & Place Committee	Attended Board Committee as observer
NHS Providers "Being an anchor institution in tackling health inequalities"	The event explored innovative approaches trusts are taking to deliver their ambitions to be anchor institutions within their local communities and what has worked well in their journeys to embed anchor working.
Visit by Councillor Clewer to GWH	Leader and cabinet member for Health & Wellbeing Wiltshire Council

Report Title	**Chief Executive's Report**				
Meeting	**Trust Board**				
Date	4 May 2023	**Part 1 (Public) [Added after submission]**	**X**	**Part 2 (Private) [Added after submission]**	
Accountable Lead	Chief Executive Officer				
Report Author	Kevin McNamara, Chief Executive Officer				
Appendices	N/A				

Purpose

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

Assurance Level

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

Board members are asked to note the report.

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

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

The Chief Executive's report provides an overview of a broad range of current issues at the Trust themed around operations, quality, systems and strategy, and workforce, wellbeing and recognition.

Report

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

This report includes updates on:

- Industrial action
- Changes to the way we manage Covid-19
- Improving services for our outpatients
- National updates on Improving Patient Care Together, the Hewitt Review and the NHS England Maternity Plan
- Staff Survey 2022 results
- Staff Excellence Awards

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

Next Steps	

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

The report includes details of our Staff Survey 2022 results. These cover a broad spectrum of issues at the Trust, but in particular the survey seeks staff views on issues including discrimination, which is one of the key areas of focus this year.

The report provides an update on our new Women's Network, which was launched last month. This new network was created following staff feedback, and now sits alongside our existing BAME, LGBTQ+ and Differently Abled staff networks and will give a collective voice to staff and opportunities to influence change for the women who work right across the Trust.

The finalists for our Staff Excellence Awards are featured in the report and these awards include a category to recognise members of staff who have gone out of their way to champion equality, diversity and inclusion in the workplace.

The report also mentions our recent NHS Pastoral Care Quality Award in recognition of our work in international recruitment and our commitment to providing high-quality pastoral care to internationally educated nurses and midwives during recruitment processes and their employment.

Recommendation / Action Required
The Board/Committee/Group is requested to:

- **Note the report**

Accountable Lead Signature	
Date	28.4.23

1. Operational updates

1.1. Industrial Action

1.1.1. British Medical Association action

Strike action involving British Medical Association (BMA) junior doctors took place for 96 hours from 6.59am on 11 April to 6.59am on 15 April inclusive.

This action, taken as part of the dispute between the British Medical Association and the Government about pay for junior doctors, followed the 72-hour action taken in March.

We once again declared a Business Continuity Incident at the start of the strike, which was stood down once it was completed.

During this very busy period, many of our staff once again went above and beyond to reduce the impact on the care we provide. Many staff cancelled their annual leave, or did not take leave when they would have normally chosen to spend time with their families, in order to support our response. Several Consultants, Specialty and Specialist Doctors, and Advanced Care Practitioners once again undertook different tasks and performed unfamiliar roles to enable us to provide safe levels of care.

We have 379 Junior Doctors in total and a significant number of this group chose to strike on one or more days of the two rounds of BMA industrial action.

More than 1,000 outpatient appointments and a number of operations were cancelled and rescheduled at short notice during the two strikes, however these cancellations only reflect part of the impact on patients, with other activity deliberately not arranged to coincide with strike days.

Regular incident control meetings involving Executives, Divisional Directors, and senior operational staff were held throughout the course of the industrial action in the Coordination Centre.

My thanks go to everyone involved in preparing for and responding to the strike.

1.1.2. Royal College of Nursing action

The Royal College of Nursing was due to hold a 48-hour strike from 8pm on 30 April to 8pm on 2 May, which would include the first May bank holiday. Following a challenge by the government in the High Court the action will now take place until 11.59pm on the Bank Holiday Monday.

This action followed the RCN’s members rejecting the Government’s pay offer. The RCN has also said it will re-ballot members for further strike action.

This strike will be without derogations and as such will include areas such as emergency and critical care for the first time. An update on the impact of this action will be provided at the Board meeting.

1.1.3. NHS Staff Council

Unison and Royal College of Midwives members voted to accept the Government's Agenda for Change pay offer and the results of other health union ballots were expected ahead of the NHS Staff Council meeting to discuss the pay offer on 2 May.

Until the dispute is resolved, we will continue to plan for strikes directly affecting our staff, along with industrial action in other public sectors which will impact upon our ability to run services – such as in education – and hope the ongoing disputes between unions and the Government are resolved as soon as possible.

It is clear that ongoing industrial action by a number of unions will continue to have a material impact on the operation of the NHS and our Trust each time impacting our ability to deliver the ambitious recovery plan we have set ourselves reinforcing the need for resolution at a national level.

2. Quality

2.1. Infection Prevention and Control changes

Following updated national guidance from the Government, acting on advice from the UK Health Security Agency, we made changes to the way we manage Covid-19 last month, bringing our approach more in line with the way we manage influenza.

The key changes are:

Testing:

- Patients should only be tested if symptomatic and it's necessary for diagnostic purposes.
- Testing of asymptomatic patients is only needed when discharging to another care setting.
- Symptomatic staff don't need to take a Covid test but should stay at home until they don't have a temperature or don't feel unwell. Exceptions apply to staff on Dove ward, the Day Therapy Unit and Coate Water Unit who require negative tests before returning to work.

Masks:

- Wearing of masks is now voluntary in all areas – except for oncology and haematology – for staff, patients and visitors.
- There is no requirement to wear masks when attending to patients in their own homes and in our front-door departments.
- Masks must continue to be worn when caring for patients with particular infections or undertaking specific procedures.
- We have moved away from the Covid Escalation Framework and are taking a more targeted approach – where outbreaks occur, masks may be used as control measure.

- We have said to staff that anyone who wishes to continue to wear a mask can do so – and we should respect everyone's views on this.

2.2. Preparing for a Perfect Week

Towards the end of April, we held a week-long event to find out how we can improve services for our outpatients.

Using Improving Together principles, we set out to understand why not all patients attend their appointments, why clinics do not always operate at 100% capacity, and whether clinical space was being fully utilised.

Across the seven days, 42 Go and See visits to the Wren unit, ENT and Cardiology departments took place. We received 32 improvement suggestions from clinicians.

Using the data, soft intelligence and learnings collected we will consider how we can improve our services for the long-term with the aim of holding a Perfect Week later in the year. This will be an opportunity to test our improvements across selected departments and look to identify further areas for change.

2.3. Care Coordination System

We have launched a new digital solution to help improve patient care and reduce the time patients have to wait for treatment.

The Care Coordination Solution uses modern data technology to help us reduce the elective waiting list, maximise our theatre utilisation, and ensure that the right patients are booked at the right time.

The solution will provide service managers, clinicians and admissions with web-based applications to effectively manage the elective waiting list, review upcoming theatre sessions and schedule bookings.

Initially, training for this software is being given to admissions, theatre teams and consultants, who will see several benefits, including:

- Allowing patients with a higher clinical need to be identified and seen sooner.
- Reducing waiting times through regularly checking that those on the lists still need our care or if their condition has changed.
- Better patient safety, with consultants able to see a full picture of patient information all stored in one system, meaning better decisions can be made about what care the patient needs.
- Time saving, as clinical and operational staff experience fewer manual workarounds.
- Improved control of theatre facilities, with consultants able to see all the theatre utilisation allowing them to schedule operations appropriately.

Where this system has been used in other parts of the NHS, improvements in patient management and theatre utilisation have been reported.

3. Systems and Strategy

3.1. Improving Patient Care Together

Last month NHS England published the findings of its review of delivery and continuous improvement in the NHS, and launched its new approach to improvement, NHS Impact.

NHSE plans to establish a national improvement board, which will agree national priorities for improvement-led delivery and co-design and establish a Leadership for Improvement programme.

We already have our own well-established Improving Together approach to improvement, and this national development highlights the importance of continuing to embed this methodology and new way of working through the operational management system.

3.2. NHS England Maternity Plan

NHS England has approved a three-year delivery plan for maternity and neonatal services.

The plan identifies 12 objectives across four themes, bringing together actions from recent national reports into maternity (including the Ockenden and Kirkup reports) as well as the NHS long-term plan and maternity transformation programme.

The themes and objectives are:

Listening to and working with women and families with compassion
- All women to receive compassionate personalised care
- Improve equity for mothers and babies by addressing key health inequalities
- Involve service users in quality, governance and co-production

Supporting the workforce
- Grow the workforce
- Retain the workforce
- Invest in skills

Developing and sustaining a culture of safety
- Developing a positive safety culture
- Learning from safety incidents and improving
- Support and oversight of maternity and neonatal services from trusts and ICBs

Meeting and improving standards and structures
- Implement best practice
- Use data well
- Develop and improve use of digital technology.

3.3. Hewitt review

Former Health Secretary, and current Chair of NHS Norfolk and Waveney Integrated Care Board, Patricia Hewitt's review into integrated care systems, commissioned by Chancellor Jeremy Hunt, was published last month.

The key recommendations of the report include:

- Reducing the number of targets set at a national level.
- Developing high accountability and responsibility partnerships for more mature systems.
- More investment in prevention, including increasing the public health grant allocation.
- Reducing use of short-term funding pots.
- Reviewing the entire NHS capital regime.

We await the next steps on how the recommendations of the review may be implemented.

4. Workforce, wellbeing, and recognition

4.1. Staff Survey 2022

Our Staff Survey results for 2022 were published in March and saw us place eighth in the country and highest in the region for our response rate, with 59 per cent of staff members sharing their feedback.

Our overall scores place us 11th in the region, up from 17th the previous year.

This successful rise was due to a number of positive improvements in many areas, including the two most improved People Promises compared with 2021 which were 'we are always learning' and 'we work flexibly'.

In comparison to 2021, we also saw a six per cent increase for questions surrounding career development, a five per cent increase in staff feeling that their team meets regularly to discuss effectiveness and a 4.5 per cent increase in staff feeling that the organisation takes positive action on health and wellbeing.

This year, we were just 3.8 points off reaching the top position, and work is underway to evaluate further areas for improvement to help us move up the league table even more next year.

We are also consistently tracking at the national average – for the last five years – within People Promise 3, 'we each have a voice that counts', that relates to questions around autonomy, control and raising concerns.

A Staff Survey working group has been stood up, which is represented by each division, HR and Transformation and Improvement colleagues who meet regularly to work through the divisional breakdown of the results and identify all actions that need to be taken forwards.

There are a number of areas that the Trust needs to refocus its efforts on at a Trust-wide level, and a number of actions unique to each division. Some of the focus areas for the wider organisation include:

- Work pressures, staffing and resources
- Morale and advocacy of the organisation you work for
- Discrimination
- Continued momentum of Improving Together and staff being able to make improvements in their own area of work.

4.2. Vaccination programmes

.
Our Trust ranked highest among all NHS Trusts in the South West in delivering both flu and Covid-19 vaccines to staff this winter.

We were also fifth in the country for Covid vaccine take-up, and eighth nationally for flu vaccinations.

Around 76 per cent of frontline staff took up the offer of a flu vaccine. In total, 86 per cent of all our staff had the vaccine at work, in the community, or chose to opt out.

This is in addition to more than 1,000 flu vaccines which have been administered to inpatients and those using our maternity services.

Around 65 per cent of staff took up the offer of a Covid-19 vaccine. In total our team gave out Covid-19 vaccines to 4,346 people this winter, including staff, students, Serco and volunteers.

4.3. Women's Network

Our new Women's Network was formally launched in March and its first official meeting will be held on 10 May, the National Day of Staff Networks.

The new network now sits alongside our existing BAME, LGBTQ+ and Differently Abled staff networks and will give a collective voice to staff and opportunities to influence change for the women who work right across the Trust.

Based on feedback received so far, key areas of interest for the network include menopause support, career development and support with flexible working arrangements to accommodate childcare needs.

The first meeting will be an opportunity for all staff to feedback on what the network should focus its activities on in the coming months. The first meeting will be an opportunity for all staff to feedback on what the network should focus its activities on in the coming months.

4.4. Disability Confident Level 3 Leader award

I am pleased to report that we have been awarded the Disability Confident Level 3 Leader Award as a Trust. This is the highest award you can hold in the Disability Confident scheme and shows our commitment to ensuring that individuals with disabilities have the opportunities to fulfil their potential and realise their aspirations within the Trust. This is also a further step towards creating a truly inclusive culture.

4.5. Staff Excellence Awards

We have announced the finalists for our 2023 Staff Excellence Awards, which are:

Star of the Year 2022/23 Award:

- Emma Burgess, Senior Sister
- Mark Chapple, Associate Director of Estates and Facilities
- Amanda Smith, Senior Healthcare Support Worker

Patients Choice Award:

- Anne Kendall, Consultant
- Azeem Ahmed, Consultant
- Stephanie Taylor, Cardiac Rehabilitation Sister
- Cardiac Rehabilitation Team

Team of the Year Award:

- Sunflower Lodge
- Urgent Treatment Centre
- Communications and Engagement Team

Wellbeing at Work Award:

- Leanne Kent, Staff Nurse
- Kenresa Stratford, Community and Events Fundraiser
- Michael Pope, Senior Dental Officer

Leading the GWH Way Award:

- Timea Novak, Consultant
- Auditi Naziat, Consultant
- Isaac Frank, GP
- Lucy Moxham, Lead Advanced Clinical Practitioner

Kindness Award:

- Claire Brice, Speech and Language Therapist
- Community Rehabilitation Assistants
- Carrie Thomas, Breast Clinical Nurse Specialist

Improving Patient Experience Award:

- Acute Rehab Physiotherapy
- Hospital @ Night and Critical Care Outreach
- Lisa Daniel, Consultant

Hero Award: Beyond the Call of Duty:

- Stewart Chikukuza, Clinical Fellow
- Louise Knight, Palliative Care and End of Life Team Leader
- Swindon Community Equipment Service

GWH Rising Star Award:

- Eleanor Drew, Trainee Physiologist
- Shrinivas Sharma, Consultant
- Charlotte Vockins, Senior HR Business Partner

Championing Equality, Diversity and Inclusion Award:

- Patient Advice and Liaison Service
- Renee Santos, Assistant HR Business Partner
- Kelly Milne, Learning and Development Coordinator

Lifetime Achievement Award:

- Sally Charlton, Transfusion Practitioner
- Mark Juniper, Consultant
- Sue Facey, Community Outreach Nurse

The awards ceremony will take place at the Steam Museum in Swindon on Friday 9 June.

4.6. STAR of the Month

Our latest STAR of the Month winners are:

- Kathryn Fuller, Physiotherapist, who was recognised for always going the extra mile to ensure that patient care is holistic and engaging, and recently co-leading on deconditioning games to encourage patients to get out of bed and walking.

- Sammi Cunningham, Mortuary and Bereavement Services Manager, who won the award for the care and compassion she showed while looking after a grieving family. Sammi listened and understood the individual needs and concerns of the family and acted with genuine professionalism and integrity throughout the time she spent with them.

4.7. External recognition

We have two finalists in the **South West Maternity & Perinatal Awards**: Dr Sarah Bates in the Leadership Category and PERIPrem / Perinatal Team in the Multidisciplinary Team Working Category. Winners will be announced on 22 May.

Swindon Integrated Care Alliance Coordination Centre awarded a certificate of appreciation in **Skills for Health's Our Health Heroes Awards**.

We have been awarded the **NHS Pastoral Care Quality Award** in recognition of our work in international recruitment and our commitment to providing high-quality pastoral care to internationally educated nurses and midwives during recruitment processes and their employment.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**4th May 2023**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Simon Wade, Chief Financial Officer Jude Gray, Director of HR Lisa Cheek, Chief Nurse				
Report Author	Al Sheward – Deputy Chief Operating Officer Rayna McDonald – Deputy Chief Nurse Claire Warner – Associate Director of HR Operations John Ridler – Associate Director of Finance				
Appendices	Use of Resources: • Statement of Financial Position • Working Capital • Income & Expenditure – Variance Run Rate • SPC Chart – Pay				

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

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

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

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

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

Our Performance

Key highlights from the report this month are:

OPERATIONAL PILLAR METRICS
Of the 6 Operational Pillar Metrics, improvements have been seen in 3 during the month of March 2023. Delivery against RTT shows a similar level to Feb 2023. Key national performance requirements (52 Weeks, 78 weeks) are being delivered in line with expectations.

Cancer 62 day - Cancer 62 day waiting times remain below standard. Improvement seen in the month of Feb to 69.3%. Further deterioration occurred in **Jan 2023**. The Cancer lead has presented their recovery plan to Feb PPPC.

RTT 18 Week Compliance – March performance shows a slight adverse reduction to 55.06%. RTT performance has been outside the control limits since May 2022. There are

no patients >104 weeks. 2 Patients >78 weeks were reported in the month of March against a requirement of zero. From April 2023 the total number of patients >65 weeks will be reported with the aim of no patients waiting >65 weeks from 31st March 2024. However, the Trust plans to work to an internal target of December 2023.

Emergency Care, Emergency Department Mean Stay – In the month of March 2023 there has been a third month of improvement in the Mean Length of Stay (MLOS) for patients in the Majors part of the Emergency Department. This is against a backdrop of attendances which returned to the normalised run rate.

Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. February saw an increase in ED attendances. The number of attendances has returned to the levels seen in October and November 2022.

Inpatient Spells, Number of Non-Criteria to reside (NC2R) days. The number of patients who remain in an Acute Hospital bed without a Criteria to Reside (NC2R) has seen an increase. This is understood to be a temporary increase with the total numbers of patients with NC2R set to reduce in 2023/24.

OPERATIONAL BREAKTHROUGH OBJECTIVES
The breakthrough objective related to time in ED over 12 hours has seen similar performance to Feb 2023. However, remains outside of the SPC control limits. This is closely linked to the mean time in ED which saw a slight improvement despite an increase in overall ED attendances. The number of patients awaiting an update from the Community Single point of Access saw a significant adverse increase in month. Partner supported discharges have shown a worsening trend in March 2023.

Alerting Watch Metrics
The 27 Alerting Watch Metrics show no significant change from February 2023 although there have been improvements across several metrics.

Our Care

Strategic Pillar Targets

1. To achieve zero avoidable harm within 5-10 years
2. To achieve consistent positive response rates in excess of 86% for Friends and Family Test (FFT).

There has been an increase in the total number of harms from 218 to 302 in month. The drivers include hospital acquired pressure harms (40 in month with 23 in February) falls (127 in month, 96 in February) and Clostridium difficile (49 in month, 39 in February). Community acquired pressure harms have reduced slightly in month.

The number of Family and Friends positive responses has reduced in March but remains above the internal target of 86%. In patient positive response rates continued to be above internal target for the third consecutive month.

Breakthrough Objectives
Pressure harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough objective. March has seen a slight decrease in community acquired pressure harms but a significant increase in hospital acquired pressure harms.

Senior Nurse leaders continue to provide close support, focus and challenge to ensure ongoing embedding of actions and improvements in line with Improving Together methodology.

Alerting Watch Metrics
The Trust complaint response rate has remained similar in month at 75%.

Although the Trust exceeded its internal trajectory for MSSA in the autumn, progress has been made with the rate now consistently below earlier results.

The Trust is over trajectory for E.coli bloodstream infections and the gap from trajectory continues to widen with little progress made in month. To address the gap an Improving Together A3 with clear actions has been developed and will be monitored through the Infection Control Group.

Non-alerting Watch Metrics
Significant points to note relating to non- alerting watch metrics include

- The total number of falls and rate per 1000 bed days has increased in month and is one of the drivers for the increased over-all harms.
- Six Serious Incidents have been declared in month, with two of them being Never Events. All will be investigated under the Serious Incident Framework
- The number of concerns has increased in month, but there has been a slight decrease in the number of complaints.
- The Trust finished the year end above the trajectory for C. difficile and Klebsiella bacteraemias but below trajectory for Pseudomonas aeruginosa bacteraemias.
- FFT overall response rate has fallen in month and is now just below the internal target.
- Emergency department has seen stability in Family and Friends response rates and an increase in positive response rates for the third consecutive month.

Our People

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

Strategic Pillar Target from A3 goals:
To aim to be in the top 20% of trusts for staff survey results and in the lower quartile for turnover within Model Hospital.

The Trust aims to improve our Staff Survey response rates year on year and increase the number of staff "recommending Trust as a place to work"

Breakthrough Objectives
The Trust Breakthrough objective is to achieve a 5% improvement in the question "*I am able to make improvements happen in my area of work*" in the Staff Survey.

Divisions are presenting their staff survey results to People, Place, Performance Committee in April, outlining their Q3F performance year to date and improvement targets for year-end 2023.

Refreshed A3s and countermeasures have been developed as part of delivery plans. The quarter 1 Pulse survey went live in April, and results will be available for analysis in May.

Alerting Watch Metrics
Sickness absence continues to alert above KPI, however has further decreased in month from 4.9% to 4.5% of which 2.6% is long term absence and 1.9% is short term absence. The Trust 'Improving Attendance' working group has identified a need to provide Band 6 and Band 7 team leaders with upskilling in absence management processes.

Voluntary turnover has again reduced in February to 11.25% and only marginally above the Trust KPI of 11%.

The in-month time to hire has increased slightly in March to 54.5 days for substantive staff; this is aligned with significant increase in recruitment activity from 135 offers in February increasing to 199 offers in March, 154 adverts placed in February and 172 adverts placed in March, 40 references received in February increasing to 189 in March. Bank TTH is being recorded monthly with focus on streamlining the pipeline to ensure timely process.

Non-Alerting Watch Metrics
In-month agency spend as a % of the total pay bill has increased slightly in March to 5.35%, but continues to be below the Trust target of 6%.

Registered and unregistered nursing bank fill remains above the KPI, driven by a reduction in agency WTE.

Use of Resources

To be completed when data available.

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

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board/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	 **Felicity Taylor-Drewe**
Date	27th April 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

April 2023

February 2023 & March 2023 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

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Breakthrough objectives This provides a more detailed analysis of performance and risks related to the 4 key metrics for improvement: patients developing pressure ulcers; over 12 hour waits in the Emergency Department; patients awaiting discharge (NCTR) and staff survey results	12-15
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Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total patients waiting more than 52 weeks	1648 (Avg)	744	852	1028	1215	1568	1926	2164	2281	2188	1,817	1,833	2,163
Total patients waiting more than 78weeks	45 (Avg)	49	50	52	34	35	44	40	45	68	62	56	2
Total patients waiting more than 104 weeks	0 (Nat)	0	0	1	0	0	0	0	1	0	0	0	0
Total elective activity undertaken compared with 2019/20 baseline	104% (Nat)	90.5%	95.5%	97.1%	87.3%	100.3%	94.2%	86.1%	97.1%	82.1%	100.1%	99.3%	108.1%
Total diagnostic activity undertaken compared with 2019/20 baseline	120% (Nat)	88.7%	94.6%	92.4%	87.9%	94.5%	88.8%	79.7%	97.0%	86.9%	89.3%	91.8%	Reported one month behind
Total Cancer patients waiting over 62 days	210 (Avg)	133	168	209	268	326	284	258	223	178	150	110	Reported one month behind
Proportion of patients meeting the faster cancer diagnosis standard	75% (Nat)	81.6%	78.9%	79.3%	75.8%	73.7%	67.1%	64.7%	73.2%	78.2%	70.8%	77.8%	Reported one month behind
Total patients treated for cancer compared with the same point in 2019/20 (first and	100% (Nat)	71.7%	150.5%	85.5%	58.6%	107.1%	106.2%	85.4%	123.3%	141.0%	118.8%	115.6%	Reported one month behind
Outpatient follow-up activity levels compared with 2019/20 baseline	75% (Nat)	85.6%	89.5%	85.9%	73.9%	94.5%	88.8%	79.7%	97.0%	86.9%	89.3%	91.8%	86.6%
Proportion of ambulance arrivals delayed over 30 minutes	44.3% (Avg)	48.4%	38.9%	26.9%	31.0%	42.9%	46.3%	49.9%	47.2%	60.1%	44.6%	47.8%	47.2%
Proportion of Patients spending more that 12 Hours in an Emergency Department (Type 1 & 3)	2% (Nat)	8.4%	7.4%	6.4%	6.5%	8.2%	8.4%	8.5%	8.2%	9.4%	8.9%	8.0%	8.0%
Proportion of patients discharged from hospital to their usual place of residence	94.1% (Avg)	93.8%	94.1%	93.8%	94.2%	93.9%	94.3%	94.2%	94.0%	93.8%	94.2%	94.6%	94.3%
GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	24.8% (Avg)	26.4%	24.8%	25.4%	24.5%	24.0%	26.1%	26.7%	25.6%	24.6%	22.6%	22.7%	24.2%
National Patient Safety Alerts not completed by deadline	0 (Int)	0	0	0	0	1	0	0	0	0	0	0	0
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (Per 100,000	0 (Nat)	0	0	0	0	0	0	6	0	0	5.7	Waiting for Data	Waiting for data
Clostridium difficile infection rate (Per 100,000 bed days)	20.2 (Avg)	36.3	11.7	12.9	11.7	17.3	41.7	17.3	41.3	5.7	5.7	Waiting for Data	Waiting for data
E. coli bloodstream infection rate (Per 100,000 bed days)	47.5 (Avg)	54.4	29.3	60.5	52.7	75.0	35.8	11.5	35.4	51.4	68.6	Waiting for Data	Waiting for data

Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Proportion of staff in senior leadership roles who are from BME background	12% (Nat)	4.7%	4.5%	4.5%	4.7%	5.9%	6.0%	6.5%	6.8%	6.8%	6.8%	6.6%	Reported one month behind
Proportion of staff in senior leadership roles who are women	62% (Nat)	70.3%	69.1%	68.9%	69.1%	67.0%	66.3%	67.3%	67.5%	67.5%	68.2%	68.4%	Reported one month behind
Average hours lost to ambulance handover delays per day	53 (Avg)	67	48	34	30	51	61	66	60	49	67	53	47
Adult general and acute bed occupancy	96% (Avg)	95.7%	96.5%	95.8%	95.3%	97.9%	95.9%	96.5%	95.9%	95.7%	96.0%	95.8%	95.5%
Summary Hospital-level Mortality Indicator	1.00	0.87	0.86	0.88	0.90	0.93	0.95	0.98	1.00	1.02	1.04	1.06	1.08
Financial efficiency - variance from efficiency plan (£'000)	+/-	-34	-424	-209	-289	-268	-247	190	-378	-338	-400	-238	Waiting for Data
Financial stability - variance from break-even (£'000)	+/-	-2506	-2006	-888	-2068	-1848	-1938	-363	-1672	-1502	-1579	-1469	Waiting for Data
Financial stability - variance from PLAN (£'000)	+/-	-387	-335	-517	-326	-268	-408	1154	389	164	106	214	Waiting for Data

Measure Name	Mean	2017	2018	2019	2020	2021	2022
Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.8	6.8	6.8	7.1	6.9	6.5	Waiting for data
Staff survey engagement theme score	6.9	6.9	6.9	7	7	6.7	Waiting for data
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	0.6	59.6%	54.1%	60.4%	57.1%	56.1%	Waiting for data

Executive Summary

Great Western Hospitals NHS Foundation Trust

Total Harms

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

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

Pressure ulcers/harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough Objective. The other harms are all presented as watch metrics later in the report.

Patient Experience (FFT)

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

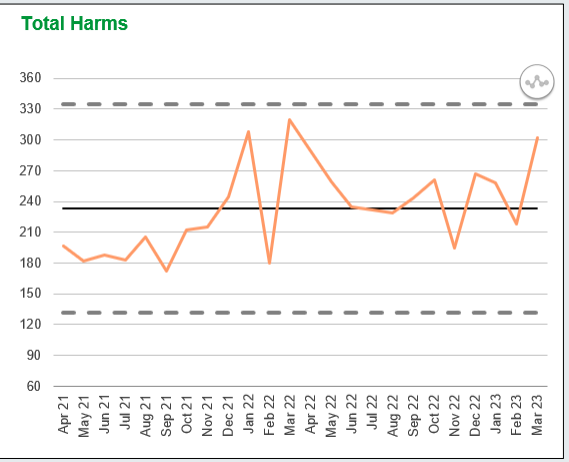
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall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

We have set ourselves a target for 2022-23 of 86% for the combined positive response rate, this is based on the mean for last year plus 2%.

Total Harms

To achieve and sustain zero avoidable harm.

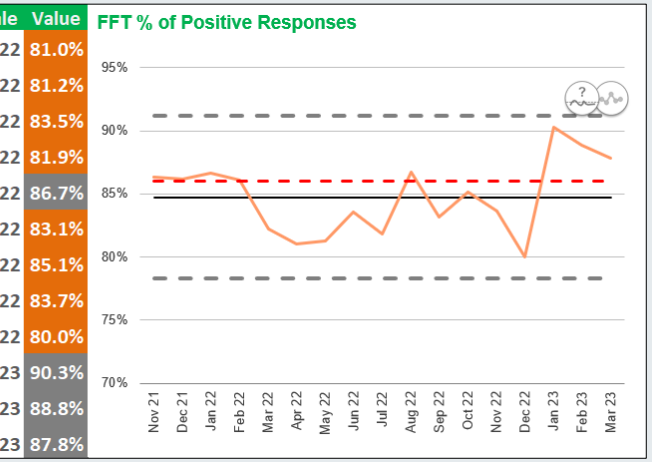
Timescale	Value
Apr 22	289
May 22	259
Jun 22	235
Jul 22	232
Aug 22	229
Sep 22	243
Oct 22	261
Nov 22	195
Dec 22	267
Jan 23	258
Feb 23	218
Mar 23	302



Patient Experience (Friends & Family Test)

To achieve consistent positive response rates in excess of 86% from patient friends and family test.

Timescale	Value
Apr 22	81.0%
May 22	81.2%
Jun 22	83.5%
Jul 22	81.9%
Aug 22	86.7%
Sep 22	83.1%
Oct 22	85.1%
Nov 22	83.7%
Dec 22	80.0%
Jan 23	90.3%
Feb 23	88.8%
Mar 23	87.8%



Counter Measures

The number of avoidable harms has increased in month and is driven by a rise in hospital acquired pressure harms (40 in month), falls and *Clostridium difficile*.

GWH has, for the first time in several months, seen a higher rate of hospital-acquired COVID than the SW average. Concurrent norovirus outbreaks meant our stock of portable air scrubbers was exhausted and we were not able to deploy them as reactively as normal. The installation of permanent units continues and will mitigate the likelihood of this happening again. *C. difficile* rates rose markedly across BSW in March and the reasons for this are being investigated across the system.

Focus for addressing hospital-acquired pressure harms include focus on ensuring skin inspections are completed on admission and a consistent approach to safety huddles.

For March, the number of Family and Friends positive responses rate has reduced by one percentage point, but remains above the internal target of 86% at 88%.

- New 'Bags of Calm' implemented in the Emergency Department to support patients with cognitive impairment
- Gold accreditation achieved from Carers Support Wiltshire for Wren outpatients.
- PALS finalists in the Staff Excellence awards for EDI work relating to implementation of the sign live system, deaf awareness cards, collaboration with Gloucester Deaf Association, expansion of interpreting and translation services, implementation of easy read and pictorial documents and flash cards.

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.

In common with many other providers, the Trust has not consistently achieved the National Cancer Standards or Access standard for RTT. Nationally expectations are being reset around targets. Countermeasures for the deteriorations seen here are listed below

Cancer 62 Day

In February, there were 29.5 breaches in total, with 21.0 of these attributed to the Urology, Skin and Colorectal pathway. Skin and Colorectal have increased demand resulting in capacity challenges. We have also seen greater than normal breaches in Urology. Over half the breaches can be attributed to our capacity for TRUS Biopsies. & LATP along with patients needing time to consider which choice of treatment they would prefer.

RTT: 18 Week Compliance

In March 2023, the RTT 18 Week Compliance deteriorated by 0.36% in month. Highest improvement in Ophthalmology performance by 2.91% (61.43%) and highest deterioration in Diabetic Medicine 7.29% (54.82%)in month

The Patient Tracking List (PTL) increased by 1,256 (3.6%), with the largest increases seen in Gastro, General Surgery and Cardiology.

Referrals increased in month by 21%, which is a 18% increase from the average rolling 8 month period. Neurology, Cardiology and Endocrinology received the largest increase in referrals in month.

52 week breaches increased in month by 326. Oral, Paeds and General Surgery deteriorated most in month. Urology, Neurology and Ophthalmology had highest reduction in comparison to last month.

2 x 78 week breaches reported in March 2023, (1x Respiratory and 1xPlastics) a decrease of 54 in month.

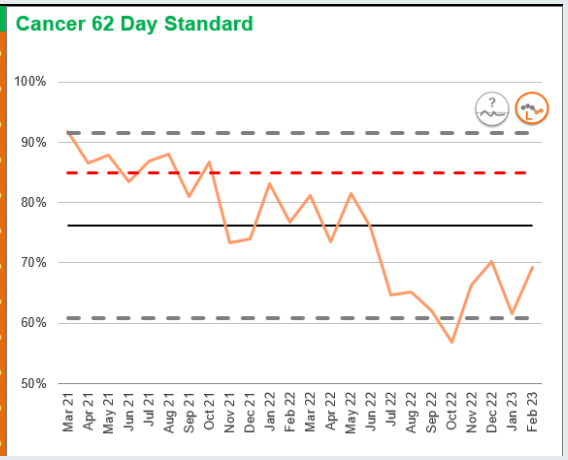
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

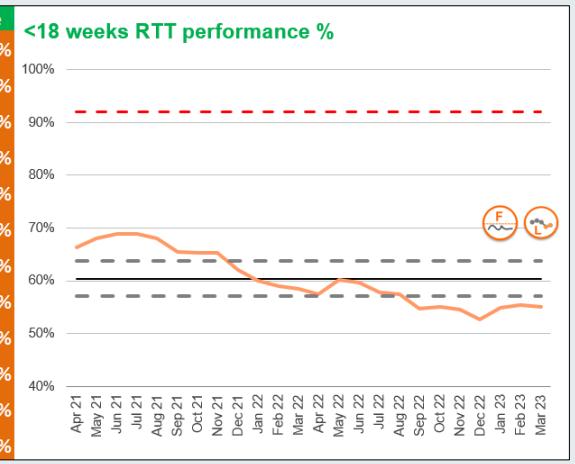
Timescale	Value
Mar 22	81.2%
Apr 22	73.5%
May 22	81.5%
Jun 22	76.0%
Jul 22	64.7%
Aug 22	65.1%
Sep 22	62.0%
Oct 22	56.9%
Nov 22	66.4%
Dec 22	70.2%
Jan 23	61.6%
Feb 23	69.3%



RTT: 18 Week Compliance

To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.

Timescale	Value
Apr 22	57.39%
May 22	60.15%
Jun 22	59.65%
Jul 22	57.85%
Aug 22	57.43%
Sep 22	54.74%
Oct 22	55.07%
Nov 22	54.60%
Dec 22	52.60%
Jan 23	54.83%
Feb 23	55.45%
Mar 23	55.06%



Counter Measures

Risk: Capacity in Dermatology & Plastics is insufficient to see and treat patients.

Mitigation:
Plastics - Seeking further Mutual aid from OUH. Plastic Consultants have agreed to see additional patients on a pay per patient basis. The challenge is that this is ad-hoc and we do not always have MOP & Theatre space available when the Consutants are free.
Dermatology – A Locum Consultant stated in October which has created greater capacity. We are using CSP for BCC patients that will reduce the number of patients being referred to the Plastics team.

Risk: Urology Pathway are often complex requiring multiple diagnostics, with multiple treatment options needing to be discussed at Tertiary centres before treatments can be planned. Patients requiring additional treatment following an incomplete TURBT procedure will breach due to recovery and planning time.

Mitigation: Pathway improvement manager is working with service to implement the best practice timed pathway which includes a Demand/Capacity review of TRUS biopsies. The Surgical team are undertaking LATP biopsy training with a view to reducing the demand on TRUS biopsies.

Risk: Insufficient theatre and clinic capacity to meet activity plan.
Mitigation:
- 2nd phase of Theatre Business Case approved. Recruitment planned for FY 2023/24 Q1.
- Additional outpatient capacity (including diagnostic) being provided across medicine and surgical specialties throughout FY 2023/24 Q1.

Risk: Insufficient capacity to recover 78 and 65 week + breach position resulting in poor RTT 18 Week compliance.
Mitigation:
- Patient level details/plans updated on weekly basis in line with recovery trajectory.
- Unfit patients/patient choice being managed in line with Trust Access Policy.

Risk: Impact on Elective capacity due to the proposed industrial action across multiple staff groups..
Mitigation:
- All elective activity on proposed strike days reviewed. Maximum clinical sessions running where staffing allows.
- Patient impact assessed and alternative sessions to be provided. Long waiting and cancer patients prioritised.

Pillar Metrics

Executive Summary

NHS
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Emergency Care – Emergency Department - Mean Stay

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

The total meantime wait for a patient in February2023 was 477 minutes against the national standard of 240 minutes, continued improvement for three months. This has been despite increased attendance from February (up 630), coupled with increased LOS (rise in 21+ days LOS bed occupancy). Flow in ED remained challenging, contributing to ambulance handover delays, although total time lost was again improved coupled with 50% better performance against BSW peer RUH.

Emergency Care – Urgent Treatment Centre - Mean Stay

Patients are not delayed within the Urgent Treatment Centre (UTC). This is a marker of a service that is functioning as expected

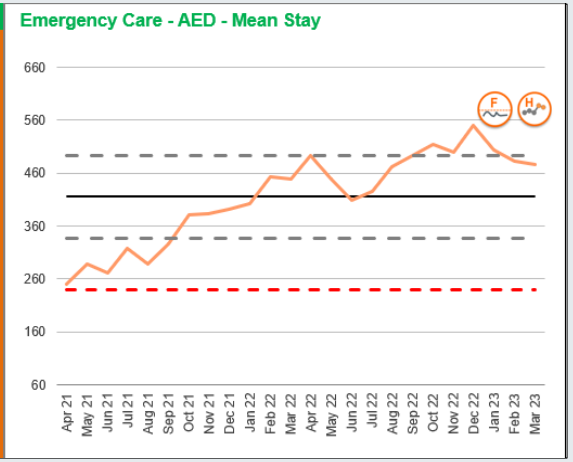
The total meantime wait for a patient in March 2023 was 147 minutes against the national standard of 240 minutes, and an improvement on February, demonstrating good flow through the service. Similar to ED, attendances increased from February, up 654

Felicity Taylor-Drewe
Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

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

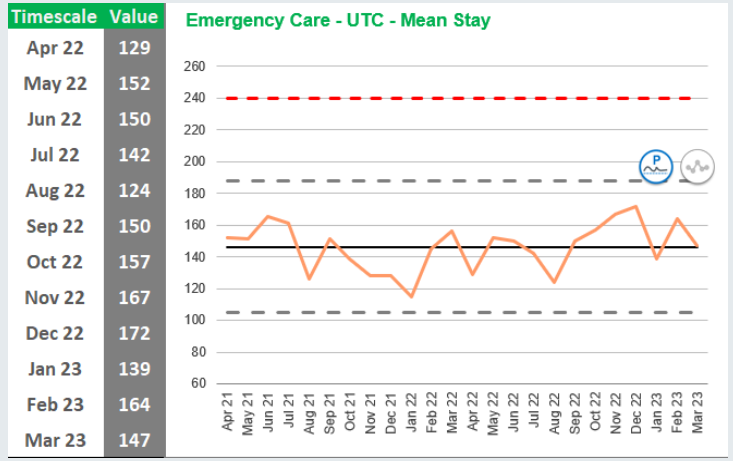
Timescale	Value
Apr 22	493
May 22	450
Jun 22	409
Jul 22	425
Aug 22	473
Sep 22	494
Oct 22	514
Nov 22	499
Dec 22	550
Jan 23	503
Feb 23	482
Mar 23	477



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Apr 22	129
May 22	152
Jun 22	150
Jul 22	142
Aug 22	124
Sep 22	150
Oct 22	157
Nov 22	167
Dec 22	172
Jan 23	139
Feb 23	164
Mar 23	147



Counter Measures

- Triage times remain improved although down slightly to 70% Triaged in 15 minutes, reflective of increased attendances.
- Weekend ED Paeds Consultant to be maintained with vacancy monies; improve quality of care and waiting times for children, whilst also supporting main ED staffing
- Pit-stop nursing maintained (challenging as now within 'normal' staffing numbers); provides clinical oversight of queue, starts assessments early & potential for simple treatments
- Support services input for admission avoidance & improved discharge - Co-ordination Centre, Flow and Community Teams
- Increased capacity for Triage of self-presenting patients (Triage cubicles x2), assessment of 'ED Majors' patients (6 bays) and provision for early ambulance assessment (Pitstop x1)

- Metric routinely meeting standard
- Roster change trial implemented for staff to increase staffing model mapped to key times of patient arrival – extension continues.
- Review of ACP staffing model and operational hours commencing to provide more reactive service.
- Single front door pathways between the Emergency Department and the Urgent Treatment Center are now in place alongside front door building work and new patient entrances.

Executive Summary

NHS
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Emergency Department & Urgent Treatment Centre - Emergency Attendances

Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC). March has seen a significant increase in attendances to both ED & UTC. Improved support services likely help with reduced numbers in January & February, external factors such as strike action likely also contributed to the increase.

Attendances are up by over 1000 compared to the same time in 2022 and 2021.

ED & UTC combined saw 10,302 patients in March (ED 5104, UTC 5198 in February). There was a corresponding increase in the number of long stay patients >21 days with a levelling of NCTR bed days.

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

This metric highlights the total number of bed days lost on inpatient spells for patients who are deemed to be Non-Criteria to Reside.

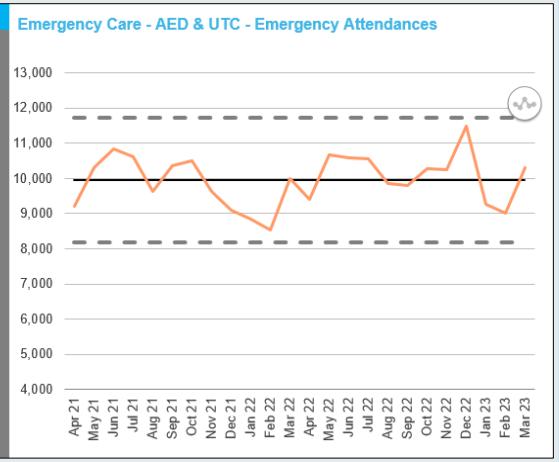
An expected increase in NCTR, last month Infections did have an impact with patients not being able to transfer out to care settings and limited agencies would delivery care. Medical outlier support work move patients out of CTR into NCTR.

Felicity Taylor-Drewe
Chief Operating Officer

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

To ensure patients are cared for in the appropriate setting

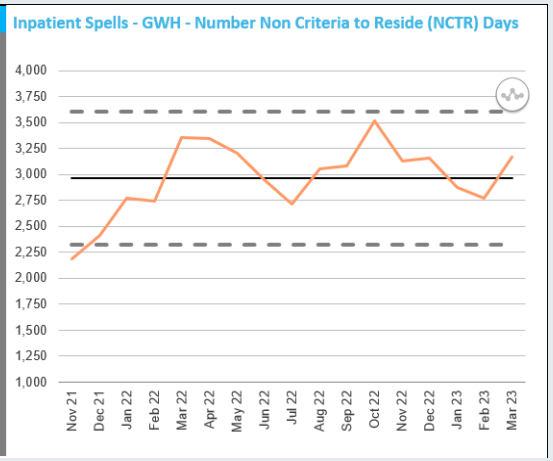
Timescale	Value
Apr 22	9,415
May 22	10,684
Jun 22	10,596
Jul 22	10,554
Aug 22	9,846
Sep 22	9,803
Oct 22	10,272
Nov 22	10,240
Dec 22	11,474
Jan 23	9,252
Feb 23	9,018
Mar 23	10,302



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

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

Timescale	Value
Apr 22	3,343
May 22	3,209
Jun 22	2,953
Jul 22	2,712
Aug 22	3,057
Sep 22	3,083
Oct 22	3,514
Nov 22	3,125
Dec 22	3,158
Jan 23	2,873
Feb 23	2,774
Mar 23	3,162



Counter Measures

- Co-ordination Centre and Navigation Hub processing referrals from community teams and ambulance service.
- SWAST reviewing processes and conveyance requirements. HALO support in ED.
- Assessment and pathway changes to support direct access from ED & UTC to most appropriate admission areas.

- Change process for referrals requiring care
- Stretch criteria to Home first model
- Discharge hub to triage other locality rereferrals
- Promote virtual ward as acute step-down capacity
- Agree new trajectories with locality around NCTR and case load, SBC GWH 20 + Swicc 15 helps to re- focus the collaborative aim and build new shorter escalation triggers.

Executive Summary

NHS
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Voluntary Staff Turnover (rate)

The annual turnover rate provides us with a high-level overview of Trust health.

Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

Staff turnover has been stable over the last 3 years until Feb/March 2021. Since Feb/March 2021 we have started to see a steady increase in turnover levels.

Since July 22 there has been a steady reduction in Vol turnover however Dec there was a small increase.

Staff Recommendation as a Place to Work

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 staff friends and family test.

In the South West we have improved our overall performance in the staff survey from 17th in 2021 to 11th in 2022. Trust performance could have an impact on our reputation as an employer, staff retention and staff morale.

If staff currently felt more positive about their working experience at GWH this will translate positively in improvement in our patient's experience.

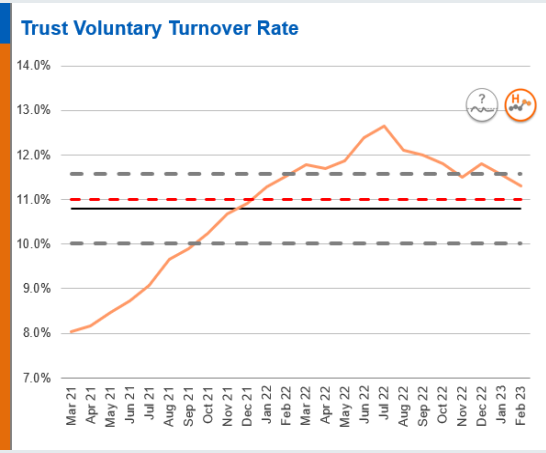
Annual staff survey results show no significant change in the question "recommend a place to work" has remain the same in 2022, however progress has been made in the overall results.

Jude Gray
Director of Human Resources (HR)

Trust Voluntary Turnover Rate

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

Timescale	Value
Mar 22	11.8%
Apr 22	11.7%
May 22	11.9%
Jun 22	12.4%
Jul 22	12.6%
Aug 22	12.1%
Sep 22	12.0%
Oct 22	11.8%
Nov 22	11.5%
Dec 22	11.8%
Jan 23	11.6%
Feb 23	11.3%



Staff % recommend the organisation as a place to work

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

Counter Measures

- The Trust will be attending the South West regional retention conference on 27th April at Exeter to share with partners from Primary, Secondary, and Social Care. The day will focus on sharing retention evidence, solutions, and innovations with practical tools and tips.
- Progress against the Trust wide retention plan 2022-25 will be presented at EPF and PPPC in April outlining priorities for the next 6 months.
- The Stay Conversation is due for relaunch over Trust-wide communication in April. Initially introduced 5 months ago to encourage staff contemplating resignation to request a conversation with HR/ workforce experts who can advise on range of options to inform their decision-making – including career planning; later career support; flexible working and retirement. Staff and Managers are linked to intranet guidance and toolkit through the initiative launch.
- The divisional staff survey results will be presented to PPPC on 28th April outlining areas of success and identified improvement priorities for countermeasures in 2023/24. Refreshed A3s are being developed to sustain the focus on question 3F 'making improvements happen in my area of work'; improving staff experience of discrimination at work from managers or colleagues; and the 'Advocacy' theme.
- The Health & Wellbeing team are focusing on the relaunch of Health & Wellbeing conversations, introducing virtual and face-to-face regular training sessions recording attendance on ESR to enable reporting of trained staff and managers, and including an optional session in the Aspiring Leader programme. Evaluation with National Trusts continues through benchmarking with the aim of improved morale and support.
- Wellbeing sandwich deliveries continued during Easter, and a working group has been set up to explore options relating to digital staff recognition.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Disparity Ratio %

The trust has launched an ED&I strategy having identified this as an essential component to a satisfied and productive workforce and a inclusive workplace.

The trust has a focus on addressing health inequalities within the local population and an effective ED&I strategy and successful implementation of this within the trust can model this approach and more effectively leverage internal expertise in this area, as well as making GWH a strong anchor institution.

We want to measure ED&I across all areas and this is currently a work in progress to identify the right metric—workforce by ethnicity can be used as a proxy measure for now.

At GWH, some staff are unevenly represented through different levels, broadly with over representation at junior levels and under representation in senior leadership positions. The nature of some roles within the trust can be static at certain levels, resulting in under -representation of certain groups.

The complexities of addressing ED&I make it a challenge for the trust, however GWH are keen to have a representative workforce across all levels of the trust.

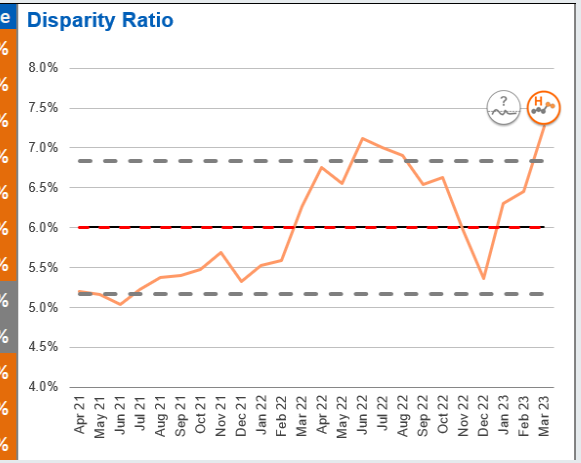
This data measures the difference in the proportion of BAME staff at lower bands (1-5) to higher bands (8a-9) compared to the proportion of White staff at those bands and tells us that our BAME staff are less likely to access progression to higher pay bands. We have seen a reduction in this disparity recently, however in January this has increased.

Jude Gray
Director of Human Resources (HR)

Disparity Ratio

To ensure a broad and diverse workforce to best represent the community we serve.

Timescale	Value
Apr 22	6.8%
May 22	6.6%
Jun 22	7.1%
Jul 22	7.0%
Aug 22	6.9%
Sep 22	6.5%
Oct 22	6.6%
Nov 22	6.0%
Dec 22	5.4%
Jan 23	6.3%
Feb 23	6.5%
Mar 23	7.3%



Counter Measures

- The Trust is in the process of completing the Equality Delivery System (EDS) review to measure EDI performance. The revised EDS supports improvement of WRES metrics and resultant actions will have a positive impact on both disparity and retention. The Trust's initial score is 'Developing Activity', reflective of the relative infancy of its first EDI strategy and the time needed to embed practice across the organisation.
- Analysis of NHS Staff Survey results shows a higher percentage of BAME staff experiencing discrimination at work from a manager/team leader (19.8%) compared to the national average (17.3%). EDI Lead to host data walks across the Trust to understand staff perceptions and inform improvement actions.
- EDI Lead and Head of Resourcing developing an EDI Ambassador Programme to be launched May 2023. Ambassadors will act as an independent voice and critical friend on interview panels for senior roles.

Executive Summary

NHS
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Financial Position (I&E Margin)

There has been a significant and growing financial deficit over the last 3 years at the Trust. Large financial deficits undermine the public trust in the NHS and put the financial viability of the organisation at risk.

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. Great Western Hospitals NHS Foundation Trust's Green Plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be net zero carbon for direct emissions by 2040 and also for indirect emissions by 2045. In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032.

In lieu of our carbon footprint data from Greener NHS (anticipated for early Q3) this report focus is on electricity and gas consumption which forms a significant part of our direct carbon footprint.

Over the coming years we will be focusing on the delivery of our Green Plan and ICS Green Plan which will be formally reported on annually and refreshed every 3 years.

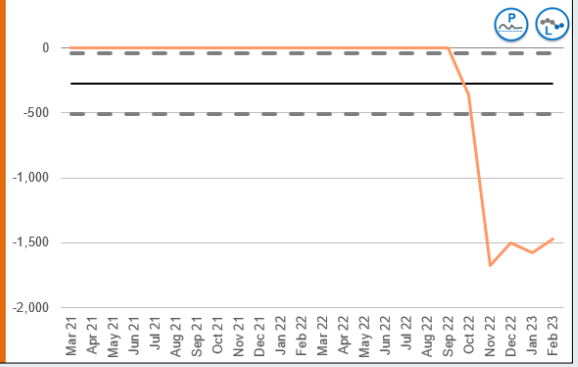
Simon Wade
Chief Financial Officer

Service | Teamwork | Ambition | Respect

System financial performance - surplus / deficit (I & E)

To achieve and sustain a break even financial position.

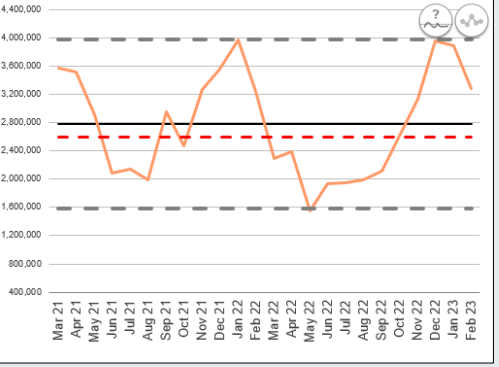
Timescale	Value
Mar 22	-0.26
Apr 22	-0.39
May 22	-2.01
Jun 22	-0.89
Jul 22	-2.07
Aug 22	-1.85
Sep 22	-1.94
Oct 22	-363
Nov 22	-1672
Dec 22	-1502
Jan 23	-1579
Feb 23	-1469



Energy consumption (kWh) – Electricity & Gas

To achieve an organisational carbon neutral footprint.

Timescale	Value
Mar 22	2,293,826
Apr 22	2,388,534
May 22	1,543,874
Jun 22	1,940,413
Jul 22	1,953,493
Aug 22	1,983,344
Sep 22	2,115,111
Oct 22	2,613,274
Nov 22	3,136,178
Dec 22	3,961,047
Jan 23	3,883,373
Feb 23	3,284,505



Counter Measures

- At M11 the ICB position is reporting a £1.4m deficit YTD due to the phasing of the intra-system risk share. 11/12ths of the risks share has been transacted with providers but only 8/9ths of it is in the yeat to date position. A forecast risk of £0.9m remains due to allocation risk around funding discharge schemes. There is funding to be received for national prescribing inflation pressures and this is fully expected in Month 12.
- At Month 11 GWH year-to-date position is a deficit of £17.8m which is £0.1m better than plan.
- Countermeasures have been put in place:
  - Relevant divisions remaining in enhanced support
  - Focus on actions to reduce run rate
  - Enhanced workforce controls
  - Targeted work on efficiencies including driving out benchmarked opportunities
  - Drive on productivity including theatre rescheduling
  - Centralised review of utilised provisions

•The board approved Green Plan has been published with targets and action plan agreed.

•Capital funding for sustainability projects has been agreed and work is underway on reducing emissions from nitrous oxide and entonox at GWH.

•GWH is the ICS Green Plan chapter lead for reducing emissions from Medical Gases.

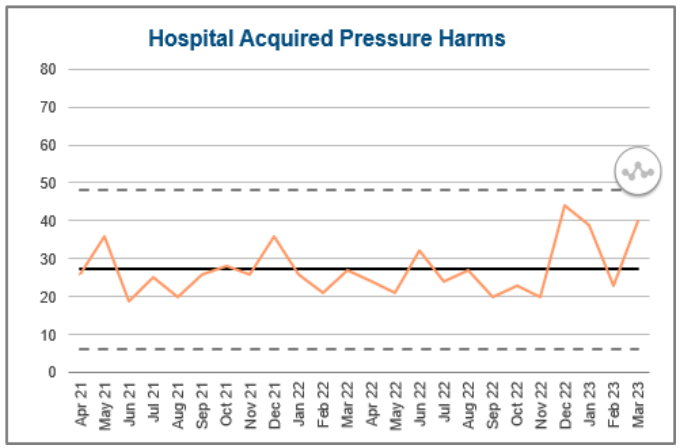
2022/23 Breakthrough Objectives

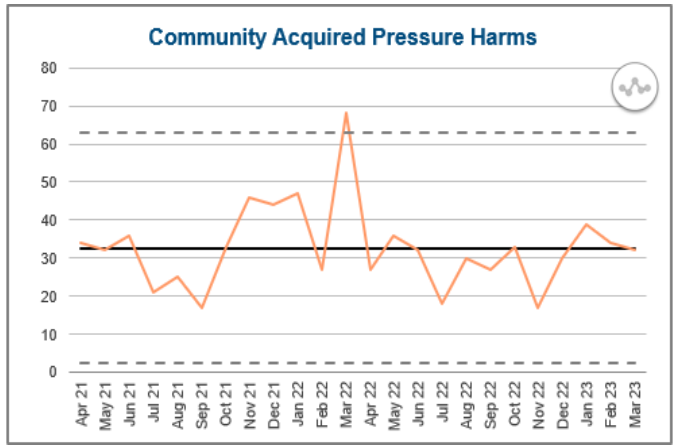
Reduction of Pressure Harms

Great Western Hospitals NHS Foundation Trust

Total Pressure Harms

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
51	57	64	42	57	47	56	37	74	78	57	72





Common cause – no significant change

Understanding the Data

The number in the charts above represents the number of pressure harms that patients have developed whilst in hospital or under the care of a community nursing team. The number reflects the total number of harms not total number of patients i.e., one patient may have two or more pressure harms.

All pressure related harms are reported and then clinically validated to determine if they were acquired whilst under the care of GWH.

Tissue viability is the overarching term that describes the speciality that primarily considers all aspects of skin and soft tissue wounds.

We are driving this measure because...

We know that pressure damage is an avoidable cause of harm to patients and believe that through using the evidence-based improvement methodology we can make a significant difference to patients.

Regular measurement is required to ensure front line teams and divisions identify themes and those actions required for improvement of pressure related harms. This will help reduce the level of pressure related harm and improve staff knowledge and skills in caring for our patients.

Performance

There were 40 hospital-acquired pressure harms during March.

- This is a significant increase compared to last month (23) and a return to the numbers seen in December and January.
- Senior leadership will be focusing on attending safety huddles to provide oversight and coaching to support embedding the Improving Together methodology to drive improvements.
- Gaps in admission skin inspections and/or in documentation has been identified as an ongoing themes . The TVN team's Education Facilitator will focus support on those wards with the highest level of harm in the month. The three areas with most harms (14 between them) will have additional focused support.
- Hybrid mattresses are now on 480 beds across GWH, SWICC and Sunflower, training is ongoing to ensure compliance.

In the community setting there were 32 pressure harms acquired during March.

- This is a small decrease when compared to the two previous months (39, 34).
- Education delivered in March for Pressure Ulcer assessment and management
- Availability of Pressure relieving equipment discussed at daily ward rounds with counter measures when shortages or adverse weather/electricity supplies are affected.
- Partnership working with therapy to review risk assessment and skin inspection at therapy visits to ensure ‘every contact counts’.
- Restore2 with additional information regarding risk of pressure damage delivered to care homes within Swindon

Risks

The continuing high caseloads for Tissue Viability and Community Nursing in addition to the difficulties in recruiting to establishment in the Community Nursing services can impact the ability to provide high quality pressure ulcer prevention management, specialist review and assessment and as a result pressure ulcer rates may increase.

2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

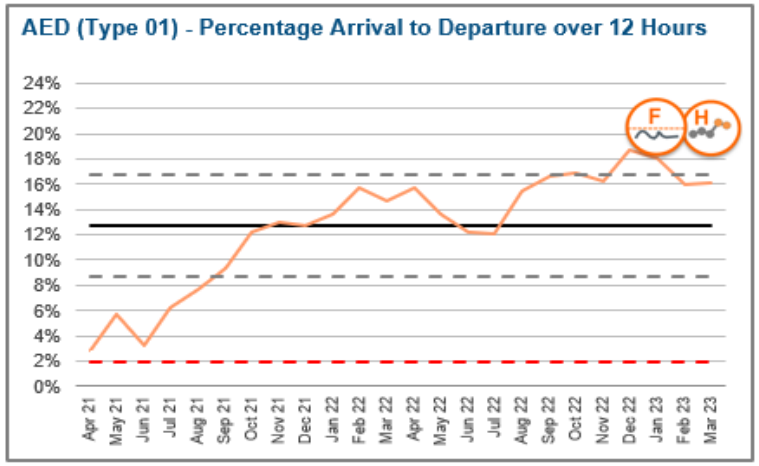
Emergency Department (Type 1) - Percentage Arrival to Departure over 12 Hours

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
15.8%	13.6%	12.2%	12.1%	15.4%	16.6%	16.9%	16.3%	18.7%	18.1%	16.0%	16.0%

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	2%
Value	Percentage
Improvement Direction	Lower is Better

Variation indicates consistently (F)alling short of the target

Special cause of concerning nature or higher pressure due to (H)igher values



Understanding the Data

Total number of patients who have a total time in ED (Type 1) over 12 hours from
arrival to admission, transfer or discharge.

The clock starts from the time that the patient arrives in ED and it stops when the
patient leaves the department on admission, transfer from the hospital or discharge is completed

We are driving this measure because...

To reduce the number of patients who have waited over 12 hours in ED. The target is to not have more than 2% of all patients who attended ED waiting over 12 hours.

Performance

- %>12 hour waits in ED – Equal to last month at 16%, with reduced mean ED time and despite increased attendances.
- x171 12-hour reportable Decisions to Admit (DTA) breaches – an increase of 47 from last month (previous criteria)
- Clinically Ready to Proceed (CRTP) automatic reporting in Careflow operational. CRTP/Waiting Bed for March 29%/71% of meantime for admitted patients (average for last 12 months). This is an improvement in ED CRTP time and indicates flow being the major contributor to delays in ED.
- Long stays increased in February with % beds occupied by long stayer (21+ days) at a similar level to March 22, and worsened position for last 3 months.
- Timing of bed availability is still challenging, often late in the day contributing to delayed transfers.

Risks

Fluctuating IP&C conditions requiring isolation/co-horting may impact on flow out of ED and contribute to increases in 12 hour waits.

LOS and % of longest stayers will impact on bed availability and flow out of ED resulting in increased time in ED and likelihood of 12 hour waits.

Increased surges of ED attendances, particularly out of hours, alongside bed availability could contribute to increases in 12 hours waits in ED.

Reconfiguration works as part of IFD, with associated capacity issues, may impact ED & UTC which may impact on 12 hour waits in ED

2022/23 Breakthrough Objectives

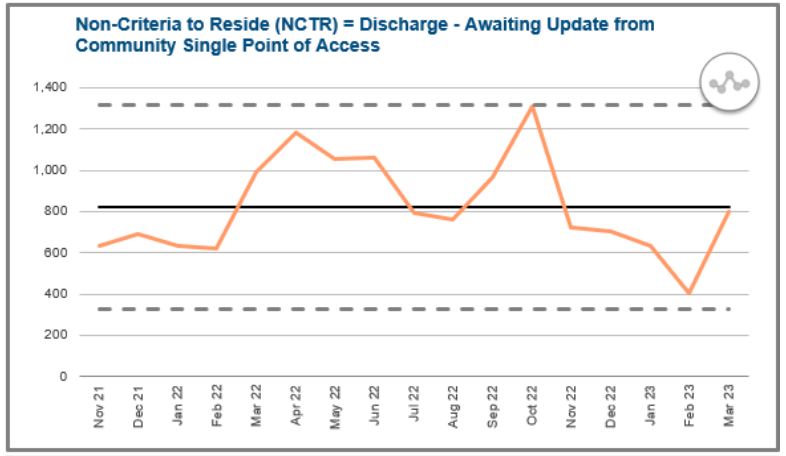
Great Western Hospitals NHS Foundation Trust

Non-Criteria to Reside (NCTR) - Partner Supported Discharge

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
1185	1053	1060	795	760	968	1309	723	703	635	406	797

Domain	Our Quality & Safety
Metric Focus	Driver
Threshold	
Value	Number
Improvement Direction	Lower is Better

Common cause - no significant change



Understanding the Data

This Breakthrough objective will primarily capture PW1,PW2,PW3 patients as by definition PW0 are simple ward led discharges. A small number of patients on PW0 may require social care support outside of healthcare needs and this group will be inclusive within this modelling.

This is linked closely to the BSW improvement work of reducing NC2R patients by 30% from a Dec 2022 baseline.

The data surrounding updates from Single Point of Access is directly related to lost bed days and therefore the time patients wait to leave the Acute Trust.

We are driving this measure because…

In a 12-month period more than 10,000 bed days were lost within the discharge criteria 'Awaiting update from Community Single Point of Access'.

Internally the aim is to refer patients that require social care support for discharge as soon as this has been identified as a discharge care need. Different referral approaches from localities can be a barrier to being proactive with discharge planning from admission.

One of the aims of this breakthrough objective to use the data to demonstrate the value of being able to refer patients to partners before they a medically safe to leave hospital, building on a collaborative uniform ICA approach.

Further delays to patients' discharges can be increased waiting for social care assessment, outcomes and inventions required to proceed with that discharge. Patients with complex care needs can experience significant lengths of stay which increases further risk of harm to the patient. Improvements through internal professional standards set by time metrics, and implementation of assessments in the community using the D2A model will support reduction in the total bed days lost.

Performance & Countermeasure

A noticeable incline in number of bed days lost against the discharge criteria – Awaiting Update from Community Single Point od Access (partner referrals).
This reflects the overall increase in NCTR numbers during March exceeding 110 with an average wait of 10 days for SW assessment at its worst time.
Patients that require an In-patient assessment had longer waits for 2 main reasons last month.
1.Wards or bays that were closed to infection meant Social workers couldn't conduct face to face assessments or gain consent for the referral made by staff. Mitigated with telephone triage where possible but this is not suitable for most patients. Current practise is that social workers are abstained from visiting areas or patients with contagious infections.
2. The success of the Home First model and its increase in number of patients being discharged on the day called for more social workers to shift from internal, to external assessments.

Countermeasures

Against a certain group of patients, the Senior Discharge Support Team have agreement from SBC social care services, that rereferrals processed by them for can go straight to the care source for discharge planning and start dates, thus reducing an average of 6 bed days lost per patient.
Have confidence that we will see a reduction again next month.

Risks

Currently not a 7-day discharge hub service.
The shift in social worker conducting assessments in peoples home once discharged has led to increase in waits for in-patient social worker allocations - mid month waits averaged 10 days.

2022/23 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Staff Survey - I am able to make improvements happen in my area of work

2017	2018	2019	2020	2021	2022 Q1	2022 Q2	2022 Q4
52.40%	49.40%	56.70%	54.50%	49.30%	50.31%	51.10%	51.95%

Domain	Our Leadership
Metric Focus	Driver
Threshold	
Value	Percentage
Improvement Direction	Higher is Better

Understanding the Data

The Staff Survey results are predominantly aimed at service improvement. It is important to know if staff could provide the care and service they aspired to give.

We are driving this measure because...

This staff survey feedback is extremely important. The result of this survey could help how staff feel about making improvements happen in their workplace.

Performance

- A3s have been updated as part of the divisional staff survey results analysis in preparation for presentation to PPPC in April. The divisions outline their Q3F performance year to date and specify their improvement target to be achieved by the end of 2023, through the A3 process and refreshed countermeasures.
- The Quarter 1 Pulse survey went live in April enabling all Trust staff to give confidential feedback on key engagement and advocacy questions, with the opportunity to provide improvement ideas.
- The Trust internal coach house department is now leading the Improving Together training across the Trust, extending the methodology to all frontline and corporate services.

Risks

- Whilst continuing the 'inch wide, mile deep' focus on question 3F, there are broader opportunities for improvement which are outlined in the divisional Staff Survey presentations which require focus.
- Divisional teams continue improving together training in different timescales, therefore the risk is that less improvement actions could be made in areas who are yet to go through training.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-22	Jan-23	Feb-23	Mar-23	Trend
RTT	No. of >=18 weeks waiters		H	16710	15539	15363	16068	
	No. of >=52 weeks waiters		H	2188	1817	1833	2163	
DM01	No. of patients on DM01 waitlist		H	10770	10329	11111	One month behind	
	DM01 performance %	99% (Nat)	H	48.0%	48.5%	54.2%	One month behind	
	DM01 6 week wait breaches		H	5597	5316	5090	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	L	70.2%	61.6%	69.3%	One month behind	
	% Cancer 31 day performance	96% (Nat)	L	80.3%	83.5%	87.7%	One month behind	

Common cause - no significant change.	Special cause of concerning nature or higher pressure due to higher or lower values.	Special cause of improving nature or higher pressure due to higher or lower values.	Variation indicates inconsistently hitting passing and falling short of the target.	Variation indicates consistently passing the target.	Variation indicates consistently failing the target.

Performance & Counter Measure

March DM01 performance has not been validated but looks to be showing another increase from the 54.2% performance in February. The number of patients on the waiting list has increased slightly to 11,111 but the number of 6 week breach has reduced to 5090. The 3 Pads in Radiology continue to be fully utilised and activity numbers continue to exceed any previous levels. We continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, which at present is in line with trajectory. Progress in activity in Ultrasound and DEXA has also decreased the waits although Ultrasound still remains the the largest issue. ERF Funding has been secured for mobile MRI for 6 months, and CT 3 days a week for 6 months will be funded by the TVCA. The site will also host 7 days a week of CT/MRI mixed supporting the CDC project.

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin pathway with 89% of the breaches being accounted for by this service. WLI activity in Dermatology is being focused on treatments through February & March. Additional capacity in Plastics is being sourced through private partner (CSP in Wootton Bassett) and through any available mutual aid from OUH.

71.1% of the 62-day breaches were with the Skin, Urology & Colorectal Pathway.

Counter Measure - Work is underway with the TVCA to implement the Best Practice Timed Pathways across all 5 (Lower GI, Urology, Gynae, Upper GI & Head & Neck) of these Pathways.

We continue to work with the OUH Plastics team for extra capacity, however, there is a clear deficit in capacity within Plastics that will impact the cancer pathway is unable to be mitigated further without significant staffing and / or investment. This is subject to a strategic service review.

The weekly Elective Access Meetings continues to support improvement work through monitoring of counter measures, identifying support and mutual aid options and review of individual patients within pathways to move on in pathway if required.

Additional capacity for LATP biopsy within the Prostate pathway will come on line from June 23 when further consultants complete their training. His will help alleviate some of the capacity issues within Radiology for TRUS biopsy (LATP is gold standard procedure for biopsy, and should be used in place of TRUS)

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-22	Jan-23	Feb-23	Mar-23	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	L	72.3%	75.8%	74.3%	77.2%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	L	50.8%	55.2%	55.2%	58.4%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	H	18.6%	18.1%	16.0%	16.0%	
	Total ED Type 1 Attendances (all arrival methods)	SPC	H	5409	5312	5903	5104	
	A&E Arrival to Departure Percentage over 12 Hours (Type 1 & Type 3)	2% (Nat)	H	9.4%	8.9%	8.0%	8.0%	
	A&E Arrival to Departure over 12 Hours (Admitted Patients)	2% (Nat)	H	40.9%	35.3%	33.6%	33.6%	
	Total Hours Ambulance Handover Waits (over 15mins)	SPC	H	3384.59	2086.60	1491.63	1443.00	
	Number of Ambulance Handover Over 15 Minute Waits	SPC	H	1184	1111	1121	1097	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	78.0%	68.0%	70.2%	71.5%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	913	729	763	725	

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Performance & Counter Measure

ED performance has demonstrated continued improvement across most areas compared to previous months, despite increased attendances. This is an indicator of the implemented measures across the 'Front Door' and support across the organisation.

Relevant teams are looking at improvement measures across the 'Front Door' , pre-hospital and post discharge with measures to improve flow & discharge rates.

Work continues with various data streams internal and external, identifying which is not accurate and looking to improve and streamline all reporting

- Triage times have decreased slightly but maintain improved performance; 70% within 15 mins compared to 72% prior month
- Total % over 12 hours has remained the same as last month; 16%
- % over 12 hours Admitted remains the same; 40.7% compared to 40.6% prior month
- % over 12 hours Non-Admission increased slightly; 5.6% compared to 4.7% prior month
- % of patients admitted reduced slightly again; 30% compared to 32% prior month

Counter measures remain in place within the Breakthrough objective slides.

Risks

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-22	Jan-23	Feb-23	Mar-23	Trend
ED	Percentage of Ambulance Handover s Over 30 Minutes	SPC		60.1%	44.6%	47.8%	47.2%	
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		688	488	487	475	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		45.3%	29.9%	30.5%	30.9%	
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		1056	915	885	887	
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		331	293	296	302	
	Non-Elective Patients Average Length of Stay (Days)	SPC		5.7	5.6	5.3	5.0	
	Community Average Length of Stay (Days)	SPC		18	23	19	18	
	Number of Stranded Patients (over 14 days)	SPC		139	134	134	136	
	Number of Super Stranded Patients (over 21 days)	SPC		88	79	77	81	
	GWH Acute Adult Bed Occupancy (%)	SPC		95.7%	96.0%	95.8%	95.5%	

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- % of patients admitted reduced slightly again; 30% compared to 32% prior month

Counter measures remain in place within the Breakthrough objective slides.

Risks

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

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

Our Performance

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-22	Jan-23	Feb-23	Mar-23
RTT	No. of >=78 weeks waiters	SPC	L	68	62	56	2
Cancer	% Cancer 2 week wait	93% (Nat)		89.8%	92.0%	88.5%	One month behind
	No. of referrals received	SPC		1327	1834	1723	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)		93.7%	95.9%	93.1%	95.6%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.2%	0.0%	0.0%	0.1%
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	69.8%	75.1%	71.0%	69.6%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		39.2%	54.4%	49.9%	47.3%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		35.1%	53.0%	39.4%	44.6%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	214	175	197	178
	Total Number of Ambulance Handovers	SPC	L	1518	1634	1597	1535
Flow	Elective Patients Average Length of Stay (Days)	SPC		3.3	3.9	3.6	3.0
	GWH Discharges by Noon (%)	SPC		17.9%	17.7%	17.9%	16.2%

Common cause - no significant change.	Special cause of concerning nature or higher pressure due to higher or lower values.	Special cause of improving nature or higher pressure due to higher or lower values.	Variation indicates inconsistently hitting passing and falling short of the target.	Variation indicates consistently passing the target.	Variation indicates consistently failing the target.

Performance & Counter Measure

ED Type 3 performance continues to meet the threshold values.

Cancer waiting times remain below standard with an increase in demand and a lack of capacity. The Colorectal Pathway is having the greatest impact on all of the 2ww standard with 38.5% of all of the breaches.

In February, 77% (227) of the 28-day breaches were for across 4 tumour sites (Colorectal, Urology, Gynae & EN)

Risks

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)		75%	75%	77%	75%	
IP&C	Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative)	0 (Nat)		0	2	3	3	
	Escherichia coli (E. coli) infections (cumulative)	69 (Nat)		69	81	96	108	
	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative)	22 (Int)		27	29	31	32	
FFT	Inpatients Positive Responses	83% (Int)		79%	86%	88%	86%	
	Maternity Response Rate	19% (Int)	L	16%	16%	18%	18%	
	Maternity Positive Responses	94% (Int)		92%	92%	90%	91%	

Performance & Counter Measure

The complaint response rate has remained similar in month .

The Trust exceeded its internal trajectory for MSSA in the autumn, however the rate is now consistently below that seen earlier in the year and has been that way for several months. If this rate can be maintained (or improved on further) we will see a significant decrease in overall numbers in 2023/24.

The Trust is over trajectory for *E. coli* bloodstream infections and the gap from trajectory widened even further in March. This is the infection where we are making least progress. An Improving Together A3 with clear actions was shared at March's Infection Control Group and progress against this will be monitored monthly through that group.

There has been no overall change in the in Inpatient positive responses for family and friends, with the internal target continuing to be exceeded for the third consecutive month.

Maternity response rates and positive responses remain slightly lower than target, a QR code has been included in communications in poster format throughout the service to provide additional opportunities for families to provide feedback.

Risks

Common cause - no significant change.

Special cause of concerning nature or higher pressure due to higher or lower values.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Dec-22	Jan-23	Feb-23	Mar-23
Harm	No. of serious incidents reported in month	SPC		3	3	3	6
	Falls rate per 1000 bed days	SPC		5.9	6.6	5.3	6.4
	No. of Falls in month	SPC		121	134	96	127
	No. falls with moderate harm or above	SPC		7	2	2	7
	Medication incidents with moderate harm	SPC		2	2	2	2
Concerns and Com	No. of concerns received	SPC		116	151	173	190
	No. of complaints received	SPC		41	37	50	46
	Number of reopened complaints	SPC		3	2	4	3
IP&C	Clostridium difficile (C. diff) infections (cumulative)	48 (Nat)		33	34	39	49
	Pseudomonas infections (cumulative)	19 (Nat)		11	12	12	15
	Klebsiella infections (cumulative)	23 (Nat)		18	20	22	26
	Covid – no. of hospital acquired	SPC		44	22	36	63

Common cause - no significant change.

Special cause of improving nature or lower pressure due to lower values.

Performance & Counter Measure

The numbers of falls and the rate per 1000 bed days has increased in month, with actual falls 127 in month.

There are a total of 14 on-going Serious Incident, with six reported in month, including two never events. The total overdue is five, which is a slight increase last month

The Clinical Practice Educator for Falls and Enhanced Care has delivered sessions on Get up , Get dressed, Keep moving. Following this a ward-based decision-making tool is in development.

A sensor mat decision tool has been developed to support staff with the identifying appropriate patients who would benefit from the use of a sensor mat.

The Trust ended the year one case over trajectory for *C. diff* infections, which is disappointing after notably good performance all year. Several cases occurred in the last two weeks of 2022/23, which reflected the picture across BSW and is being investigated collaboratively across the system. The Trust was comfortably under trajectory for *Pseudomonas aeruginosa* bacteraemias and slightly over for *Klebsiella* bacteraemias, which also saw a sudden rise in cases toward the end of the year. The actions from the A3 on CAUTI reduction should bring *Klebsiella* rates down as well as *E. coli*.

Risks

There is a risk in the Patient Experience team due to long term sickness, this is being managed through re distribution of work.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Dec-22	Jan-23	Feb-23	Mar-23
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)		95.4%	98.3%	94.4%	96.6%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)	H	104.5%	114.3%	111.7%	109.8%
FFT	Overall response rate (%)	27% (Int)		19.6%	29.8%	30.2%	26%
	Positive response (%)	86% (Int)		80%	90%	89%	88%
	ED & UTC Response Rate	19% (Int)	H	19%	22%	20%	20%
	ED & UTC Positive Responses	77% (Int)		72%	84%	78%	81%
	Inpatients Response Rate	24% (Int)		20%	26%	31%	26%
	Daycases Response Rate	24% (Int)		21%	30%	25%	26%
	Daycases Positive Responses	96% (Int)		96%	96%	97%	95%
	Outpatients Positive Responses	99% (Int)	H	100%	98%	98%	96%
	Maternity Positive Responses	94% (Int)		92%	92%	90%	91%

Common cause - no significant change.

Special cause of improving nature or lower pressure due to higher values.

Performance & Counter Measures

Registered Nurse Safe Staffing fill rates are higher than last month whereas Health Care Assistant rates are slightly reduced this reflects the additional controls in place to manage enhanced support requests.

FFT Data shows reduction in response rates for the inpatient areas, all other areas have shown minimal movement, with Emergency department and Urgent Treatment Centre delivering above target. Positive response rates remain above or close to internal targets.

Improvement actions mplemented include:

- New First Impressions Count training delivered in March with a focus on supporting front line/reception/administration staff
- Focus on improvements for nutrition and hydration taking place in ED and UTC with team raising awareness and focus for all staff to ensure all patients receiving appropriate food and drink
- New Changing places facility completed on the children's unit awaiting confirmation of formal opening date with Mums on a Mission group

Risks

Use of Resources

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Nov-22	Dec-22	Jan-23	Feb-23
Use of Resources	Capital Expenditure (£'000)	SPC		597	1118	652	2270
	Pay (£'000)	SPC		23452	22388	22868	21772
	Non Pay (£'000)	SPC		14816	15878	15521	17019

Performance & Counter Measure

The Trust has capital expenditure of £2,270k in February against the CDEL programme in total for 2022/23 of £12.5m. Total Capital Expenditure at Month 11 year to date is £7.9m below plan. Of this, £5.5m relates to Trust CDEL schemes, with the remaining £2.4m slippage on externally funded schemes.

Though the Year capital expenditure is low, the capital team have been meeting with divisions, project leads, and procurement to monitor progress and ensure the allocated funding is spent as best as possible.

Pay costs are c£1.1m lower than the previous months as pay reserves have been released in month. Pay overall is however our biggest cost and a key contributor of our variances.

Non-Pay costs have increased significantly from 2019/20, with the 2022/23 run rate relatively static in year but it has increased this month vs. Previous month and this is predominantly driven by non-pay and clinical supplies and utility increased costs.

Risks

The Trust is expected to breakeven for this financial year. There are remaining risks that mainly relate to further elective recovery activity costs being above income levels received and also inflationary costs. Other risks include negotiation of financial outturns with commissioners of cost & volume vs income. These are not expected to impact on the breakeven financial position this year.

Common cause - no significant change.

Our People

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	5.8%	4.9%	4.5%	One month behind	

Performance & Counter Measure

- Sickness decreased further in month to 4.5%. Of this 2.6% is short term and 1.9% is long term. Covid-19 related absence has reduced in month, reporting as 0.66% of total sickness absence in February.
- Current National benchmarking data for November 2022 (NHS Digital) shows a National sickness level of 5.4% and South West sickness level of 5.3%, compared to 4.9% for GWH. The Trust remains within the top 40% nationally.
- The Trust 'Improving Attendance' working group has identified a need to provide Band 6 and Band 7 team leaders with upskilling in absence management processes. Learning can be booked on an absence workshop through ESR training.

Risks

	
Common cause - no significant change.	Variation indicates consistently failing the target.

Our People

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Workforce	% of leavers within 1st year of employment	31.2% (Int)		22.7%	23.6%	28.6%	One month behind	

Plan Area	Metric	2017	2018	2019	2020	2021	2022 Q1	2022 Q2	2022 Q4
Staff Survey	Staff Survey response rates	46.5%	43.6%	40.0%	53.4%	39.5%	21.4%	23.6%	21.6%
	My immediate manager takes a positive interest in my health and well-being	68.8%	67.5%	74.8%	69.2%	64.4%	Not in Quarterly Survey	Not in Quarterly Survey	Not in Quarterly Survey

Common cause - no significant change.

Performance & Counter Measure

- The % of leavers within 1st year of employment has further increased in month to 28.6%, with 'Work/Life Balance' and 'Relocation' remaining as prevalent reasons for leaving.
- Retention working group is being mobilised to track progress against the Trust Action Plan.

Risks

- High turnover in Senior Management positions will impact on performance and improvement continuity.

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend Vs Last Month	Trend Vs Mar-22
	Vacancy																	
W	Vacancy Rate	%	7.00%	6.33%	8.03%	7.31%	6.94%	7.48%	6.70%	6.31%	6.56%	5.97%	6.23%	7.43%	6.40%	5.30%	↓	↓
W	Vacancy Rate	WTE	-	321.55	415.32	377.16	358.52	386.57	347.09	328.65	343.04	313.11	329.52	392.94	335.02	276.66		
W	All Nursing Vacancy	%	7.00%	4.59%	7.40%	6.44%	5.27%	5.62%	4.88%	5.58%	5.95%	5.27%	5.62%	6.51%	5.20%	3.65%	↓	↓
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	110.90	184.68	160.51	131.68	140.23	122.71	141.28	151.92	135.61	146.64	170.25	135.53	94.47		
W	All Registered Nursing Vacancy	WTE	-	29.34	109.82	112.98	119.04	130.70	121.67	113.32	102.85	87.51	91.41	92.65	77.18	43.38		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	15.34	33.55	52.23	53.91	63.29	55.96	50.49	51.28	43.73	54.94	47.18	36.73	27.43		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	81.56	74.86	47.53	12.64	9.53	1.04	27.96	49.07	48.10	55.23	77.60	58.35	51.09		
W	Medical Vacancy	%	7.00%	6.89%	9.00%	8.68%	8.94%	9.57%	6.53%	3.64%	5.73%	5.80%	5.43%	5.61%	8.49%	6.86%	↓	↓
W	Medical Vacancy	WTE	-	47.14	63.55	60.96	62.75	67.19	45.84	25.59	40.26	40.74	38.33	39.16	59.19	47.86		
W	STT/AHP Vacancy	%	7.00%	7.36%	7.84%	7.11%	7.44%	8.94%	8.25%	7.57%	6.89%	6.09%	6.54%	6.97%	6.29%	7.66%	↑	↑
W	STT/AHP Vacancy	WTE	-	60.99	64.89	58.82	61.57	74.04	68.37	62.72	57.10	50.49	54.28	57.85	51.64	63.84		
W	SMA Vacancy	%	7.00%	8.95%	8.97%	8.50%	8.98%	9.21%	9.66%	8.68%	8.21%	7.55%	7.88%	10.97%	7.96%	6.37%	↓	↓
W	SMA Vacancy	WTE	-	102.52	102.20	96.87	102.52	105.11	110.17	99.06	93.76	86.27	90.27	125.68	88.66	70.50		
W	Recruitment Time to Hire - Trust Sub	Days	46.00	56.90	61.20	67.70	67.90	62.00	61.10	74.70	63.70	74.30	72.30	91.30	50.90	54.50	↑	↓
W	Recruitment Time to Hire - Trust Bank	Days	46.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	117.90	127.80	↑	↑
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,076.56	5,169.51	5,162.20	5,168.30	5,167.69	5,183.80	5,204.80	5,226.19	5,248.35	5,289.43	5,289.16	5,236.02	5,224.47		
W	Budgeted vs Worked WTE Variance	WTE	-	240.44	58.44	89.92	91.14	138.16	191.33	121.30	71.71	184.20	87.52	51.09	109.88	237.86		
W	Actual Worked vs Budgeted %	%	-	4.74%	1.13%	1.74%	1.76%	2.67%	3.69%	2.33%	1.37%	3.51%	1.65%	0.97%	2.10%	4.55%		
W	Total Workforce Cost £	£	-	£19.99M	£23.15M	£22.93M	£23.22M	£21.61M	£22.66M	£26.58M	£23.35M	£23.45M	£23.54M	£22.87M	£21.77M	£46.43M		
W	Agency Spend as % of Total Spend	%	6.00%	7.60%	6.88%	6.57%	6.36%	4.18%	6.23%	5.65%	6.53%	6.17%	5.97%	5.60%	4.98%	5.35%	↑	↓
W	Agency Spend £	£	-	£1.77M	£1.51M	£1.44M	£1.42M	£0.91M	£1.37M	£1.55M	£1.53M	£1.48M	£1.41M	£1.28M	£1.23M	£1.27M		
W	Agency WTE	WTE	-	139.35	113.88	124.59	117.85	121.32	134.43	137.51	127.69	113.12	109.26	102.88	90.00	106.82		
W	Bank WTE	WTE	-	386.55	316.65	311.77	304.96	377.97	375.45	285.71	258.31	354.47	278.67	310.93	323.25	377.11		
W	Registered Nursing Bank Fill	%	45.00%	47.78%	45.28%	44.86%	47.09%	44.52%	37.70%	46.59%	48.32%	53.80%	43.60%	52.86%	55.30%	54.71%	↓	↑
W	Unregistered Nursing Bank Fill	%	70.00%	62.47%	63.53%	69.76%	75.59%	72.53%	69.81%	72.94%	66.26%	70.85%	62.98%	74.32%	71.78%	77.63%	↑	↑

Our People

NHS
Great Western Hospitals
NHS Foundation Trust

Workforce Scorecard

Type	Metric	Unit/Measure	Target	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend Vs Last Month	Trend Vs Mar-22
	Retention																	
W	All Turnover %	%	13.00%	15.59%	14.89%	14.82%	15.46%	15.90%	15.00%	14.87%	14.69%	14.52%	14.90%	14.84%	14.42%	-	↓	↓
W	Voluntary Turnover %	%	11.00%	11.66%	11.89%	11.88%	12.38%	12.64%	12.07%	12.00%	11.78%	11.54%	11.84%	11.57%	11.25%	-	↓	↓
W	Number of Leavers	Headcount	-	70	68	55	80	78	49	65	57	54	68	73	42	-		
W	Number of RN Leavers	Headcount	-	25.00	21.00	18.00	17.00	16.00	12.00	15.00	8.00	6.00	13.00	16.00	8.00	-		
W	Registered Nursing Vol Turnover	%	-	9.91%	10.37%	10.48%	10.47%	10.48%	10.11%	10.02%	9.61%	8.92%	8.79%	8.58%	7.99%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	14.00	10.00	12.00	22.00	13.00	15.00	16.00	17.00	17.00	19.00	15.00	12.00	-		
W	Unregistered Nursing Vol Turnover	%	-	14.30%	14.35%	14.23%	15.39%	15.69%	15.02%	15.29%	15.72%	15.62%	16.37%	16.73%	16.57%	-		
W	Leavers within 1st Year of Employment	%	-	25.71%	25.00%	34.55%	28.75%	29.49%	24.49%	20.00%	28.07%	29.63%	22.06%	24.66%	28.57%	-		
W	Number of starters	Headcount	-	85	93	89	70	56	99	103	103	84	56	107	71	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	5.22%	5.43%	5.48%	5.53%	5.63%	5.62%	5.59%	5.59%	5.55%	5.55%	5.41%	5.29%	-	↓	↑
D	Sickness Absence %	%	3.50%	6.65%	6.08%	4.68%	5.13%	6.01%	4.73%	4.77%	5.34%	4.87%	5.79%	4.90%	4.49%	-	↓	↓
W	Long Term Sickness %	%	2.00%	2.79%	2.60%	2.60%	2.70%	2.67%	2.70%	2.52%	2.36%	2.36%	2.48%	2.51%	1.91%	-	↓	↓
W	Short Term Sickness %	%	1.50%	3.86%	3.47%	2.09%	2.43%	3.34%	2.03%	2.24%	2.99%	2.51%	3.31%	2.39%	2.58%	-	↑	↓
W	Sickness Absence Cost £	£	-	£935.5k	£806.7k	£642.2k	£678.0k	£842.5k	£648.5k	£638.9k	£767.6k	£650.4k	£749.9k	£687.4k	£575.4k	-		
W	WTE Days Lost	WTE	-	9,661.7	8,559.9	6,926.0	7,280.7	8,728.5	6,887.2	6,780.7	7,952.9	7,096.4	8,768.5	7,364.2	6,109.2	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	87.38%	87.36%	87.75%	87.87%	87.74%	86.70%	87.22%	85.79%	86.39%	86.40%	86.61%	86.79%	87.69%	↑	↑
W	Role Essential MT %	%	85.00%	89.17%	89.05%	89.33%	89.62%	89.64%	88.56%	89.28%	87.99%	88.75%	88.94%	89.06%	89.03%	89.66%	↑	↑
W	CQC Safe MT %	%	85.00%	85.64%	85.73%	86.22%	86.17%	85.91%	84.90%	85.22%	83.65%	84.10%	83.93%	84.18%	84.54%	85.71%	↑	↑
W	Appraisal Compliance %	%	85.00%	68.85%	70.05%	73.03%	74.55%	75.56%	75.75%	75.04%	76.32%	79.31%	81.43%	81.16%	83.33%	82.25%	↓	↑
W	Non Medical Appraisal Compliance %	%	85.00%	69.66%	71.44%	74.99%	77.85%	77.91%	78.12%	78.03%	77.94%	78.88%	81.08%	80.60%	82.33%	80.68%	↓	↑
W	Medical Appraisal Compliance %	%	85.00%	63.13%	60.29%	58.82%	50.37%	58.38%	58.41%	53.44%	64.63%	82.84%	84.13%	85.44%	91.07%	93.90%	↑	↑
	Demographics																	
W	Staff in Leadership Roles %	%	-	3.37%	3.37%	3.43%	3.34%	3.32%	3.17%	3.24%	3.32%	3.21%	3.17%	3.20%	3.26%	3.26%		
W	Staff in Leadership Roles WTE	WTE	-	197.00	197.00	202.00	197.00	195.00	188.00	194.00	199.00	194.00	193.00	192.00	196.00	197.00		
W	% of Leadership Roles who are Female	%	-	67.51%	66.50%	65.84%	65.48%	65.64%	67.02%	66.49%	67.34%	68.04%	67.88%	68.23%	68.37%	67.51%		
W	% of Leadership Roles who from BME	%	-	5.08%	5.58%	5.45%	5.58%	5.64%	5.85%	6.19%	6.53%	5.67%	5.70%	6.77%	6.63%	6.60%		
W	Male % of Workforce	%	-	17.37%	17.45%	17.51%	17.66%	17.57%	17.43%	17.62%	17.45%	17.36%	17.38%	17.55%	17.50%	17.72%		
W	Female % of Workforce	%	-	82.63%	82.55%	82.49%	82.34%	82.43%	82.57%	82.38%	82.55%	82.64%	82.62%	82.45%	82.50%	82.28%		
W	BME % of Workforce	%	-	19.81%	20.16%	20.39%	20.65%	20.81%	21.05%	21.24%	21.48%	21.83%	21.94%	22.54%	22.75%	23.25%		
W	White % of Workforce	%	-	70.95%	70.59%	70.31%	70.17%	70.21%	69.99%	69.71%	69.60%	69.33%	69.16%	68.74%	68.71%	68.24%		

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

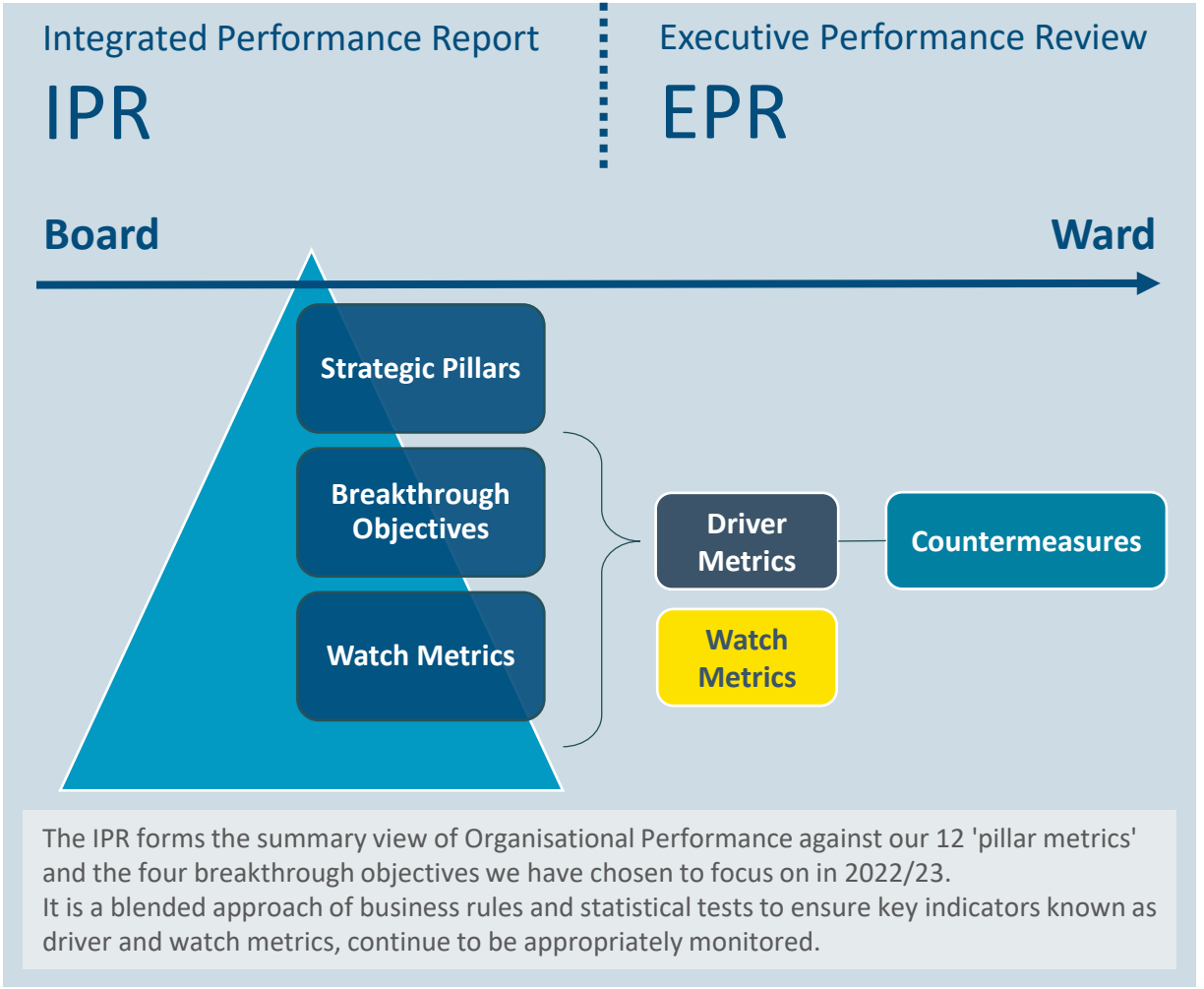
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

- Tissue viability – reducing pressure ulcers
- A&E arrival to departure over 12 hours
- Staff survey – I am able to make improvements happen in my area of work
- Non-criteria to reside – reducing patients waiting in hospital

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

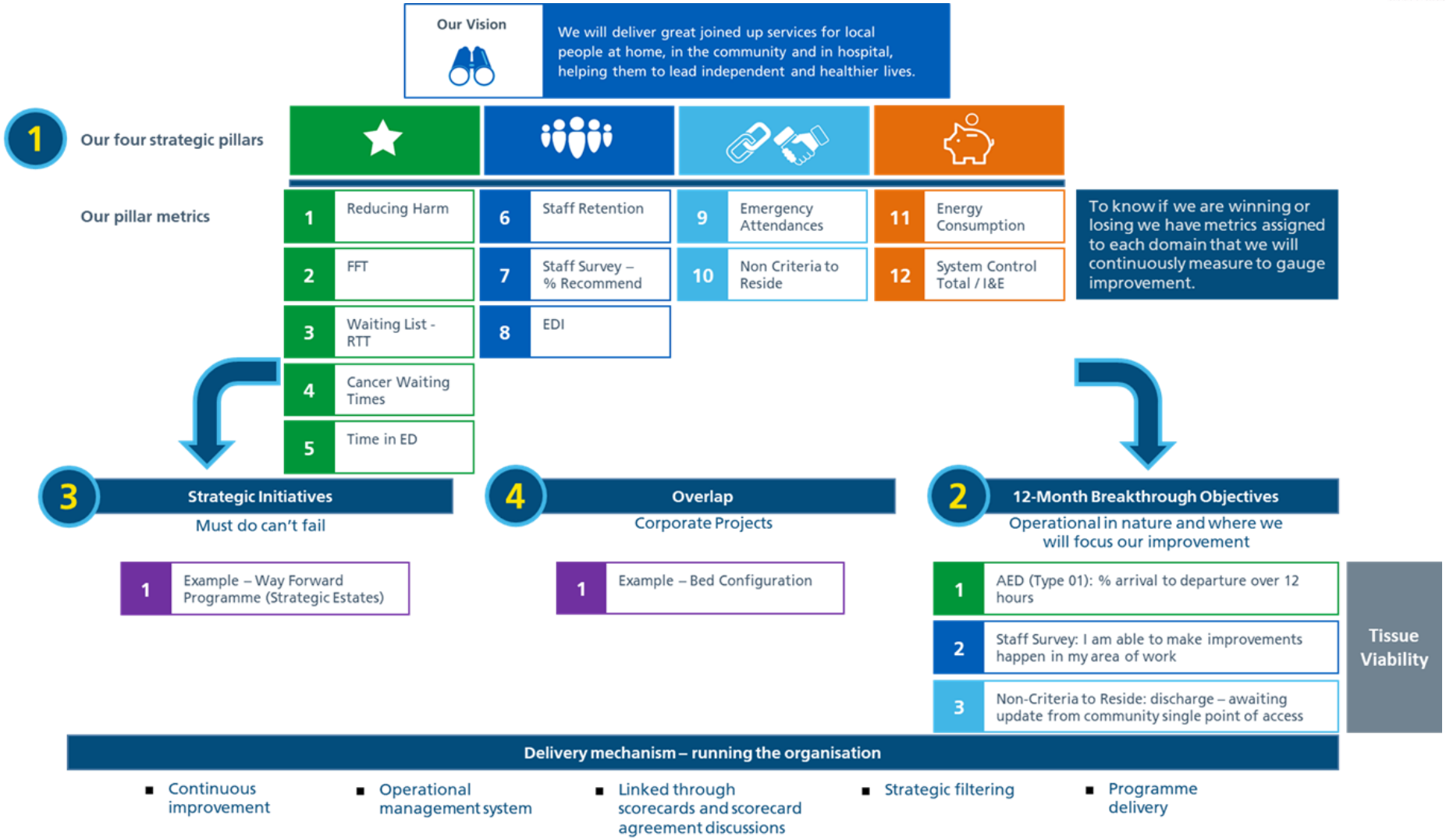
Our Vision

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

Our four strategic pillars

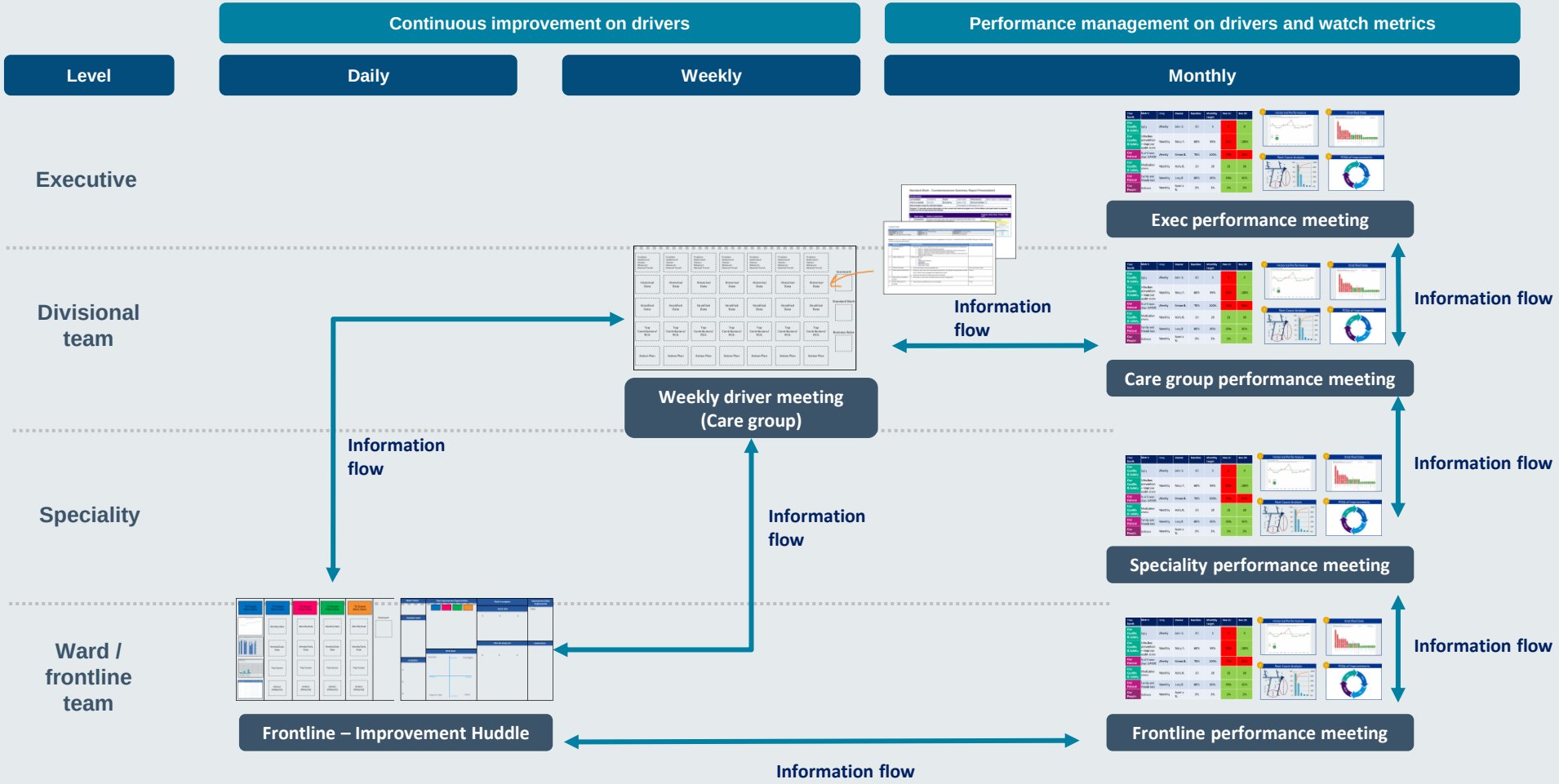
- Outstanding patient care and a focus on quality improvement in all that we do
- Staff and volunteers feeling valued and involved in helping improve quality of care for patients
- Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers
- Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care

Strategic Planning Framework



Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



Building a culture of continuous improvement

NHS
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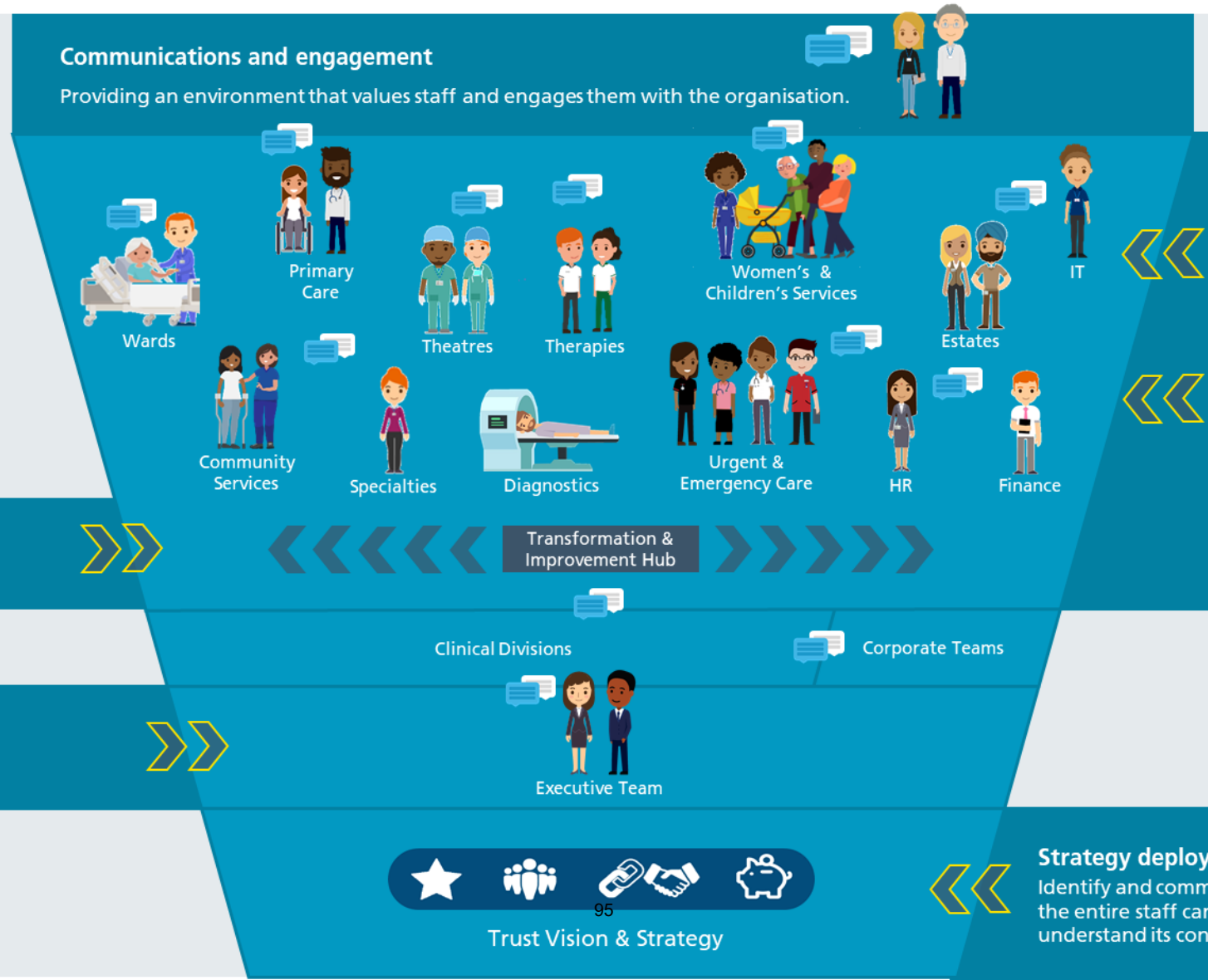
NHS Foundation Trust



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

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

Transformation & Improvement Hub
Develop an internal capability to develop and sustain improvement journey.

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

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

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

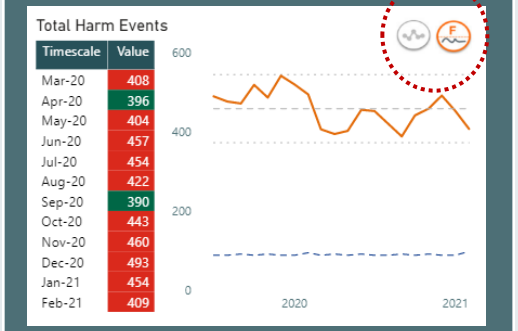
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons:

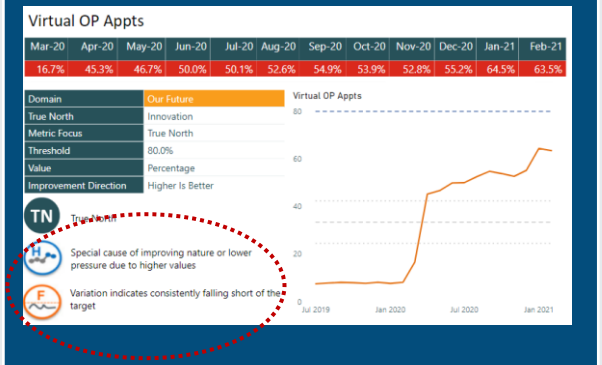
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

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

Agreed Terms

NHS
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

NHS
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.

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Agreed Terms

NHS
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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.

Report Title	**Improving Together Metric Refresh**						
Meeting	**Trust Board**						
Date	**4th May 2023**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]		Agenda Item [Added after submission]	
Accountable Lead	Claire Thompson, Chief Officer for Improvement & Partnerships						
Report Author	Emily Beardshall, Deputy Director of Improvement & Partnership						
Appendices	Metric refresh presentation recommendations from TMC						

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

Assurance Level

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

Process

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

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

Report

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

This report presents a recommended change for the Improving Together Pillar Metrics and Breakthrough Objectives for 2023/24. Given the current metrics have been in place since mid-2022/23 it has been agreed at TMC that a light touch refresh is made with minimal change to the overall structure and emphasis of the measures.

The suggested changes take account of learning to date on the implementation and measurement of improvements rather than representing a significant deviation from the current strategic priorities of the operational management system.

Having reviewed the metrics, their alignment with divisional, specialty and front line metrics as well as recent intelligence such as the staff survey results and NHSE priorities for 23/24, TMC agreed that we:

- refine measures for pillars 3, 8 and 12
- change measure for ED breakthrough objective
- add productivity as a new breakthrough objective
- remove NCTR as a breakthrough objective (pillar metric would remain)

This adjusts rather than fundamentally changes our current priorities for the operational management system (constancy of purpose) and maintains 4 breakthrough objectives (retaining the "inch wide, mile deep" focus).

Links to Strategic Pillars & Strategic Risks – select one or more	★			
	x	x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)				**Risk Score**
	Improving Together is a key part of mitigation to BAFS1 – Outstanding Patient Care			/
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Improving Together Steering Group, Improvement Sub-Committee, Trust Management Committee			
Next Steps	• Agree Trust lead for productivity breakthrough objective • Implement changes to measures with leads for pillar metrics and breakthrough objectives • Review with divisions via Executive Review Meetings to ensure alignment with divisional and specialty driver metrics • Complete revised or new A3s where needed • Alignment between breakthrough objectives and 2023/24 Quality Account priorities • Update Integrated Performance Reporting for 2023/24 – May TMC and May Committees reporting to June Trust Board. • Map out process for full metric refresh for 2024/25 aligning to refreshed GWH strategy. Process to begin in July 23.			

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	X		
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	X		
Explanation of above analysis: The subject of this report relates to the delivery of healthcare services, which we know currently do not take due account of protected characteristics or do enough to address health inequalities. The focus of pillar metric 8 provides some assurance on the promotion of EDI within the trust.			

Recommendation / Action Required

The Board is requested to:

Note the changes to the Improving Together Pillar Metrics & Breakthrough Objectives which will be brought through May Committees (month 1 reporting for 2023/34).

Any further questions can be raised with Emily Beardshall, Deputy Director – Improvement & Partnerships

Accountable Lead Signature	
Date	27/04/23

Great Western Hospitals
NHS Foundation Trust

Improving Together Metric Refresh 2023-24

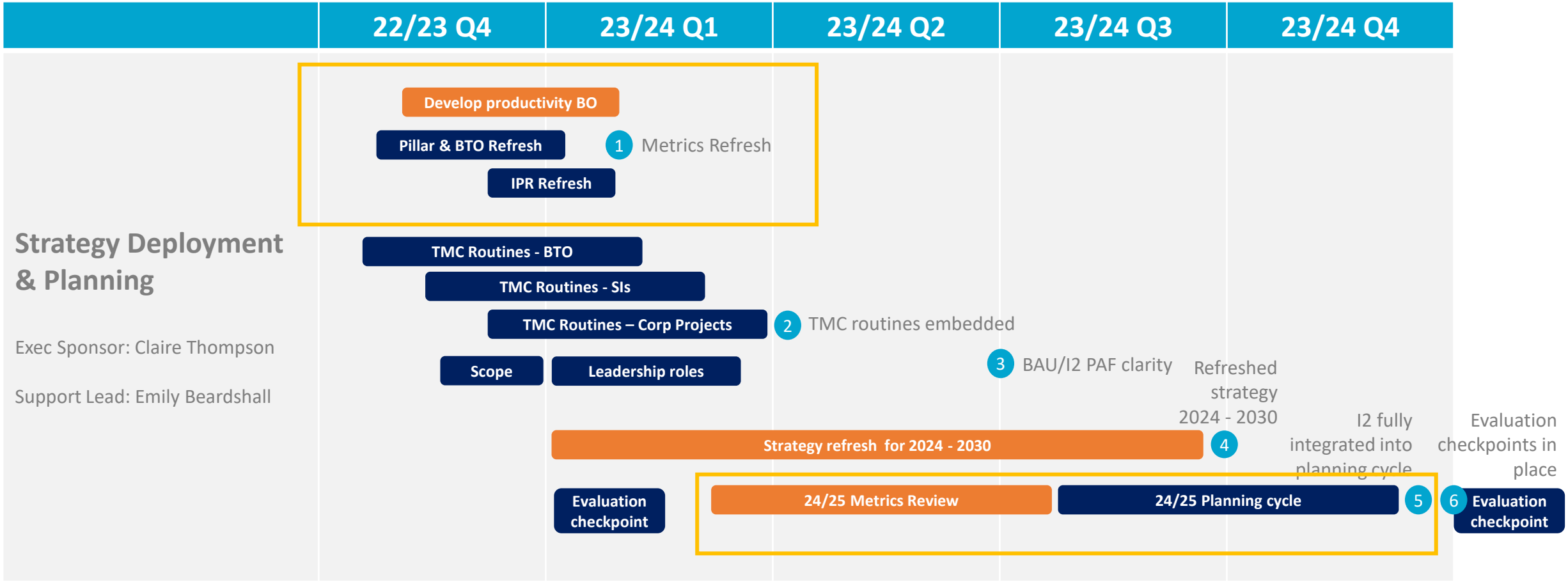
Trust Board - 4th May 2023

Improving
together

Metric Refresh

Great Western Hospitals NHS Foundation Trust

Light touch metric refresh for 2023/24 followed by a more complete review for 2024/25 are important elements of the strategy deployment element of the Improving Together roadmap.



Current Pillar Metrics

Great Western Hospitals NHS Foundation Trust

	Pillar Metrics	Aim	Measure
	1 Reducing Harm	To achieve and sustain zero avoidance harm	Total harms
	2 FFT (Friends & Family Test)	To achieve consistent +ve response rates in excess of 86% from FFT	FFT % of positive responses
	3 Waiting list – RTT (Referral to Treatment)	To achieve & sustain 92% of all patients waiting less than 18 weeks for 1st definitive treatment	< 18 week compliance
	4 Cancer waiting times	To achieve & sustain 85% 62 day performance for patients on a cancer pathway	Cancer 62 day standard
	5 Time in ED (Emergency Department)	To achieve & sustain 85% a mean time of 240 mins for all patients attending ED & UTC	Mean stay in ED and UTC
	6 Staff Retention	To achieve and maintain a maximum voluntary turnover rate of 11%	Trust voluntary turnover rate
	7 Staff Survey - % Recommend	To improve our staff engagement score as demonstrated in the annual staff survey	Staff survey – I would recommend my organisation as a place to work
	8 ED & I (Equality, Diversity, and Inclusion)	To ensure a broad & diverse workforce to best represent the community we serve	Trust disparity ratio
	9 Emergency Attendances	To ensure patients are cared for in the appropriate setting	Emergency care (ED & UTC) attendances
	10 No Criteria to Reside	To treat the right patients in the right place, to ensure delivery of high quality care	Number of NCTR days
	11 Sustainability / Carbon footprint	To achieve an organisational carbon neutral footprint	Energy consumption (KWh) – Elec & Gas
	12 System Control Total / I & E (Improvement & Efficiency)	To achieve & sustain a break even financial position	ICB financial surplus/deficit (I&E)

Current Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

- Breakthrough objectives set in Summer 2022
- Aim was for rapid improvement over a 12-18 month period
- Level of improvement seen for current breakthrough objectives (Feb data)

Breakthrough Objectives

		Aim	Progress
BTO	Time in ED / % > 12 hours	Patients > 12 hours is no more than 2% of ED attendances	Position worsened
BTO	Pressure Harms	30% reduction in harms	No significant change
BTO	Staff Survey = % improvements	Achieve 55% in staff survey (5.7% improvement)	2.6% improvement
BTO	NCTR – Comm Single Point of Access	30% improvement in top cause	58% improvement Exceeded expectation

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
14.7%	15.8%	13.6%	12.2%	12.1%	15.4%	16.6%	16.9%	16.3%	18.7%	18.1%	16.0%

Total Pressure Harms

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

2017	2018	2019	2020	2021	Pulse 2022 Q1	Pulse 2022 Q2	2022	Pulse 2022 Q4
52.40%	49.40%	56.70%	54.50%	49.30%	50.31%	51.10%	51.90%	52.72%

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
993	1185	1053	1060	795	760	968	1309	723	703	635	406

Areas for Refinement

Great Western Hospitals NHS Foundation Trust

Our four strategic pillars

- Outstanding care and a focus on quality improvement in all that we do
- Staff & volunteers feeling valued and involved in helping improve quality of care
- Improving quality of care by joining up acute and community services in Swindon and through partnerships with other providers
- Using our funding wisely to give us a stronger foundation to support improvements in quality

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	FFT (Friends & Family Test)
3	Waiting list – RTT (Referral To Treatment)
4	Cancer waiting times
5	Time in ED (Emergency Department)
6	Staff Retention
7	Staff Survey - % Recommend
8	ED & I (Equality, Diversity, and Inclusion)
9	Emergency Attendances
10	Criteria to Reside
11	Sustainability / Carbon footprint
12	System Control Total / I & E (Improvement & Efficiency)

= ? area of review for 2023/24

Breakthrough Objectives

BTO	Time in ED / % > 12 hours
BTO	Pressure Harms
BTO	Staff Survey = % improvements
BTO	NCTR – Comm Single Point of Access
BTO	Productivity TBC

New for 2023/24?

	Pillar Metrics		TMC recommendation	
Pillar metrics	1	Reducing Harm		
	2	FFT (Friends & Family Test)		
	3	Waiting list – RTT	3	Waiting list – > 65 weeks
	4	Cancer waiting times		
	5	Time in ED – mean time		
	6	Staff Retention		
	7	Staff Survey - % Recommend		
	8	ED & I – disparity ratio	8	ED & I – staff survey discrimination
	9	Emergency Attendances		
	10	No Criteria to Reside		
	11	Sustainability / Carbon footprint		
	12	System Control Total / I & E	12	GWH Control Total / I & E
Breakthrough Objectives	BTO	Time in ED / % > 12 hours	BTO	Time in ED - Clinically ready to proceed
	BTO	Pressure Harms		
	BTO	Staff Survey - % improvements		
	BTO	NCTR – Awaiting Comm SPA	BTO	NCTR – **Remove**
			BTO	Productivity - **Addition**

TMC discussed options to remain with the current set of metrics or make changes.

Pillar 3. Planning guidance and national focus is on reducing longest waits for patients in order to minimise harm and social impact of current waiting times. National mandate to eliminate over 65 week waiters by March 2024. Focus on delivery of 92% incomplete RTT pathways being below 18 weeks is unlikely to be the main focus for a number of years

Pillar 8. The current metric of disparity ratio is hard to provide granular countermeasures for and there is a desire to respond to and show changes in staffs' lived experience.

Pillar 12. Responding to feedback in 22/23 that we should focus action on our organisational position (as part of the system) we will replace the system control total with our own financial plan target.

BTO 1. Pillar metric 5 remains a measure of the mean time spent in ED. The breakthrough measure supports increased visibility of causes for delay within the ED/front door pathway. By making the gap between "ready to go" and admission visible this measure supports countermeasures focused on improving processes and flow at the front door whilst also developing improvements concentrating on the reasons for delays in onward flow.

BTO 4. Remove NCTR - improvement delivered, and replace with productivity metric. GWH has seen a 23% decrease in productivity since 2019/20. Whilst this has recovered during 2022/23 further improvement is needed to ensure that activity levels can be restored to provide more timely diagnostic and elective care alongside generating income inline with the submitted 2023/24 operational and financial plans. Delivery of the submitted plans is estimated to deliver an improvement in productivity from -18% to -14% against 2019/20 levels. This may be further improved through delivery of other efficiencies. There is good mapping to divisional and specialty driver metrics. An A3 is currently in development for productivity improvement.

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Improving together

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		29th March 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance, and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance, but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access	R	A	Attendance fell during January/February to their lowest level in 22/23. The Trust performed relatively well against the 4 hour standard and saw mean waiting times reduce to 8 hours from the previous high of 9+ hours. Industrial action and a decrease in the number of non-criteria to reside patients in the Trust are thought to have contributed to this improved performance. Unfortunately, 16% of patients still experienced wait times in excess of 12 hours.	Monitor Actions	April 2023
Integrated Performance Report – Elective Access - RTT	R	A	Management of the March 78 week cohort continues, with patient-by-patient reviews continuing and extending to patients who will be waiting over 78 weeks in April and May to ensure next steps are in place and being expedited, and any complexities of pathways understood so these can be mitigated. A RTT training workshop is being scheduled in April for Trust operational management teams, to support with applying RTT and Elective Access rules into practice.	Monitor Actions	April 2023

			Post committee note – FTD to provide update once the end of year position is established.		
Integrated Performance Report – Elective Access – DM01	R	A	Overall waiting times for diagnostics improved by 5.7% in February (54.2%) with MRI/CT scans continuing to see good progress. The committee was heartened to note the continued delivery of all scans for cancer referrals within the two week target. Other diagnostic services such as Ultrasound and Dexa scans remain under pressure and significantly below target.	Monitor Actions	April 2023
Integrated Performance Report – Cancer	A	A	Committee members were re-assured last month of the Amber/Amber rating following the latest Cancer Services Quarterly Assurance Report presented which continues to focus on the hot spots with Dermatology and Plastics.	Monitor Actions	April 2023
Non-Criteria to Reside	A	A	Committee members noted that this is the 4th month in a row that there has been a reduction in the number of bed days lost through non criteria to reside. It was also noted that GWH is the second best performing trust in the South West at time of reporting. The committee heard a number of positive discharge initiatives including Home First and the success of the Co-ordination Centre where work is taking place with partners reviewing processes and is very action orientated.	Monitor Actions	April 2023
Peer Trauma Network Results	G	G	Committee members received a very positive update on the findings of the 2022 NHS England annual Major Trauma Peer Review. Clinical and Nursing leadership was praised and the multi-disciplinary pathways were flagged as working well. No immediate risks or serious concerns were identified, and numerous examples of good practice were noted. A couple of concerns were raised which the management team are working on.	Monitor Actions	April 2023

Issues Referred to another Committee – Coding Risk	
Topic: Financial Risk due to issues with Coding resource, expertise and practice.	**Committee: Finance, Infrastructure & Digital Committee**

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		26th April 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance, and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance, but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access	R	A	The Trust continues to perform relatively well against the 4-hour standard and saw a reduction in mean waiting times. Industrial action and a decrease in the number of non-criteria to reside patients in the Trust are thought to have contributed to this improved performance.	Monitor Actions	May 2023
Integrated Performance Report – Elective Access - RTT	R	A	Positive news in terms of end of year compared to the previous month. Management of the March 78 week cohort continues, with patient-by-patient reviews continuing and extending to patients who will be waiting over 78 weeks to ensure next steps are in place and being expedited, and any complexities of pathways understood so these can be mitigated. A similar position from last month was reported. Activity performance for March was strong against plan.	Monitor Actions	May 2023

Integrated Performance Report – Elective Access – DM01	R	A	DM01 performance was the highest it has been in two years at 56% with MRI/CT scans continuing to see good progress, in line with the performance delivery plan. Overall, the service is continuing to show steady progress being made which the committee felt is a sustainable improvement.	Monitor Actions	May 2023
Integrated Performance Report – Cancer	R	A	Committee members received an update on cancer performance which showed no decrease in 62-day waiting performance, however, an increase in the number of patients waiting & predicted March decline. This was a similar position reflected across the whole of England, where GWH are performing better than all England performance. Continued focus with plan on the hot spots within Colorectal, Urology, Dermatology and Plastics. Issues highlighted in terms of Colorectal which reported 13.62% over 62 days and impacted by some strike action.	Monitor Actions	May 2023
Theatres Programme Assurance Report	A	G	Assurance was provided by the Deputy Divisional Director, SWC on the Theatre Improvement Programme along with national benchmarking exercises, regional theatre projects and the actions resulting from these. Members noted and acknowledged the significant improvements within the service.	Monitor Actions	May 2023

Issues Referred to another Committee –	
Topic:	**Committee:**

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Nicholas Bishop	Dr Nicholas Bishop		23 March 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
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Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report: **Pillar Metrics**	A	A	Decrease in total number of harms from 258 to 218. Improvements in falls rates and pressure harms.		
IPR: Friends and Family Test (FFT)	A	A	Positive responses have reduced by 1% overall to 89% but remains above our target of 86%. Positive response rates in all areas remain above or close to internal targets.		
IPR: Pressure Harms	A	A	Pressure harms in the hospital and the community have both reduced for this month. More than 150 new mattresses have been purchased which will reduce risk of pressure harms.		
IPR: Hospital Acquired Infections	R	A	MSSA remains above trajectory almost wholly due to poor cannula practice. Efforts are concentrating on reducing the currently 30% use		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			of ante cubital fossa (at the elbow) for cannula replacement. E.coli rates have also increased, all associated with urinary catheters.		
IPR: Falls:	A	A	There has been a significant reduction in the rate of falls during February.		
Perinatal Quality Surveillance Tool	A	G	Good performance on midwife to birth ratio at 1:26. This is partly due to the shorter month of February with fewer deliveries. We are now at full recruitment level for inpatient midwives.		
Ockenden	A	A	There has been no change although work continues to move the “reds” to “green”. The Committee requested trajectory and/or likely date for meeting these goals.		
Patient Experience Report	A	G	A comprehensive report outlining all the work in association with the Friends & Family Test and patient experience. Concerns rose in the last quarter but complaints reduced. Slight increase in reopened complaints. This was the last of the quarterly reports which henceforth will be 6-monthly.		
Guardian of Safe Working	A	G	Overall the number of exceptions raised were relatively low although most were the F1 year trainees. The expectation is that these reports will move to 6-monthly but with the continuation of junior doctor strike action, the decision was made to keep them quarterly for the moment. The reports will in future be taken by the People & Culture Committee.		
Freedom to Speak Up	A	A	There were only five concerns raised under FTSU since August 2022. There were more HR related referrals than is typical and fewer safety issues. The Committee debated whether this was because other routes exist for raising safety concerns. The Lead Guardian intends to relaunch FTSU using learning from Oxford about hard to reach staff who do not access their NHS email.		
Safeguarding Adults	A	G	The Committee welcomed the news that the St Luke’s training venue was now available to the Trust. This comprehensive report listed all		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			the achievements and risks in the last 6 months. Good progress has been made in Mental Capacity Act compliance.		
Safeguarding Children	A	A	The main concerns remain to be compliance with Level 3 Safeguarding Training. The Committee was assured that all efforts were in place to increase training but with constant staff turnover this will always be difficult. Nevertheless we were told that the service was safe as all those awaiting Level 3 training should have received Levels 1 and 2.		
Monthly Safe Staffing Report	A	A	Little substantial change since the last report. Poor fill rates are the exception to what is otherwise good. The Committee was pleased to hear about recent promotions for three internationally educated nurses.		

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Claudia Paoloni	Dr Claudia Paoloni		20 April 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR Pillar Metric: Total Harms	A	A	Increase in total number of harms from 218 to 302. Significant factors are in an increase in hospital acquired pressure harms, falls and *Clostridium difficile (C.diff)* numbers. Going forwards, as we are no longer testing for Covid routinely, this will impact our total harms numbers and so consideration is being made on how to manage this in the future. Two Never Events were reported and are being investigated appropriately.		
IPR Pillar Metric: Patient Experience	A	A	FFT positive responses have reduced in March but still remain within the internal target of 86%. FFT positive responses in Maternity is 91%, just short of its target 94%.		
IPR Breakthrough Objective: Pressure Harms	A	A	Hospital acquired pressure harms have increased from 23 to 40. Community acquired pressure harms have reduced slightly in month. Whilst somewhat disappointing, there is going to be a review of how pressure		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			harms are measured to ensure that we can focus on addressing areas of most impact. Senior leadership will continue to focus on safety huddles providing oversight and coaching support, with specific focus in gaps on admission skin inspections which has been identified as an ongoing concern. There has been a reduction in DTIs (deep tissue injuries) but an increase in Category 2 pressure ulcers and there appears to be some association in the use of medical devices which is being investigated.		
IPR Alerting Watch Metric: Hospital Acquired Infections	R	A	Increasing *C.diff* rates rose in March from 39 to 49. This is currently under review to identify a cause. In March GWH has seen a higher rate of hospital acquired Covid than the South West average as well as in Norovirus outbreaks, as a result the capacity of our portable air scrubbers has been limited. Still awaiting completion of the installation of permanent units which will mitigate this harm.		
IPR Non Alerting Watch Metric: Falls	A	A	There has been an increase in the rate of falls during March from 96 to 127. Education and decision making tools have been enhanced.		
Quarterly Maternity & Neonatal Quality & Safety Report	A	G	The Committee was assured by the metrics within this report. There had been a gap analysis against a regional maternal death which identified some learnings around translation services which are being addressed. A deeper dive of the Ockenden report has addressed an action plan to work towards moving the 'red' actions forwards. March saw three serious incidents of which one has been referred to HSIB and two under local investigation. Following initial investigation there is no common theme.		
Perinatal Mortality Review Tool Q3	G	B	100% compliance across all measures and the system remains embedded.		
15+ Risk Report	A	A	This is a new report to identify and address any 15+ risks that fall under the Quality & Safety Committee. There is one risk to report relating to timely triage and delays in time critical interventions and treatments for patients utilising Major Chairs/Paeds (walk-in and ambulance).		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			The building of the new Emergency Department should see an improvement in patient pathways which should in part address this risk. Additional actions to include provision of “Hello Nurse” in the Paediatric area/reception. A review of the impact of emergency chairs following the opening of new UTC is being undertaken.		
Emergency Department Dashboard	R	A	There has been a reduction in attendances since December, however length of stay still remains high with 16% to 18% of all ED patients having a stay greater than 12 hours. There is work being done to understand the drivers for this, especially at peak times. The SHINE audit has identified two particular areas that are being addressed – ECG recording within 10 minutes of arrival and NEWS scores recording on admission. Part of this is related to availability of equipment and logistics which are being improved. Patient feedback has shown good results of 90% positive or more in all areas, except pain management which scored 84% which will now be a focus of quality rounds with specific education to focus on pain management.		
Getting It Right First Time (GIRFT)	Not rated at this stage	Not rated at this stage	With the appointment of a new GIRFT Lead, there has been a renewed focus on GIRFT activity within GWH. A centralised support has now been identified to help coordinate and support services, and a new overarching governance process is being put in place to ensure that we can have better oversight around recommendations and improvements that may be required following scheduled GIRFT visits or deep dives. The report did identify that GWH does perform very well compared with national and local peers in several areas, but rates of day surgery still remain insufficient compared to peers and nationally. The hope is that working at a system level will mean learnings from regional peers can be shared.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Clinical audit	A	G	Following some focused activity in the completion of multiple projects, the close of 2022/23 had resulted in only 430 projects being carried over. Going into 2023/24, there are 486 new projects planned. 204 national projects are overdue at 4%. We are awaiting the final national audit programme details which are mandatory for us to participate in. But the level of internal support for data management analysis and reporting has been strengthened following a recent restructure of the team with the introduction of a dedicated facilitator for divisions.		
Draft Quality Account 2022/23	Not rated	Not rated	In order to prepare the Quality Account going forwards, and in alignment with improving together breakthrough objectives, the Committee considered a proposal for three Quality Account priorities: • Reducing the incidence of hospital and community acquired pressure ulcers • Reducing the number of patients in the hospital who are ready to be discharged to care elsewhere in our community • Reducing the amount of time patients spend in our emergency department before they are ready to go home or move on into a hospital bed The final version should be available to be share with the Board by the end of June 2023.		
safe	A	A	There has been a slight improvement in the average fill rate for nurses and midwives. A slight reduction in the full rate for HCA and the three ward areas identified are being focused on in the retention and recruitment plan. This monthly report has a mandated measure which has limited detail and greater assurance comes through the 6-montly report.		

Issues Referred to another Committee	
Topic	**Committee**

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Finance, Infrastructure and Digital Committee – 27 March 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Faried Chopdat	**Faried Chopdat**		**27 March 2023**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF SR7

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Limited	Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these
Significant	Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives
Full	Blue – Delivered and fully embedded

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
FINANCE					
Finance Risks & Way Forward Programme Risks	A	A	The Committee noted that Finance's risk management process and reporting, including that of the Way Forward Program, is adequate and effective. Whilst the Committee was reassured of the scoring of risks for 2022/23, we noted that several Finance-related risks are likely to increase as we enter the 2023/24 year. We noted several risks relating to the Way Forward Program that was adequately mitigated and removed from the risk register resulting in the Committee's assurance evaluation as A/G.	Monitor quarterly through FIDC.	FIDC Meetings 2023
Month 11 Finance position	G	G	As noted in Month 10, the assurance level remains G/G. The Trust received income from the ICB to fund the planned deficit (£19.4m), of which £17.7m is reported in the Month 11 position. Excluding this income, the Trust reports a shortage of £1.5m in the month, of which £0.2m is favourable to the plan. The latest forecast position is breakeven with no material movements in forecast positions. Given the challenges with the forecast plan for 2023/24, the financial situation will likely trend towards a rating of R/R.	Monitor monthly through FIDC	FIDC Meetings 2023
Debtors	G	G	The Committee received a detailed update and positive assurance of the Debtors position as of February 23. We noted the improvements in the current position and the continued focus on collecting and managing aged debt within the Finance function and the SBS teams.	Monitor through FIDC	FIDC Meetings 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
CIP Programme Update	A	A	The in-month position is that £0.81m of efficiency is delivered against the plan of £1.04m resulting in an adverse variance of £0.24m. It is forecast that 70% of the plan will be delivered at year-end. No further opportunities are identified due to the increased focus on 2023/24 planning. As a result, there remains a significant risk to the complete delivery of the 2022/23 plan with a projected £3m shortfall that will form part of the 2023/24 targets. It is anticipated that this risk will be amplified to R/R given that the shortfall will be carried into the next financial year – approximately £7.7m of cash-releasing savings have been identified so far within the 2023/24 plan to date.	Monitor monthly through FIDC	FIDC Meetings 2023
ESTATES & FACILITIES					
Estates and Facilities Risks	A	G	The Committee was assured that the risk management process and reporting risks for Estates and Facilities, which includes Health, Safety, Fire and Security Risks are adequate and effective. Whilst the overall risk remains amber, we were satisfied that management continues to take appropriate actions to mitigate risks.	Monitor through FIDC	FIDC meetings 2023
ERIC – Benchmarking data comparison Update	A	A	Following the approval of the Estates Return Information Collection (ERIC) submission in July 2022, FIDC requested further insight to illustrate where GWH sits across peers in the region. A number of key metrics comparing GWH with other acutes across the South West region was presented with a number of variations noted.	Monitor through FIDC	FIDC meetings 2023
Department of Health & Social Care PFI Centre of Best Practice Survey Process	-	-	The Committee noted a comprehensive update on the CoBP GWH survey process, proposed commercial arrangements, legal documentation, and progress timelines. The Committee approved the contents of the report, including the development of an agreed rectification plan, produced, and implemented within 14 months of the completion plan, built, and implemented within 14 months of the completion of the survey.	Monitor through FIDC	FIDC meetings 2023
Sustainable Travel Plan 2022-2025	-	-	The Travel Plan was presented to the Committee for noting. The aim of the Plan is intended to recognise, develop, and set a pathway for Great Western Hospitals' commitment to sustainable transport through the enablement of alternative modes of travel. The Plan supports the Trust's Staff Travel Choice Policy 2021. It will help the transition away from single occupancy internal combustion engine vehicles to distribute journeys more sustainably across alternative modes of travel.	Review periodically via FIDC	FIDC meetings 2023
PROCUREMENT					
Procurement Quarterly Update	A	G	Procurement continues to deliver against the 2022/23 Plan, and the current savings delivered is £2.1m against a complete plan of £1.76m. The focus is on identifying savings for the 2023/24 plan. Key risks such as PO compliance, cost pressures, and inflation were noted. Overall, management has made good progress in identifying mitigation plans and savings and assisting with capital procurement during the quarter.	Monitor through FIDC	FIDC meetings 2023

Issues Referred to another Committee	
Topic	**Committee**
None	-

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Finance, Infrastructure and Digital Committee – 24 April 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Faried Chopdat	**Faried Chopdat**		**24 April 2023**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	BAF SR7

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

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Full	Blue – Delivered and fully embedded

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
FINANCE					
Month 12 Finance position	A	G	A verbal update was presented on the Month 12 Finance position. Several key risks were noted, including audit challenges on provisions, etc. However, the Committee was satisfied with the mitigation actions to address risks.	Monitor monthly through FIDC	FIDC Meetings 2023
Capital Plan	G	G	Capital spending was behind plan throughout the year as capital plans did not progress as anticipated. Trust teams proactively managed slippage by developing a governance process with Procurement and capital scheme leads to bring forward other items of spending where it was appropriate to do so and helped support the effective delivery of patient care in a safer, more robust environment. At the end of the financial year, the trust reported a small underspend of £0.017m on CDEL and an underspend of £1.49m on total capital expenditure.	Monitor monthly through FIDC	FIDC Meetings 2023
CIP Programme Update	R	A	In-month, £1.32m of efficiency has been reported against a plan of £1.04m, resulting in an over-achievement of £0.28m. The Month 12 position is that £9.08m of efficiencies have been delivered in the year, which is 79% delivery against the £11.1m target. Given the efficiencies achieved non-recurrently in 2022/23, there is a £3m carry forward of the target to 2023/24 efficiency targets. The Trust target for 2023/24 has been finalised at £16.7m. Currently, 65% of the identified saving is recurrent.	Monitor monthly through FIDC	FIDC Meetings 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Community Diagnostic Centres Business Case	A	G	BSW providers across primary, community and secondary care have come together as a collective to deliver enhanced diagnostic services to the local population. The BSW community diagnostic Centre (CDC) scheme is bringing forward a business case to provide additional, networked diagnostic capacity in the community, with investment in staff, equipment, and facilities. The Committee reviewed the business cases and supported the principle of development of a system-based community diagnostic provision across BSW. The risk is rated A as there is a dependency for funding to be approved at the national level, notwithstanding several operational risks that may present themselves as the Trust aligns with new ways of working.	Board discussion and approval	FIDC meetings 2023
IT AND DIGITAL					
IT & Digital Risks	A	A	The Committee is assured that the risk management process and reporting risks for IT and Digital are adequate and effective; however, further work is required to improve the maturity of the risk management process as a whole – management has undertaken a review to improve the approach and oversight of risks for the division as whole, and the update will be provided to FIDC in July 2023.	Monitor through FIDC	FIDC meetings 2023
Shared EPR Risks	R	A	The Shared EPR Procurement is progressing on track with a preferred bidder identified and notified - Oracle Health – previously known as Cerner. Contract finalisation / negotiation now underway. Overall, the inherent programme risk is Red due to the lack of benefits to support the FBC, including estimated increased costs, resourcing challenges, and the risk that the FBC needs to be approved.	Monitor through FIDC	FIDC meetings 2023
ESTATES & FACILITIES					
Site Utility & Resilience Update	A	G	The Committee received an update on how the Trust manages the ongoing risk regarding the capacity and resilience within our primary utility services across the Great Western Hospital & Brunel Treatment Centre. The Committee was reassured by management's plan to address the ongoing risk regarding the capacity and resilience within the primary utility services across the Great Western Hospital & Brunel Treatment Centre.	Monitor through FIDC	FIDC meetings 2023

Issues Referred to another Committee	
Topic	**Committee**
None	-

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Mental Health Governance Committee

Accountable Non-Executive Director	Presented by	Meeting Date
Lizzie Abderrahim	**Lizzie Abderrahim**	**21 April 2023**

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Yes	BAF Numbers	1.4a[1]

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Use of the Mental Health Act [MHA] Q4			Risk continues to be rated as amber to reflect [1] GWH's ability to fulfil its statutory functions is dependant on the performance of other agencies. In relation to actions there had been no breaches in the reporting period; although a duty of candour letter had been issued in relation to the lapsing of a s.5(2) detention. The target for mandatory training had been exceeded and there were improved rates of compliance with Enhanced MHA Training. There were issues associated with the use of ED as de facto place of safety when the designated places of safety were full and there were delays in obtaining MH assessments out of hours but appropriate actions were in place to address these.		
Mental Capacity Act [MCA]: Update			Ratings remain consistent. Mandatory MCA training was exceeding the target and the benefits of the upskilling programme were evident though the audits that been undertaken. A range of initiatives had also been developed to deliver MCA training [MCA Masterclass - SIM training video – poster highlighting learning from CQC inspections] and whilst these were all positive interventions it was agreed		

[1] Safeguarding / Mental Health / DOLS

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
			that the actions rating should remain at amber to reflect that early stages and that implementation relied on a limited number of people.		
Report on the use of Deprivation of Liberty Safeguards [DoLS]			Ratings remain consistent. There had been increase in number of applications and it was recognised that this reflected an increased awareness resulting from MCA upskilling programme. However, it remained the case that the supervisory bodies lacked the capacity to complete the statutory assessments and a number of patients therefore continued to be cared for outside the legal framework. This issue continued to be monitored on the risk register and, with an LPS and MCA Lead now in post, it had been possible to escalate complex cases.		
Update on Development of Liberty Protection Safeguards [LPS]			The fact that implementation was now delayed to 2025 is reflected in the red risk rating. The actions rating was changed from amber to green to reflect the progress that had been made since the last meeting. The completion of the LPS Maturity Matrix shows that satisfactory progress was being made [although progress will be stalled pending the publication of the code of practice] and benchmarking had demonstrated that GWH is far ahead against others. A training need analysis that will establish the number of roles and the level of training required was planned for Q1 and focussed training on the Human Rights Act was planned as a first step in ensuring that paediatric staff are prepared for implementation of LPS.		
Mental Health Governance Workplan Q4 Report			Ratings remained consistent. Progress during Q4 had been as expected and the year concluded with the seven 7 actions that remained at amber being carried forward into 2023/24 workplan. There were two actions relating to LPS and MCA that remained at red for reasons outside GWH control.		
Mental Health Governance Workplan 2023/24			A robust plan for 2023/24 was presented and an amber actions rating reflected the early stages of the plan's implementation.		
15+ Risk Report			No 15+ risks reported. One risk had been downgraded to 12 and the reasons for this were challenged as was the effectiveness of controls and it was agreed that the scoring and controls would be revisited. There was also discussion about whether there were other risks that might merit 15+ score and it was agreed that there would be review of MH risks to ensure that risk register reflects a better understanding of what's happening within GWH. For these reasons an amber trading was attached the actions [this had previously been green]		
Audit Reports			The 2022/23 audit programme had been broadly achieved with the deadline of one audit extended to enable the completion of final actions. It was agreed that there		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
			was a robust approach to audit and that there was an established record of the annual audit programme being fulfilled and for this reason a blue rating for actions was considered appropriate.		
Emergency Department [ED] / Mental Health Liaison Team [MHLT] Update			The ongoing challenge relating to the lack of acute mental health beds meant that the risk rating continued to be red and, whilst the challenges in ED were chronic, there was evidence of action being taken to address those challenges. There had been improvements in the MHLT performance in relation to referral to assessment timeframes and the chronic workforce challenge seen within MHLT was being alleviated with the team now at almost full establishment. Whilst there had been lower volumes of mental health attendances there had been an increase in incidents of violence and aggression and the loss of beds in the observation bay due to escalation had created issues. Preparations for the decant had also begun and the combined effect of this happening alongside decisions being taken by AWP to focus on reducing out of area placements and to make changes to their estate to address the need for single sex accommodation, was to be monitored. For these reasons, it was agreed that the actions rating should remain amber.		
Children's Services / Child and Adolescent Mental Health Service [CAMHS] Update			The national shortage of specialist Tier 4 beds persisted and the workforce pressures in CAMHS continued resulting in limited capacity to undertake assessments with no liaison service at all on Saturdays. This limited capacity had impacted on bed capacity and flow and the children's ward had been over bed capacity on twenty occasions in reporting period. Established mitigations remained in place and the focus on collaborative work had continued supported by positive working relationships, although the SLA was still not formalised. Work on the creation of a safe room had been delayed and safe environment risk assessments continued to be done for every child / young person admitted. There had been a decrease in number of incidents in the reporting period although one serious incident had resulted in a police investigation. In these circumstances it was agreed that the risk rating continued to be red and the actions rating should remain at amber.		
It was agreed that ratings were not appropriate for the following items and that assurance should be provided through a narrative description.					
Legislation and Guidance Update	There had been no changes to legislation but guidance had been issued including: ▪ NG225 [use of traffic light assessment in ED]. The relevance of this to ED staff and the MHLT was to be worked through as misapplication of the guidance had the potential to create significant problems. ▪ NHSE guidance on supporting children with MH problems. A gap analysis had been completed at system level.				

Key Issue	Assurance Level	Committee Update	Next Action (s)	Timescale
Learning from Incidents	A detailed report was provided and information that detailed claims against the Trust had been included for first time.			

Report Title	**Staff Survey Results 2022**				
Meeting	**Trust Board**				
Date	**4 May 2023**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Jude Gray				
Report Authors	Angela Morris – HR Business Partner Charlotte Vockins – Senior Assistant HR Business Partner				
Appendices					

Purpose

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

Assurance Level

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

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

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

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Report

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

The National Staff Survey 2022 took place in the autumn of 2022 across all staffing groups, all areas of the Trust, and included Bank staff for the first time.

The Trust Pillar Metric "Recommending my Organisation as a Place to Work" has remained.

The Trust breakthrough objective "I can make improvement happen in my area of work" has improved significantly when compared to last years result but remains below the national average and slightly below the Trust Target of 55%.

There has been an improvement in the Staff Morale theme. However, the associated sub themes of advocacy and work pressures/burnout show a decline in the survey, and is also reflected in the free text comments.

We report better than national average scores for staff agreeing with the statement *"I think that my organisation respects individual differences (e.g., cultures, working styles, backgrounds, ideas, etc.)"* and, although below national average, our BME staff are reporting that they are experiencing reduced levels of bullying and harassment from patients, service users, colleagues, and managers compared to 2021.

The Trust also reported better than the national average for the statement "*My organisation takes positive action on health and well-being"* for the second year in a row.

The purpose of this paper is to share the results and to encourage a dialogue about the breakthrough objective and focus areas for 23/24 supported by the Improving Together methodology.

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	X		X	X	X
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
					NA

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Trust level results have been shared at TMC and People and Culture Committee
Next Steps	

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

Explanation of above analysis:

The report highlights that BME are experiencing reduced levels of bullying and harassment from patients, services users, colleagues, and managers, however this remains slightly above the national average and higher when compared to White staff. The correlation is also seen between staff who have a disability compared to staff without a disability.

While the gap between BME and White staff has reduced between 2021 and 2022, there is still a 16.4% gap between BME staff believing that the organisation provides equal opportunities for career progression or promotion (43.6% of BME staff compared to 60% of White staff).

Recommendation / Action Required

The Board/Committee/Group is requested to:

- Committee to review results and areas of focus for 23/24 in line with the Improving Together methodology

Accountable Lead Signature	Claire Warner (for Jude Gray)
Date	14 April 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Staff Survey Results

2022 Data (2023 Publication)

2022 Staff Survey – National Context

Great Western Hospitals NHS Foundation Trust

- A total of **636,348** of NHS staff from **215 trusts** in England, took part in the 2022 Staff Survey. The results give an overview of NHS staff engagement in the autumn 2022.

National Results:

- Nationally, the greatest decline is within the 'Compassionate Culture' theme. The sub-score question "staff recommending friend or relative needed treatment" has declined. The 2022 result was 62.9%, a decrease of 4.5% compared to 2021 and 11.3% compared to 2020.
- Since 2021, although with a background of reducing COVID levels, staff have continued to deal with a high level of work pressures driven by record breaking months for attendances in A&E, the elective surgery back log and high sickness absence.
- Within the survey period the cost of living crisis heightened and the RCN, for the first time in its history, balloted members on strike action therefore, unsurprisingly, national satisfaction with pay is lower than pre-pandemic levels.

GWH Staff Survey

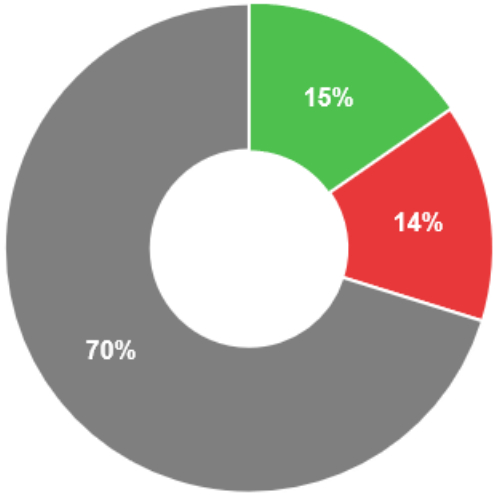
Great Western Hospitals NHS Foundation Trust

- Trust staff were surveyed between September and November 2022
- Bank workers were also surveyed for the first time
- Substantive response rate of **58.7%** compared to IQVIA sample median response rate of 44.7%
- Positive increases in response rates reflects efforts made in a targeted comms plan and incentives offered

	Usable Sample	*Completed*				*Response Rate*
		Paper	*Online*	*Telephone*	*Total*	
2022 Sub.	5,369	0	3,149	0	3,149	58.7%
2022 IQVIA	660,768	23,121	271,960	10	295,091	44.7%
2021 Sub.	5,156	0	2,428	0	2,428	47.1%
2021 IQVIA	708,812	32,676	283,524	9	316,209	44.6%
2022 Bank	503	0	143	0	143	28.4%
2022 IQVIA Bank	57,301	0	10,902	2	10,904	19.0%

Headline Findings by Question

Great Western Hospitals NHS Foundation Trust

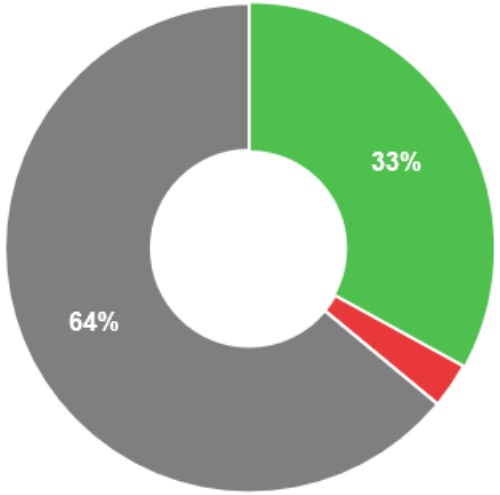


16 (15%) question(s) scored significantly better than the sector

15 (14%) question(s) scored significantly worse than the sector

73 (70%) question(s) showed no significance in relation to the sector average or comparisons could not be drawn

In 2021, 5 were better and 35 were worse than the sector comparison*



32 (33%) question(s) scored significantly better than in 2021

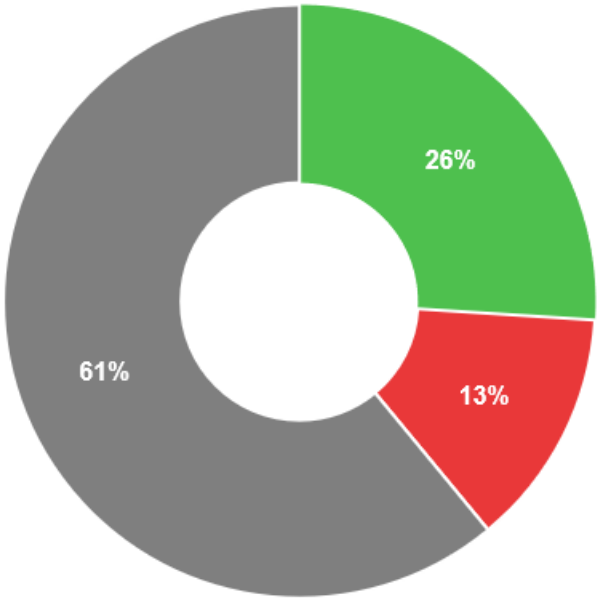
3 (3%) question(s) scored significantly worse than in 2021

63 (64%) question(s) showed no significance in relation to the 2021 score or score is suppressed

In 2021, 33 had declined and none had improved.

Bank v Substantive Results

Great Western Hospitals NHS Foundation Trust

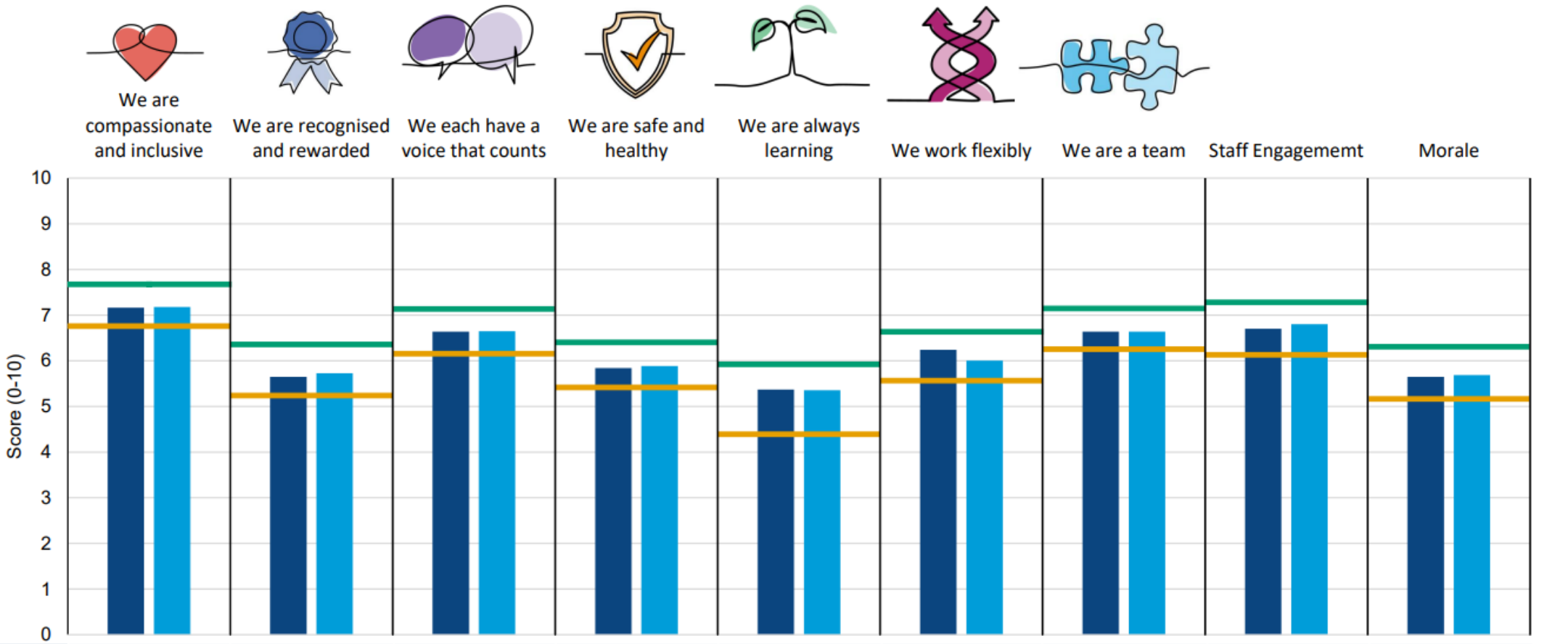


- 24 (26%) question(s) scored significantly better than the substantive score
- 12 (13%) question(s) scored significantly worse than the substantive score
- 56 (61%) question(s) showed no significance in relation to the substantive score or comparisons could not be drawn

GWH Results by People Promise & Theme

Great Western Hospitals NHS Foundation Trust

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.2	5.6	6.6	5.8	5.4	6.2	6.6	6.7	5.6
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	3143	3132	3116	3137	3020	3121	3138	3144	3144

Areas to Celebrate Success

Great Western Hospitals NHS Foundation Trust

GWH scores above the national benchmark for “We work flexibly”

- All 4 questions have improved and are ahead of the benchmark.
- In particular, 71.4% of staff said they were comfortable to approach their manager about flexible working.

People Promise element – We work flexibly

Other areas of success

- There have been increases in the four questions in Compassionate Leadership: 68.5% said that line managers care about their concerns.
- There are also improvements in staff being understanding and kind to each other (71.5% vs 68.3% in 2021) and appreciate each other (68.4% vs 65.7%)

Identified Priorities

Great Western Hospitals NHS Foundation Trust

Advocacy

- The score for the subtheme Advocacy (6.4) is behind the national average (6.6).
- 56.4% would be happy with the standard of care if a friend or family member needed treatment (61% in 2021). The national average is at 56.5%.

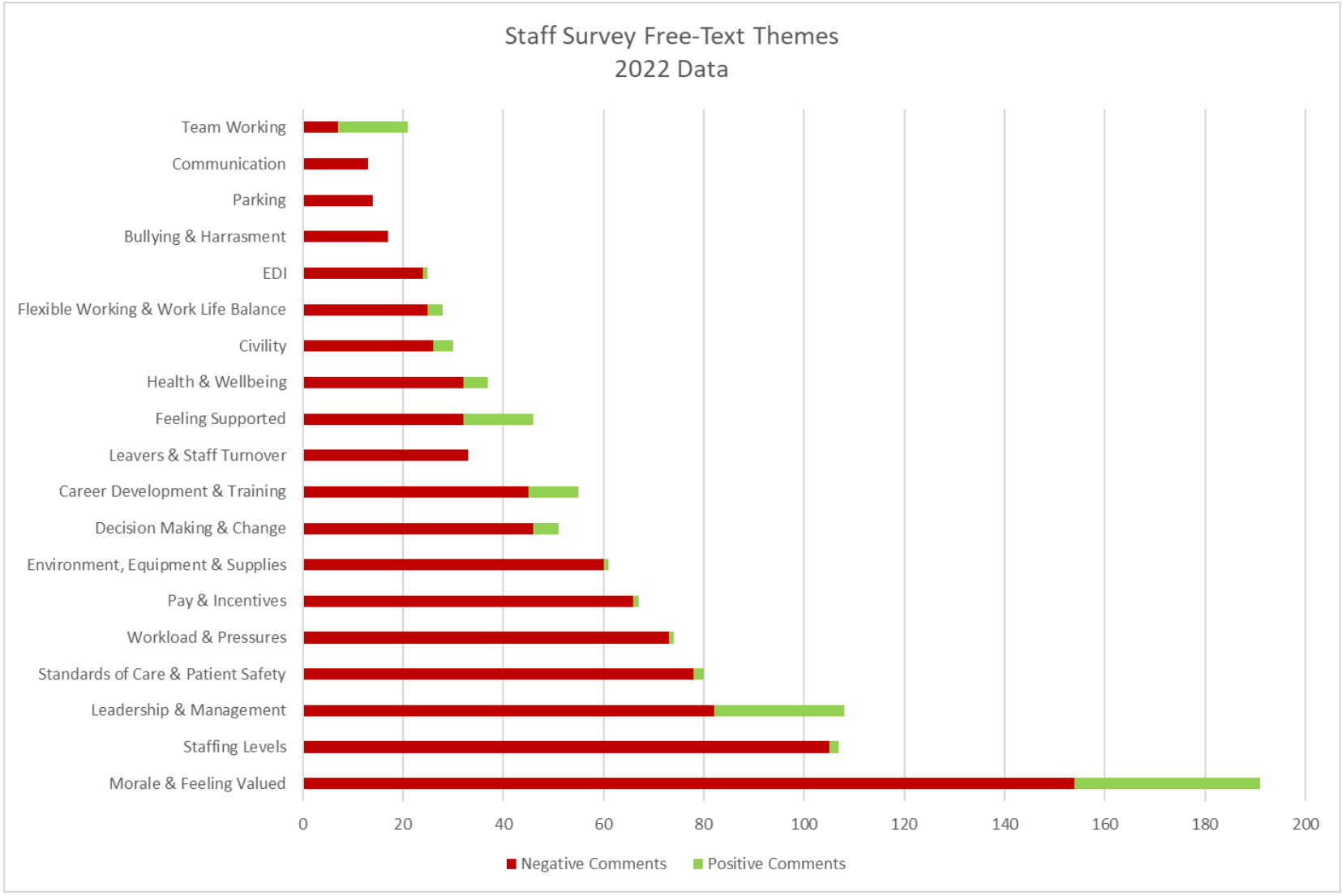
Work Pressures

- The score for the subtheme Work Pressure (4.8) is behind the national average (5.0).
- Although improving, only 48.8% agree they have adequate materials and supplies to do their job (49.3% in 2021).

In line with Improving Together methodology the Trust needs to understand the root causes behind these results starting with an A3 analysis to identify countermeasures.

Free Text Analysis

2022 Data



South West Ranking

Great Western Hospitals NHS Foundation Trust

Rank	Acute Trusts	Response Rate	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale	Total Score	Total Score inc. Response Rate
1	Yeovil District Hospital Foundation Trust	50%	7.6	6.4	7.1	6.3	5.9	6.6	7.1	7.2	6.2	60.4	65.4
2	Somerset NHS Foundation Trust	46%	7.5	6.2	7.0	6.2	5.5	6.4	6.9	7.1	6.1	58.9	63.5
3	Royal Berkshire NHS Foundation Trust	57%	7.4	6.0	7.0	6.2	5.7	6.3	6.9	7.2	6.0	58.7	64.4
4	University Hospital Southampton NHS Foundation Trust	55%	7.5	6.0	6.9	6.1	5.8	6.4	6.9	7.1	6.0	58.7	64.2
5	Oxford University Hospital NHS Foundation Trust	51%	7.3	5.9	6.8	6.1	5.6	6.2	6.8	7.0	5.8	57.5	62.6
6	Dorset County Hospital NHS Foundation Trust	43%	7.3	5.9	6.8	5.9	5.5	6.2	6.8	6.9	5.8	57.1	61.4
7	Royal United Hospitals Bath NHS Foundation Trust	53%	7.4	5.9	6.7	5.7	5.4	6.1	6.7	6.9	5.7	56.5	61.8
8	University Hospitals Bristol and Weston NHS Foundation Trust	45%	7.4	5.9	6.8	5.9	5.2	5.9	6.8	6.9	5.7	56.5	61.0
9	Royal Devon University Healthcare NHS Foundation Trust	37%	7.4	5.9	6.7	6.0	4.8	6.1	6.7	6.8	5.8	56.2	59.9
10	University Hospitals Dorset NHS Trust	46%	7.3	5.7	6.7	5.8	5.3	6.0	6.7	6.8	5.6	55.9	60.5
11	**Great Western Hospitals NHS Foundation Trust**	59%	7.2	5.6	6.6	5.8	5.4	6.2	6.6	6.7	5.6	55.7	61.6
12	North Bristol NHS Trust	51%	7.2	5.7	6.6	5.8	5.3	6.0	6.6	6.8	5.7	55.7	60.8
13	Torbay and South Devon NHS Foundation Trust	38%	7.2	5.8	6.6	5.8	5.2	6.1	6.7	6.7	5.6	55.7	59.5
14	Portsmouth Hospitals NHS Foundation Trust	39%	7.1	5.7	6.6	5.7	5.5	5.8	6.6	6.7	5.5	55.2	59.1
15	Royal Cornwall Hospitals NHS Trust	46%	7.1	5.7	6.5	5.8	5.1	6.0	6.6	6.5	5.6	54.9	59.5
16	University Hospitals Plymouth NHS Trust	38%	7.1	5.7	6.5	5.7	5.3	5.8	6.5	6.6	5.5	54.7	58.5
17	Salisbury NHS Foundation Trust	48%	7.1	5.6	6.6	5.8	4.7	5.9	6.5	6.7	5.4	54.3	59.1
18	Gloucestershire Hospitals NHS Foundation Trust	50%	6.8	5.4	6.2	5.6	5.0	5.6	6.3	6.3	5.3	52.5	57.5
	Average	**44%**	**7.2**	**5.7**	**6.6**	**5.9**	**5.4**	**6.0**	**6.6**	**6.8**	**5.7**	**55.9**	**60.3**

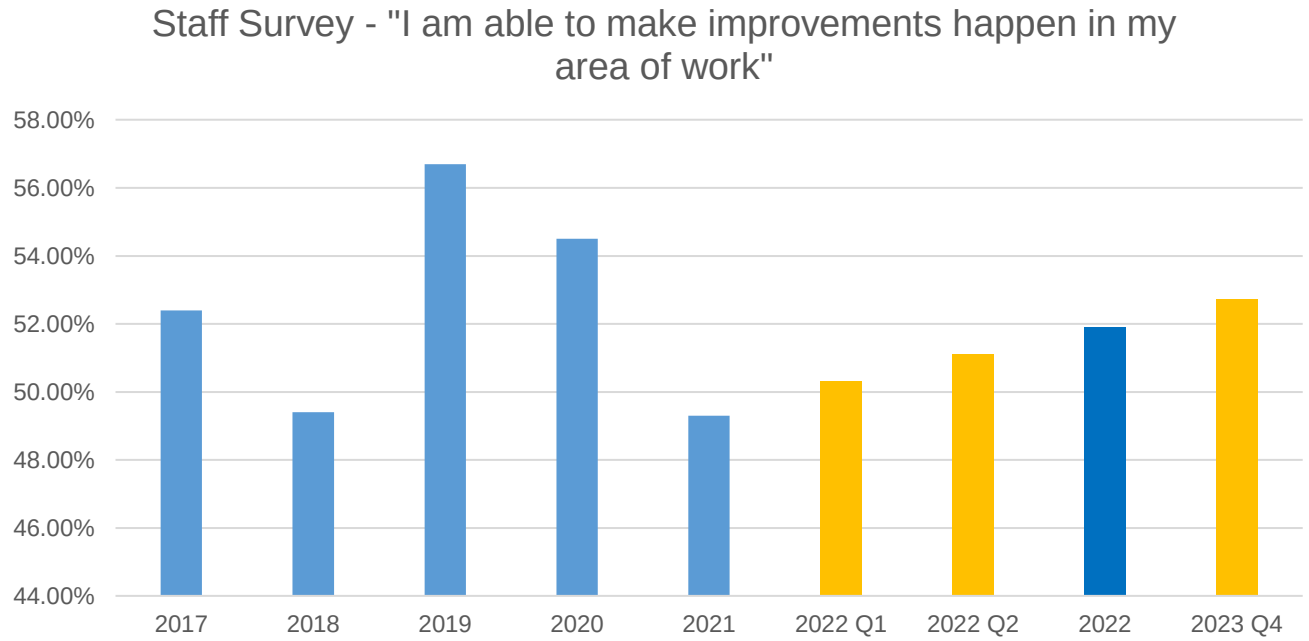
Below Average
At Average
Above Average

The Trust ranked 11th when benchmarked against the National Staff Survey themes for all organisations across the South West (17th in 2021)

Pillar Metric - Outcome

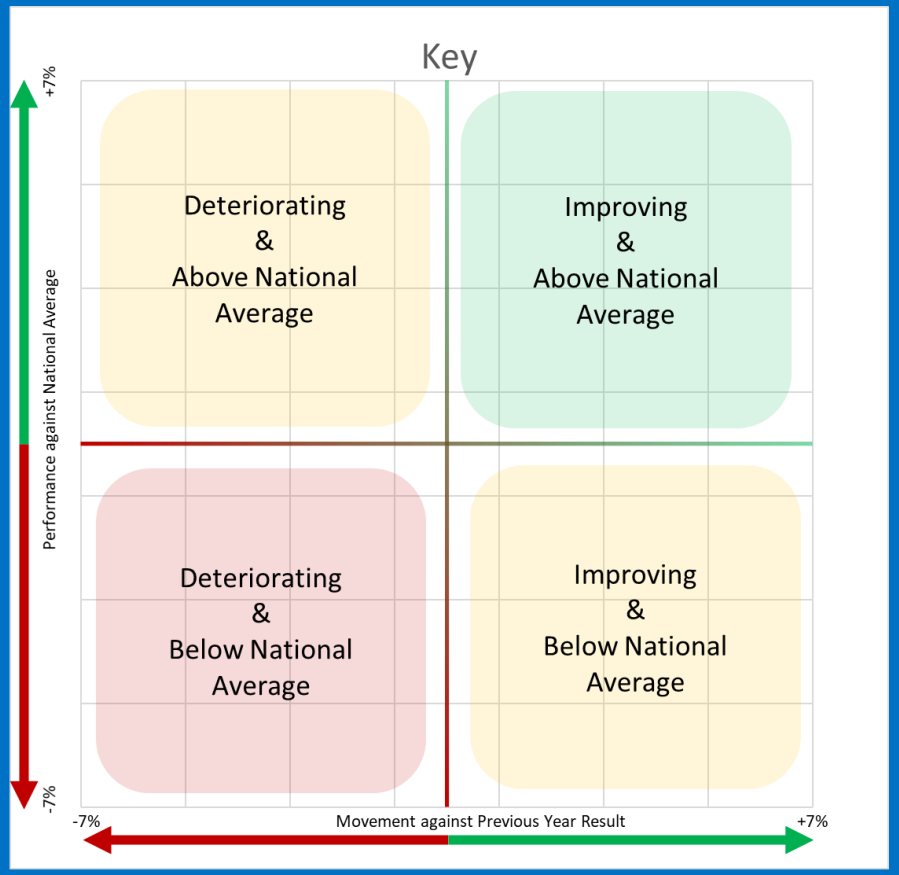
Great Western Hospitals NHS Foundation Trust

Question 3F: “I am able to make improvements happen in my area of work”

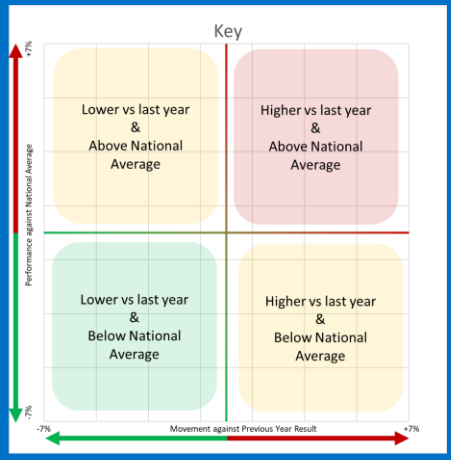


- The score for the Improving Together focus question “I am able to make improvements happen in my area of work” increased from 49.2% in 2021 to 52.0% in 2022 and further improvement in Q4.
- 320 staff trained on Improving Together and a further 130 staff undergoing training currently (boot camp, frontline and speciality training)
- Monthly Trust Wide Staff Survey Working Group

New Presentation of Results*



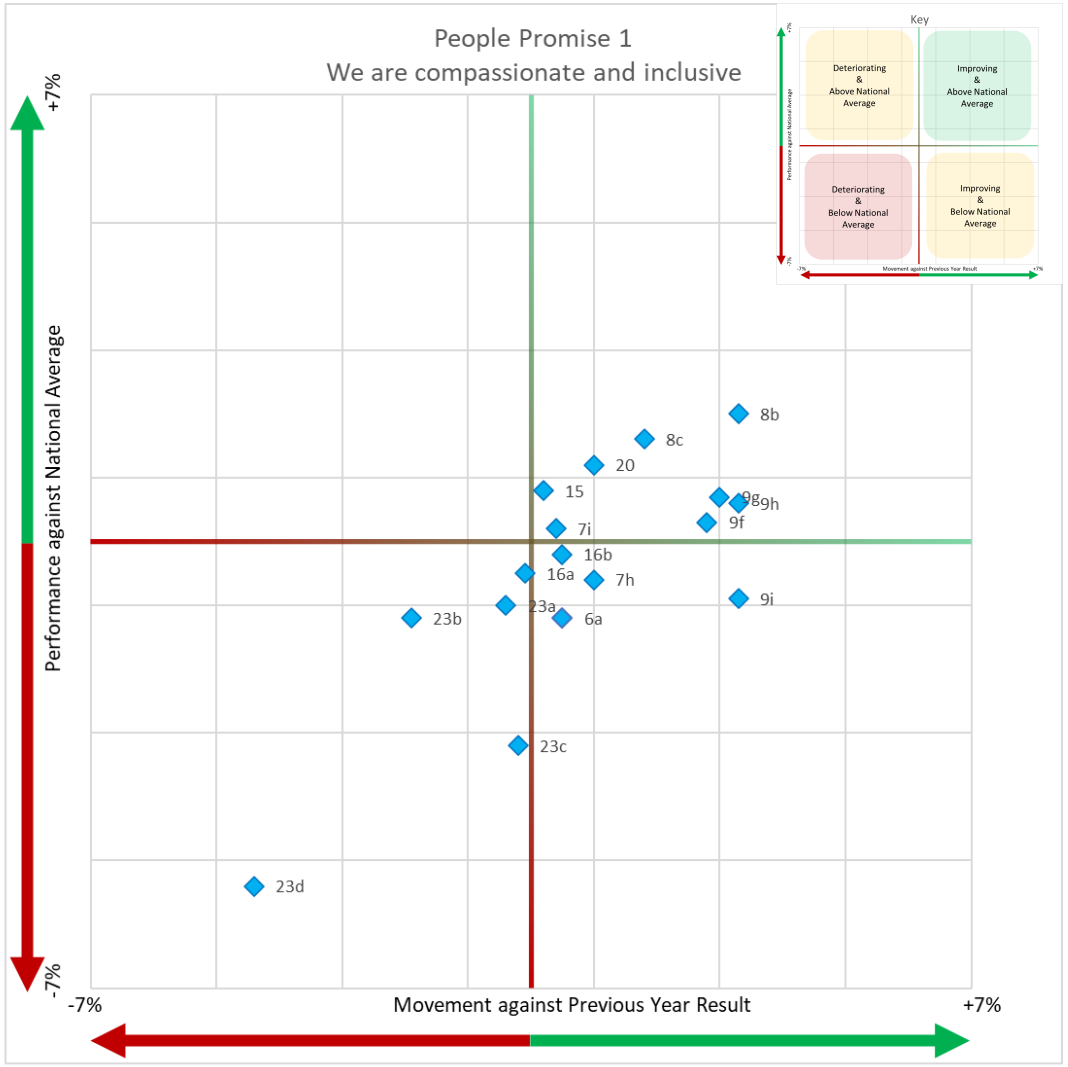
* Burnout is negatively scored and presented (lower is better)



People Promise 1
We are compassionate and Inclusive

Promise 1: We are compassionate and inclusive

Great Western Hospitals NHS Foundation Trust



Service Teamwork Ambition Respect

People Promise 1

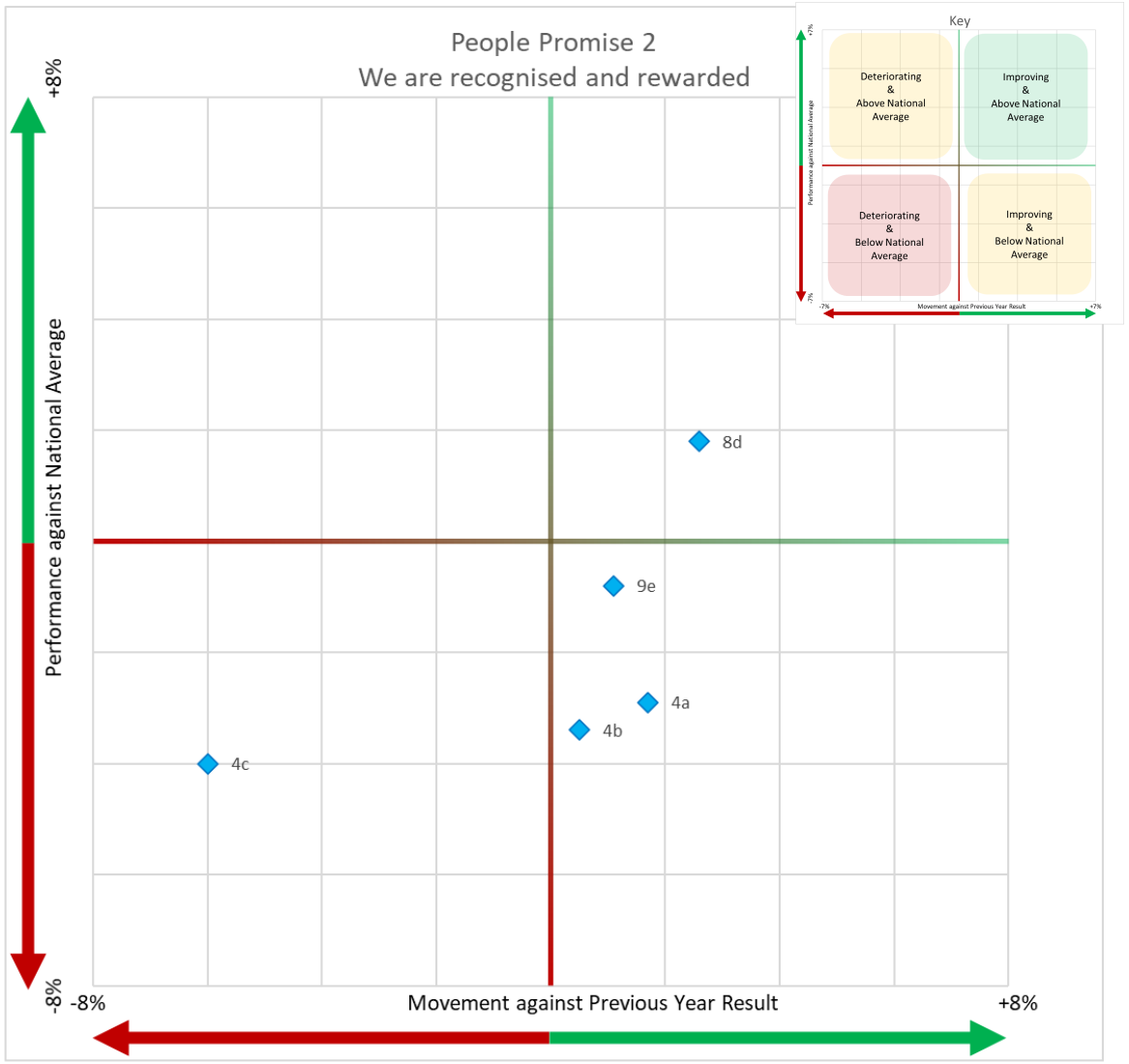
We are compassionate and inclusive

Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
6a	I feel that my role makes a difference to patients / service users (Agree/Strongly agree).	86.1%	0.5%	87.3%	-1.2%
7h	I feel valued by my team (Agree/Strongly agree).	68.1%	1.0%	68.7%	-0.6%
7i	I feel a strong personal attachment to my team (Agree/Strongly agree).	64.4%	0.4%	64.2%	0.2%
8b	The people I work with are understanding and kind to one another (Agree/Strongly agree).	71.6%	3.3%	69.6%	2.0%
8c	The people I work with are polite and treat each other with respect (Agree/Strongly agree).	72.6%	1.8%	71.0%	1.6%
9f	My immediate manager works together with me to come to an understanding of problems (Agree/Strongly agree).	66.7%	2.8%	66.4%	0.3%
9g	My immediate manager is interested in listening to me when I describe challenges I face (Agree/Strongly agree).	70.1%	3.0%	69.4%	0.7%
9h	My immediate manager cares about my concerns (Agree/Strongly agree).	68.7%	3.3%	68.1%	0.6%
9i	My immediate manager takes effective action to help me with any problems I face (Agree/Strongly agree).	63.5%	3.3%	64.4%	-0.9%
15	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (Yes).	56.4%	0.2%	55.6%	0.8%
16a	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (No).	91.7%	-0.1%	92.2%	-0.5%
16b	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (No).	91.1%	0.5%	91.3%	-0.2%
20	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) (Agree/Strongly agree).	70.5%	1.0%	69.3%	1.2%
23a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	72.5%	-0.4%	73.5%	-1.0%
23b	My organisation acts on concerns raised by patients / service users (Agree/Strongly agree).	67.1%	-1.9%	68.3%	-1.2%
23c	I would recommend my organisation as a place to work (Agree/Strongly agree).	53.3%	-0.2%	56.5%	-3.2%
23d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	56.5%	-4.4%	61.9%	-5.4%

- Overall the results demonstrate improvement on this promise with a high proportion of questions tracking above national average
- Q8b is highlighted as both improving and above the national average which demonstrates progress on work within the Trust on civility and respect.
- Question 23d score has declined for the second consecutive year and therefore is highlighted as an area of focus and may align to work pressures and recommending the organisation as a place to work and for treatment.

People Promise 2
We are recognised and rewarded

Promise 2: We are recognised and rewarded



People Promise 2

We are recognised and rewarded

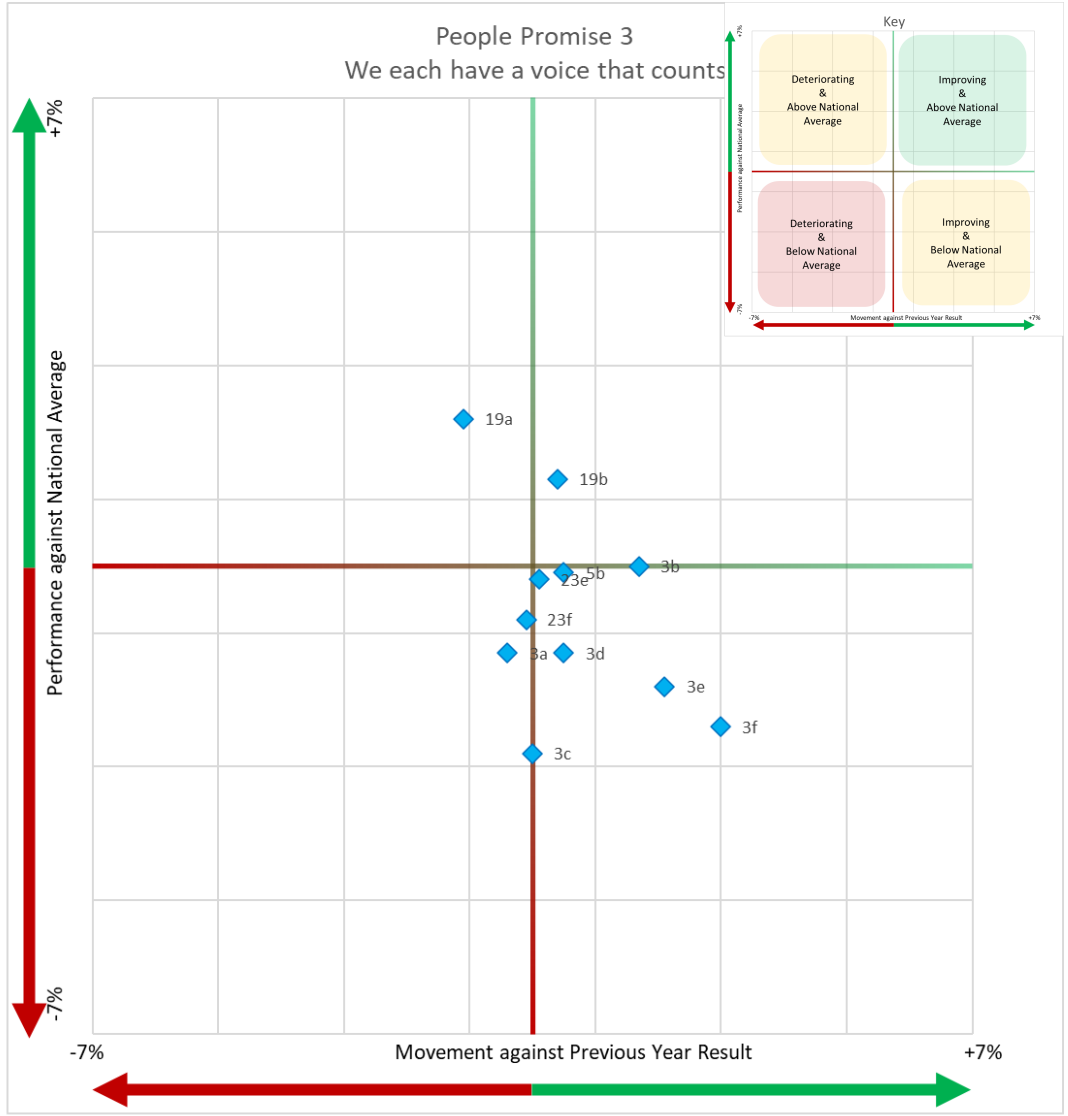
Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
4a	The recognition I get for good w ork (Satisfied/Very satisfied).	48.3%	1.7%	51.2%	-2.9%
4b	The extent to w hich my organisation values my w ork (Satisfied/Very satisfied).	37.7%	0.5%	41.1%	-3.4%
4c	My level of pay (Satisfied/Very satisfied).	21.1%	-6.0%	25.1%	-4.0%
8d	The people I w ork w ith show appreciation to one another (Agree/Strongly agree).	68.4%	2.6%	66.6%	1.8%
9e	My immediate manager values my w ork (Agree/Strongly agree).	69.4%	1.1%	70.2%	-0.8%

- Four questions relating to recognition under this promise have improved against last year's result, although remain slightly behind the national average.
- Q8d is improving and above national average. This may demonstrate recognition awards such as hidden hero's, star of the month and staff excellence awards.
- The decreased satisfaction on pay follows the national trend and not surprising given the current pay dispute with the government.
- The Trust has implemented winter enhanced bank rates and advice on accessing financial support however this has not improved staff satisfaction with level of pay.

People Promise 3
We each have a voice that counts

Promise 3: We each have a voice that counts

Great Western Hospitals NHS Foundation Trust



People Promise 3

We each have a voice that counts

Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
3a	I alw ays know w hat my w ork responsibilities are (Agree/Strongly agree).	85.0%	-0.4%	86.3%	-1.3%
3b	I am trusted to do my job (Agree/Strongly agree).	90.7%	1.7%	90.7%	0.0%
3c	There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	70.0%	0.0%	72.8%	-2.8%
3d	I am able to make suggestions to improve the w ork of my team / department (Agree/Strongly agree).	69.6%	0.5%	70.9%	-1.3%
3e	I am involved in deciding on changes introduced that affect my w ork area / team / department (Agree/Strongly agree).	48.6%	2.1%	50.4%	-1.8%
3f	I am able to make improvements happen in my area of w ork (Agree/Strongly agree).	52.3%	3.0%	54.7%	-2.4%
5b	I have a choice in deciding how to do my w ork (Often/Alw ays).	51.6%	0.5%	51.7%	-0.1%
19a	I w ould feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	73.0%	-1.1%	70.8%	2.2%
19b	I am confident that my organisation w ould address my concern (Agree/Strongly agree).	57.0%	0.4%	55.7%	1.3%
23e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	60.1%	0.1%	60.3%	-0.2%
23f	If I spoke up about something that concerned me I am confident my organisation w ould address my concern (Agree/Strongly agree).	46.4%	-0.1%	47.2%	-0.8%

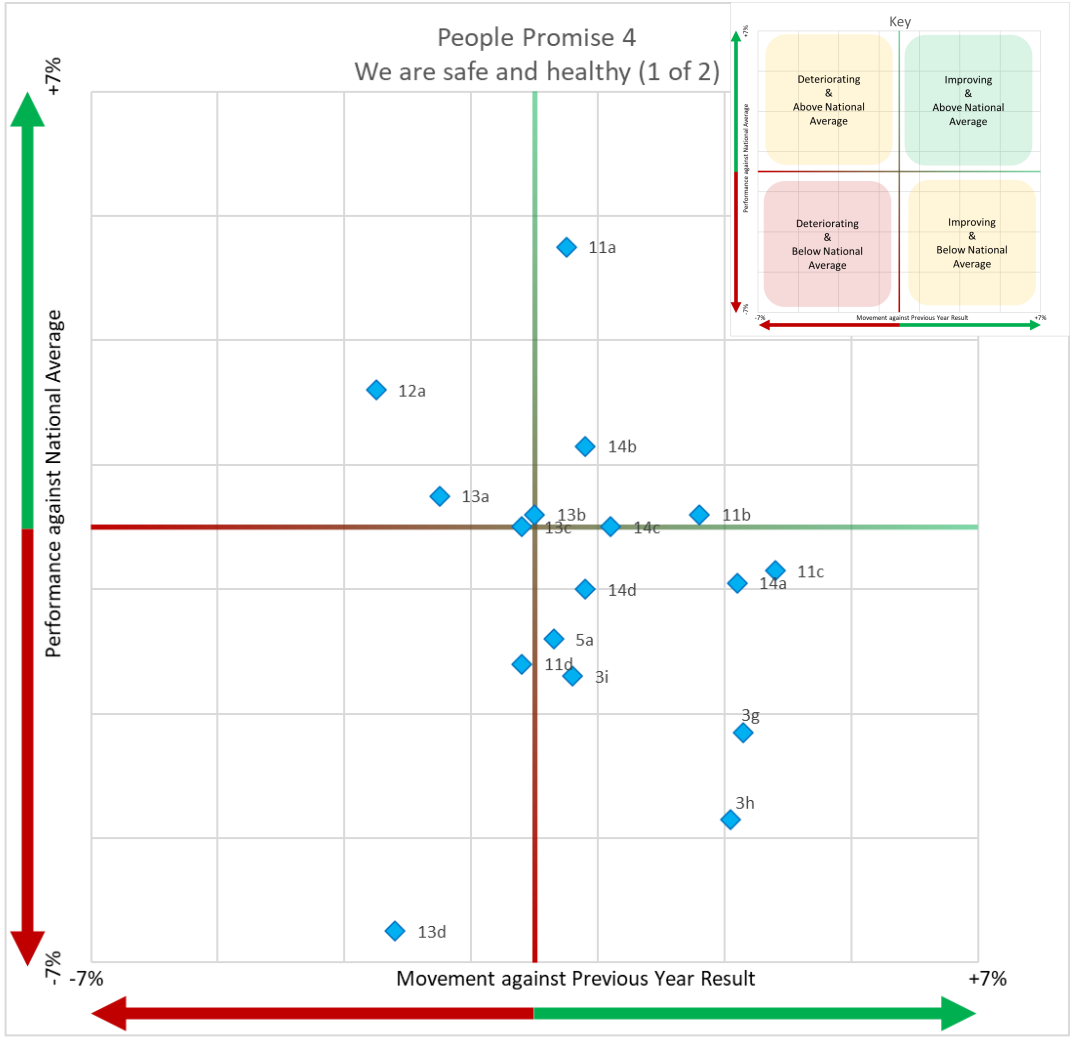
- Staff feel encouraged to have their say (e.g. staff survey and open forum).
- Q3f as the Trust's Improving Together driver metric has made the most significant improvement under this promise.
- The score for Q19a has tracked above national average however has deteriorated by 1.1% from the Trust's 2021. This could be aligned to initiatives such as Freedom to Speak and work around Just and Learning Culture.

Great Western Hospitals
NHS Foundation Trust

People Promise 4
We are safe and healthy

Promise 4: We are safe and healthy (1 of 2)

Great Western Hospitals NHS Foundation Trust



People Promise 4

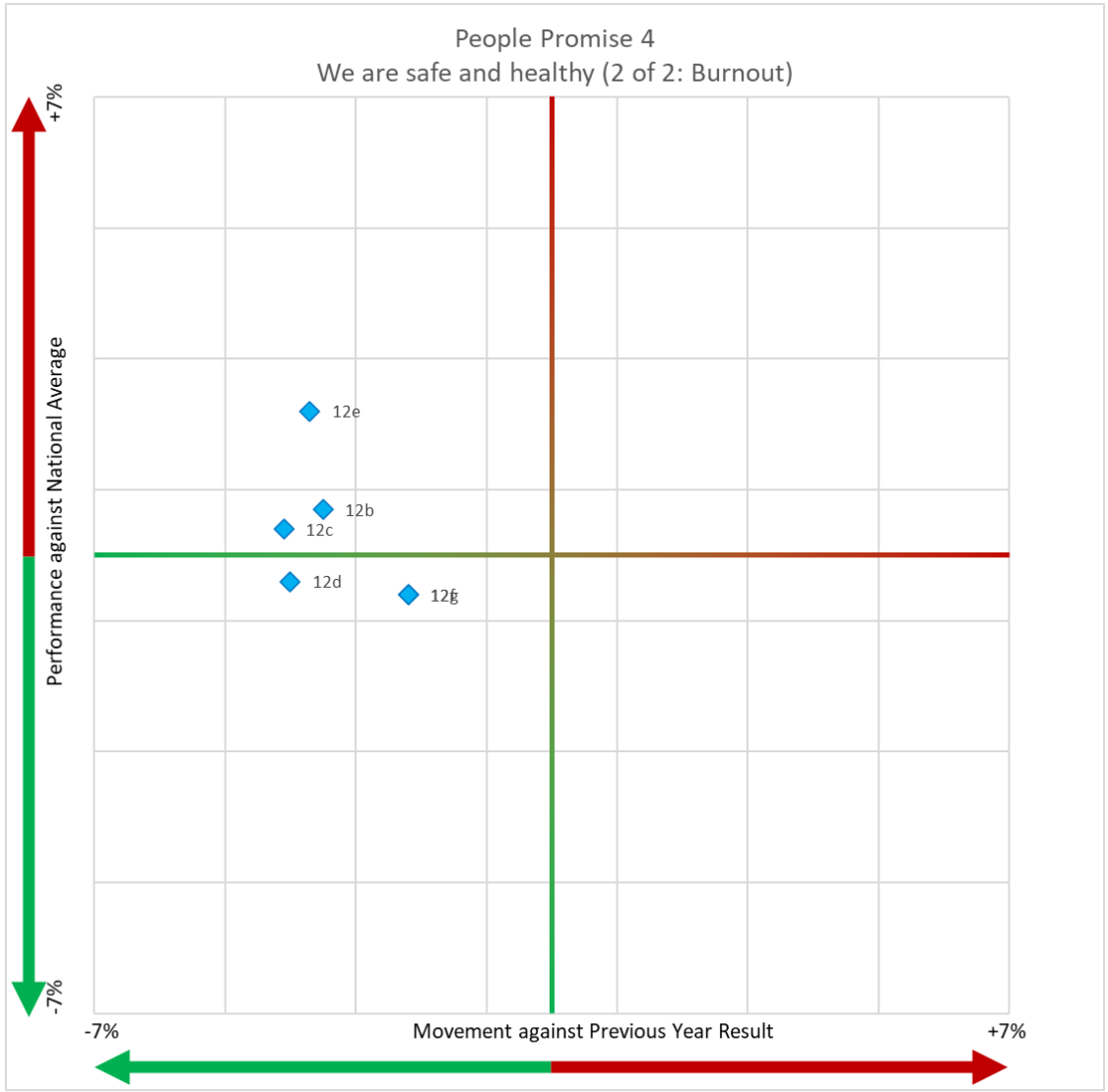
We are safe and healthy (1 of 2)

Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
3g	I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	39.6%	3.3%	42.9%	-3.3%
3h	I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	48.8%	3.1%	53.5%	-4.7%
3i	There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	22.7%	0.6%	25.1%	-2.4%
5a	I have unrealistic time pressures (Never/Rarely).	20.5%	0.3%	22.3%	-1.8%
11a	My organisation takes positive action on health and well-being (Agree/Strongly agree).	60.1%	0.5%	55.6%	4.5%
11b	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities (No).	69.6%	2.6%	69.4%	0.2%
11c	During the last 12 months have you felt unwell as a result of work related stress (No).	54.2%	3.8%	54.9%	-0.7%
11d	In the last three months have you ever come to work despite not feeling well enough to perform your duties (No).	41.1%	-0.2%	43.3%	-2.2%
12a	How often, if at all, do you find your work emotionally exhausting (Often/Always).	39.3%	-2.5%	37.1%	2.2%
13a	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (Never).	85.5%	-1.5%	85.0%	0.5%
13b	In the last 12 months how many times have you personally experienced physical violence at work from managers (Never).	99.4%	0.0%	99.2%	0.2%
13c	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues (Never).	98.2%	-0.2%	98.2%	0.0%
13d	The last time you experienced physical violence at work, did you or a colleague report it (Yes).	61.8%	-2.2%	68.3%	-6.5%
14a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public (Never).	71.0%	3.2%	71.9%	-0.9%
14b	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers (Never).	89.7%	0.8%	88.4%	1.3%
14c	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues (Never).	80.0%	1.2%	80.0%	0.0%
14d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it (Yes).	46.4%	0.8%	47.4%	-1.0%

- 65% of questions within this promise have improved against last year's result.
- Positive action on wellbeing events, mental health first aider support and H&W champions is recognised by staff and highlighted as 4.5% above the national average (11a).
- It is recommend that we continue to build on this support offered, a focus action could include encouraging staff to report if they experience physical violence at work.

Promise 4: We are safe and healthy (2 of 2: Burnout)

Great Western Hospitals NHS Foundation Trust



People Promise 4

We are safe and healthy (2 of 2: Burnout)

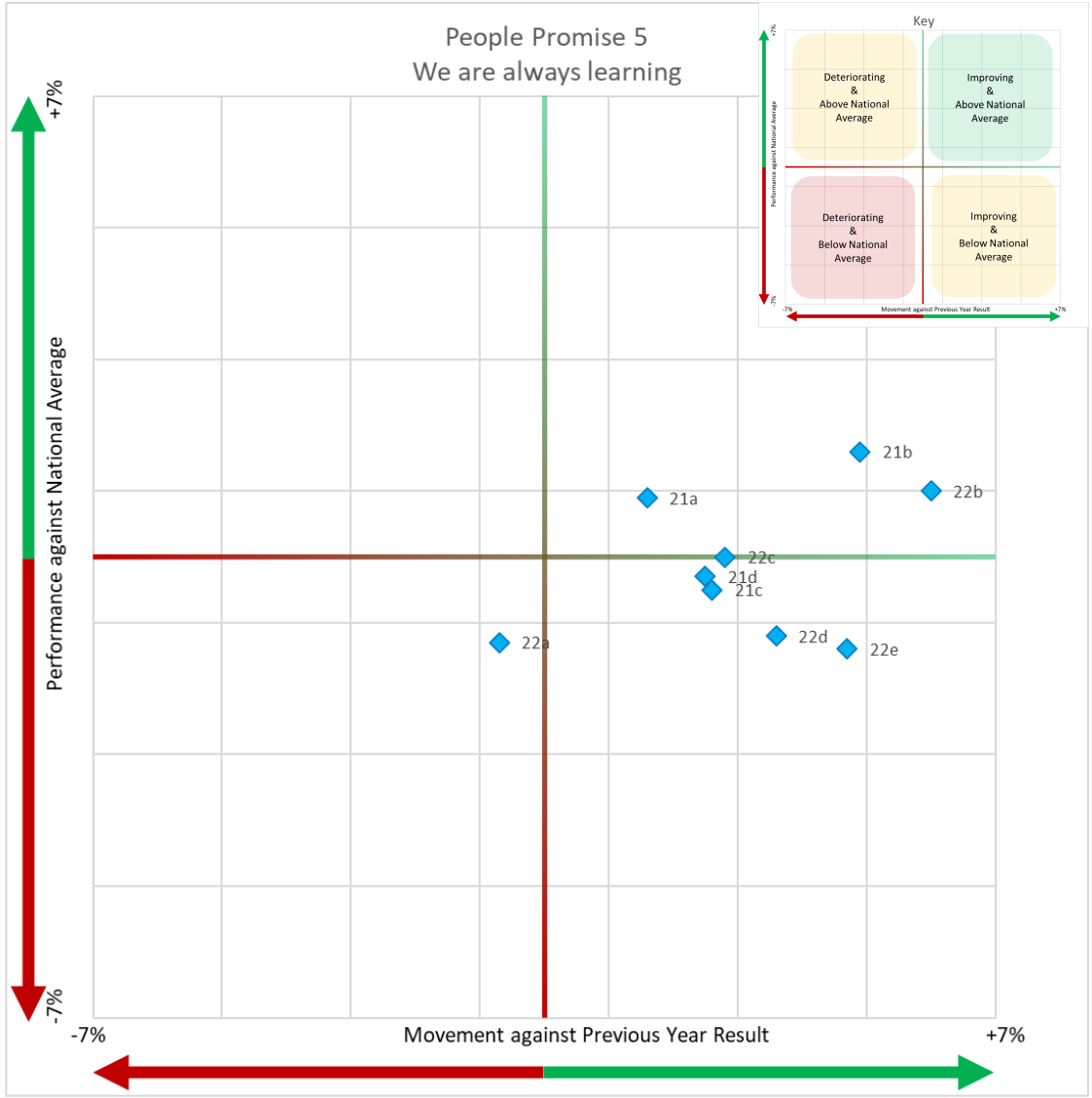
Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
12b	How often, if at all, do you feel burnt out because of your work (Often/Always).	35.5%	-3.5%	34.8%	0.7%
12c	How often, if at all, does your work frustrate you (Often/Always).	40.7%	-4.1%	40.3%	0.4%
12d	How often, if at all, are you exhausted at the thought of another day/shift at work (Often/Always).	31.1%	-4.0%	31.5%	-0.4%
12e	How often, if at all, do you feel worn out at the end of your working day/shift (Often/Always)	49.3%	-3.7%	47.1%	2.2%
12f	How often, if at all, do you feel that every working hour is tiring for you (Often/Always).	21.4%	-2.2%	22.0%	-0.6%
12g	How often, if at all, do you not have enough energy for family and friends during leisure time (Often/Always).	31.4%	-2.2%	32.0%	-0.6%

- These questions are reversed (lower the better).
- All questions within this promise have improved since last year's score, however some areas remain below the national results.

People Promise 5
We are always learning

Promise 5: We are always learning

Great Western Hospitals NHS Foundation Trust



People Promise 5
We are always learning

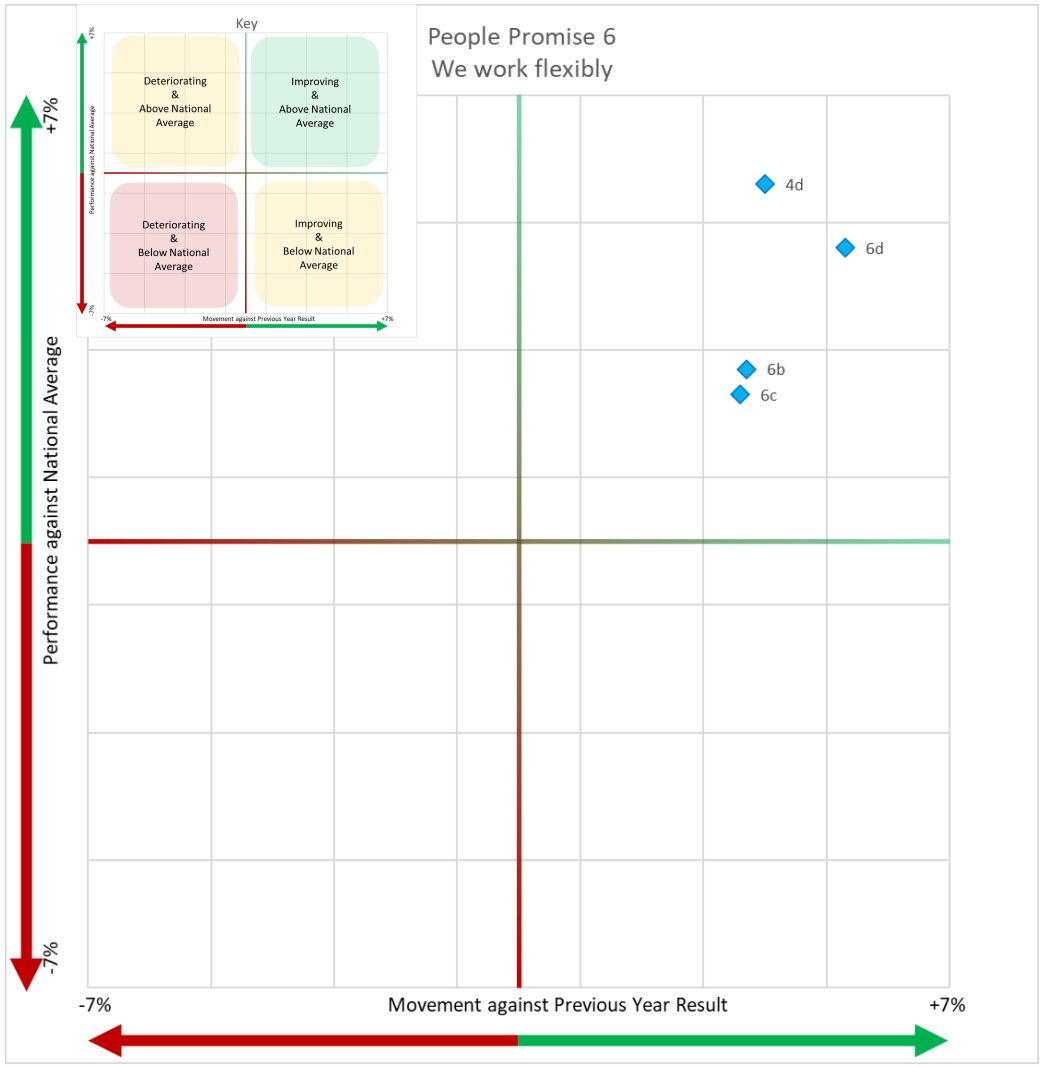
Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
21a	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review (Yes).	82.3%	1.6%	81.4%	0.9%
21b	It helped me to improve how I do my job (Yes, definitely).	23.1%	4.9%	21.5%	1.6%
21c	It helped me agree clear objectives for my work (Yes, definitely).	31.4%	2.6%	31.9%	-0.5%
21d	It left me feeling that my work is valued by my organisation (Yes, definitely).	31.0%	2.5%	31.3%	-0.3%
22a	This organisation offers me challenging work (Agree/Strongly agree).	68.3%	-0.7%	69.6%	-1.3%
22b	There are opportunities for me to develop my career in this organisation (Agree/Strongly agree).	54.4%	6.0%	53.4%	1.0%
22c	I have opportunities to improve my knowledge and skills (Agree/Strongly agree).	67.8%	2.8%	67.8%	0.0%
22d	I feel supported to develop my potential (Agree/Strongly agree).	52.6%	3.6%	53.8%	-1.2%
22e	I am able to access the right learning and development opportunities when I need to (Agree/Strongly agree).	55.0%	4.7%	56.4%	-1.4%

- All questions relating to development meetings and appraisals continue to improve and are above the national average.
- More staff feel there are opportunities to develop their career (e.g. career development mapping, career workshops for A&C staff, scope for growth career conversations pilot).
- The results suggest there is an opportunity to extend the improvements made to support staff being offered more challenging work.

People Promise 6
We work flexibly

Promise 6: We work flexibly

Great Western Hospitals NHS Foundation Trust



People Promise 6
We work flexibly

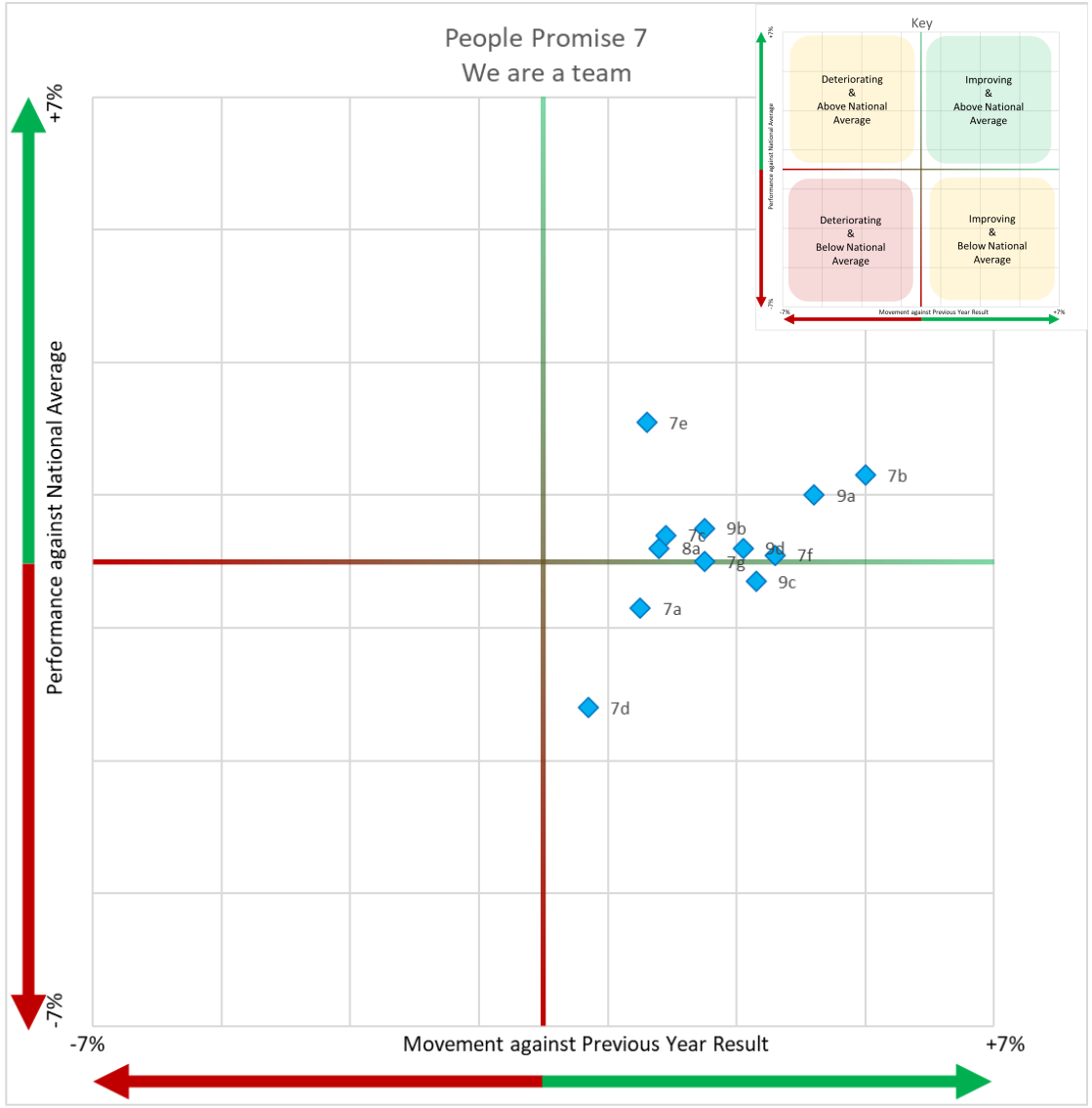
Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
4d	The opportunities for flexible working patterns (Satisfied/Very satisfied).	58.4%	4.0%	52.8%	5.6%
6b	My organisation is committed to helping me balance my work and home life (Agree/Strongly agree).	46.9%	3.7%	44.2%	2.7%
6c	I achieve a good balance between my work life and my home life (Agree/Strongly agree).	54.0%	3.6%	51.7%	2.3%
6d	I can approach my immediate manager to talk openly about flexible working (Agree/Strongly agree).	71.5%	5.3%	66.9%	4.6%

- All questions within this promise are above national average and improving (e.g. flexible working policy, retire & return, home/hybrid working).
- The only question below national average in 2021 was Q6c, which is now above national average.

People Promise 7
We are a team

Promise 7: We are a team

Great Western Hospitals NHS Foundation Trust



People Promise 7
We are a team

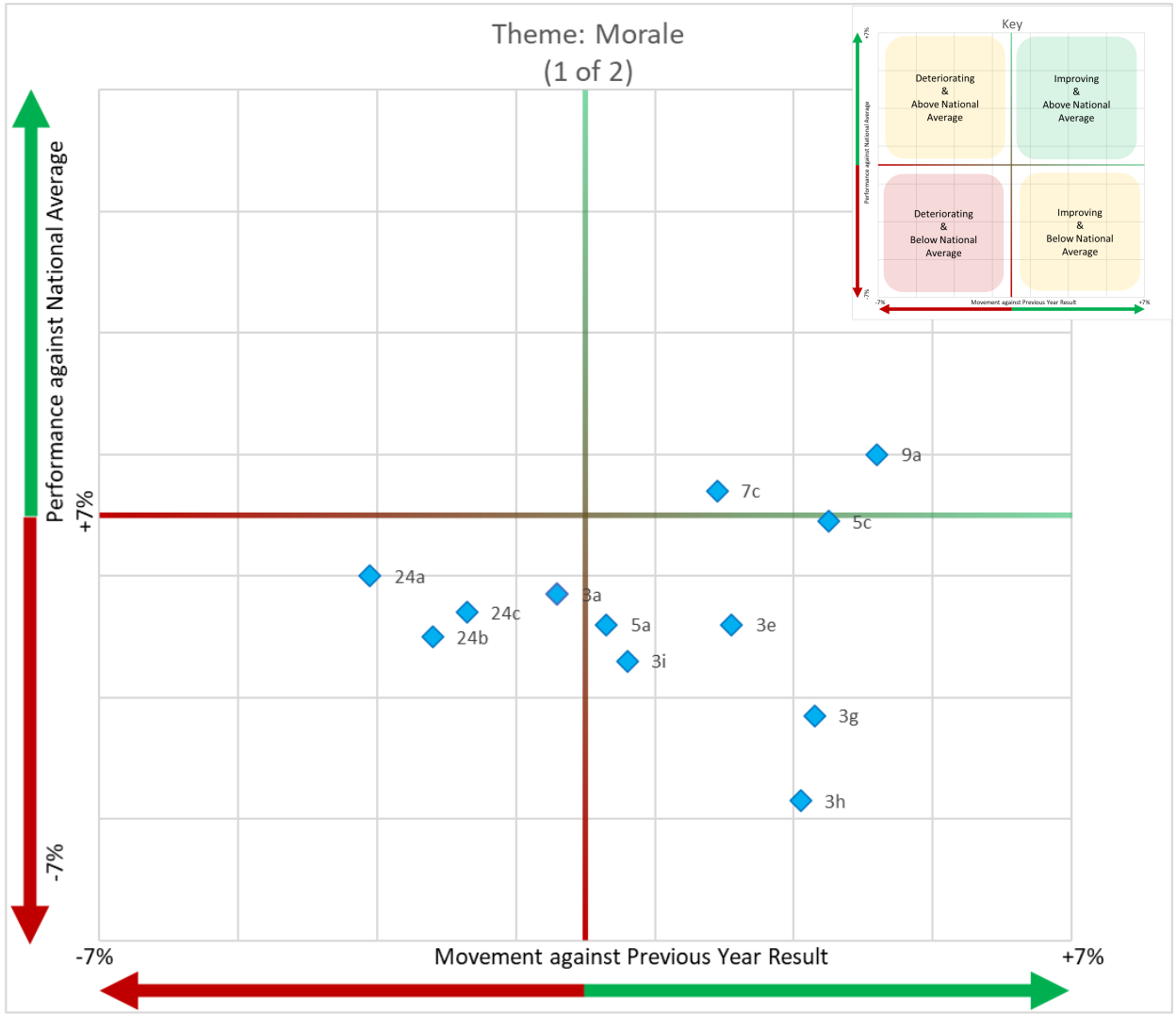
Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
7a	The team I work in has a set of shared objectives (Agree/Strongly agree).	71.6%	1.5%	72.3%	-0.7%
7b	The team I work in often meets to discuss the team's effectiveness (Agree/Strongly agree).	59.2%	5.0%	57.9%	1.3%
7c	I receive the respect I deserve from my colleagues at work (Agree/Strongly agree).	70.8%	1.9%	70.4%	0.4%
7d	Team members understand each other's roles (Agree/Strongly agree).	68.5%	0.7%	70.7%	-2.2%
7e	I enjoy working with the colleagues in my team (Agree/Strongly agree).	83.2%	1.6%	81.1%	2.1%
7f	My team has enough freedom in how to do its work (Agree/Strongly agree).	57.3%	3.6%	57.2%	0.1%
7g	In my team disagreements are dealt with constructively (Agree/Strongly agree).	55.5%	2.5%	55.5%	0.0%
8a	Teams within this organisation work well together to achieve their objectives (Agree/Strongly agree).	51.8%	1.8%	51.6%	0.2%
9a	My immediate manager encourages me at work (Agree/Strongly agree).	70.7%	4.2%	69.7%	1.0%
9b	My immediate manager gives me clear feedback on my work (Agree/Strongly agree).	62.6%	2.5%	62.1%	0.5%
9c	My immediate manager asks for my opinion before making decisions that affect my work (Agree/Strongly agree).	56.6%	3.3%	56.9%	-0.3%
9d	My immediate manager takes a positive interest in my health and well-being (Agree/Strongly agree).	67.6%	3.1%	67.4%	0.2%

- All questions within this promise are highlighted as improving against 2021 result, and the majority have improved against national average.
- In comparison to last year, more staff feel they have enough freedom in how to carry out their role and that their managers ask for their opinion before making decisions that affect their work.
- This all positively supports the Improving Together methodology.

Theme
Morale

Theme – Morale (1 of 2)

Great Western Hospitals NHS Foundation Trust



Theme: Morale
(1 of 2)

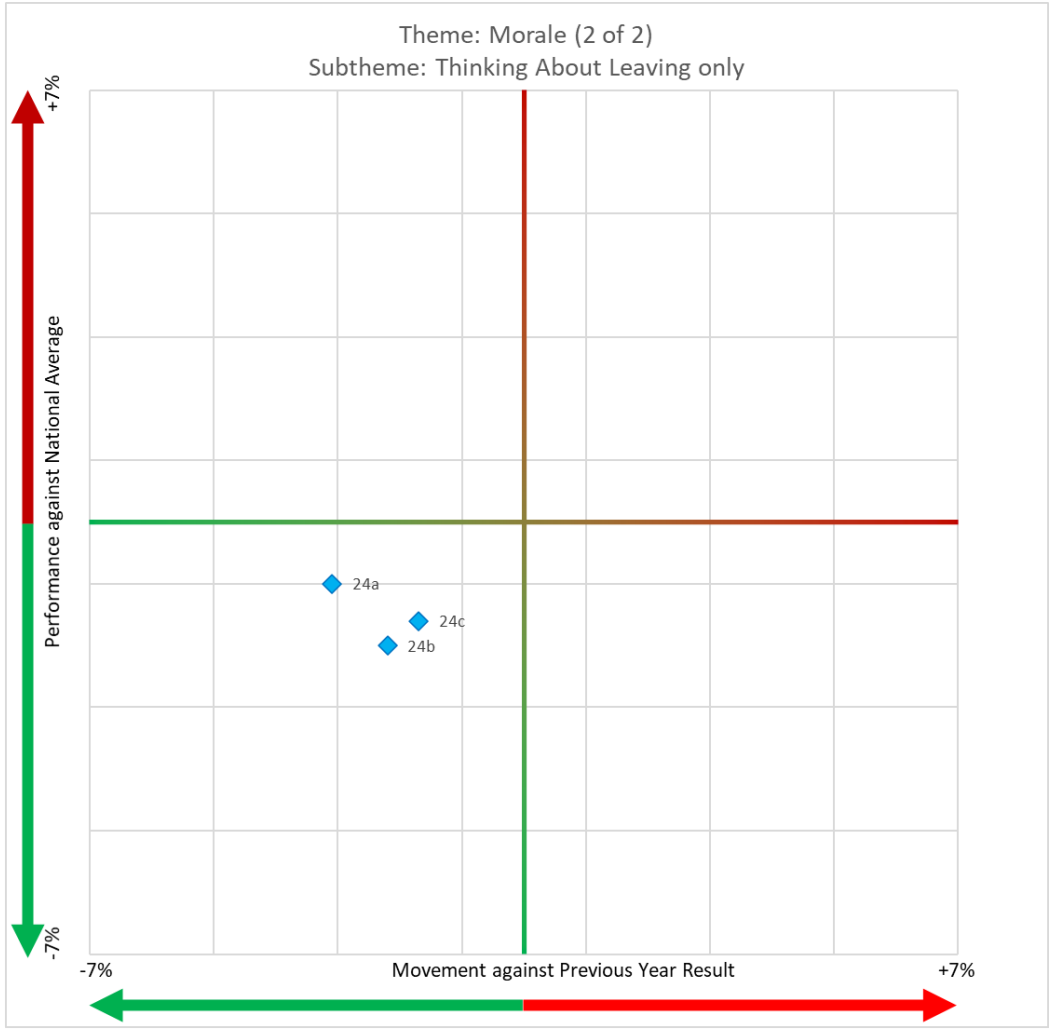
Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
3a	I always know what my work responsibilities are (Agree/Strongly agree).	85.0%	-0.4%	86.3%	-13%
3e	I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	48.6%	2.1%	50.4%	-18%
3g	I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	39.6%	3.3%	42.9%	-3.3%
3h	I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	48.8%	3.1%	53.5%	-4.7%
3i	There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	22.7%	0.6%	25.1%	-2.4%
5a	I have unrealistic time pressures (Never/Rarely).	20.5%	0.3%	22.3%	-18%
5c	Relationships at work are strained (Never/Rarely).	43.9%	3.5%	44.0%	-0.1%
7c	I receive the respect I deserve from my colleagues at work (Agree/Strongly agree).	70.8%	19%	70.4%	0.4%
9a	My immediate manager encourages me at work (Agree/Strongly agree).	70.7%	4.2%	69.7%	10%
24a	I often think about leaving this organisation (Agree/Strongly Agree).	30.9%	-3.1%	319%	-10%
24b	I will probably look for a job at a new organisation in the next 12 months (Agree/Strongly Agree).	210%	-2.2%	23.0%	-2.0%
24c	As soon as I can find another job, I will leave this organisation (Agree/Strongly Agree).	15.2%	-17%	16.8%	-16%

Subtheme: Work Pressures

- Although an improving picture (eg. safer staffing) this promise is highlighted as below the national average.
- More staff feel they are able to meet all the conflicting demands on their time and have adequate materials, supplies and equipment to do their work than last year, however remains below the national average.
- Overall, the sub group of work pressures is significantly below the national average and is a focus for the Trust as previously highlighted.

Theme – Morale (2 of 2 Thinking About Leaving)

Great Western Hospitals NHS Foundation Trust



Theme: Morale (2 of 2)

Subtheme: Thinking About Leaving only

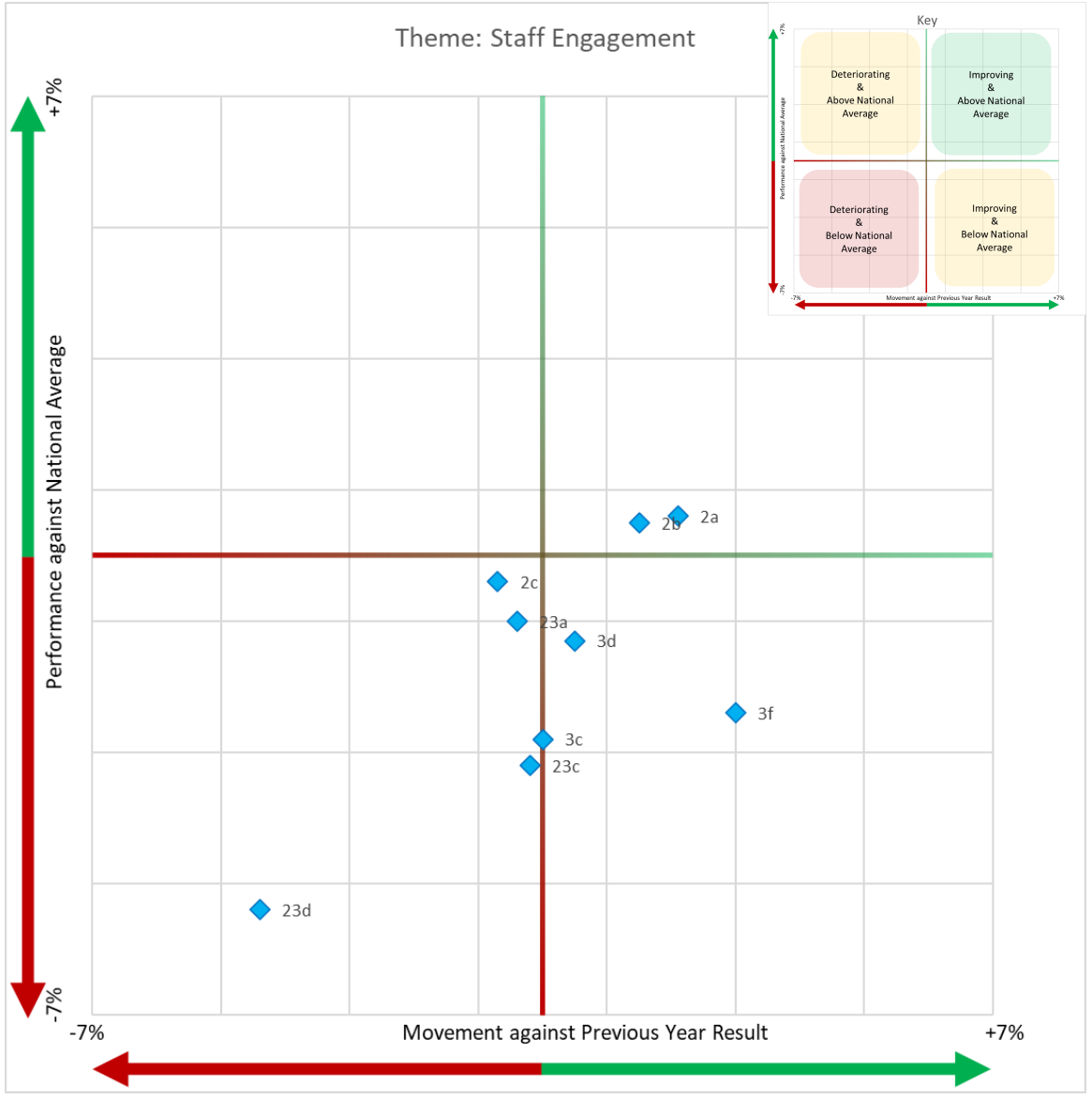
Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
24a	I often think about leaving this organisation (Agree/Strongly Agree).	30.9%	-3.1%	31.9%	-1.0%
24b	I will probably look for a job at a new organisation in the next 12 months (Agree/Strongly Agree).	21.0%	-2.2%	23.0%	-2.0%
24c	As soon as I can find another job, I will leave this organisation (Agree/Strongly Agree).	15.2%	-1.7%	16.8%	-1.6%

- These questions are reversed (lower the better).
- The three questions relating to leavers are encouragingly lower than last year and below national average demonstrating positive impact of stay conversations, stay and thrive.
- Staff response to wanting to leave the organisation (Q24a) is improving however this is not reflected in the staff advocacy questions therefore should be explored further.

Theme
Staff engagement

Theme – Staff engagement

Great Western Hospitals NHS Foundation Trust



Theme: Staff Engagement

Number	Question	Actual Score	Vs LY	National Average	Vs Nat. Av.
2a	I look forward to going to work (Often/Always).	53.1%	2.1%	52.5%	0.6%
2b	I am enthusiastic about my job (Often/Always).	67.2%	15%	66.7%	0.5%
2c	Time passes quickly when I am working (Often/Always).	72.1%	-0.7%	72.5%	-0.4%
3c	There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	70.0%	0.0%	72.8%	-2.8%
3d	I am able to make suggestions to improve the work of my team / department (Agree/Strongly agree).	69.6%	0.5%	70.9%	-13%
3f	I am able to make improvements happen in my area of work (Agree/Strongly agree).	52.3%	3.0%	54.7%	-2.4%
23a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	72.5%	-0.4%	73.5%	-10%
23c	I would recommend my organisation as a place to work (Agree/Strongly agree).	53.3%	-0.2%	56.5%	-3.2%
23d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	56.5%	-4.4%	619%	-5.4%

Subtheme: Advocacy

- Nationally and within the Trust the advocacy sub-score has declined.
- Q23c has deteriorated which is disappointing given the Trust's investment in engagement and recognition schemes.
- The result for Q23d should be a focus due to the decline against 2021 score and national average and aligns to the advocacy concern as previously highlighted.

BME and Disability Overview

BME Overview

Great Western Hospitals NHS Foundation Trust

Successes

- BME staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months has reduced notably by 4.1%, meeting the national average, and reduced by 2.4% for White staff, above national average.
- BME staff experiencing harassment, bullying or abuse from colleagues in last 12 months has reduced notably by 4.4%, slightly lower than national average. There has also been an improvement for White staff by 1.9%, meeting the national average.
- Notably, there is a marked reduction of 6.6% of BME staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months.
- BME staff believing that the organisation provides equal opportunities for career progression or promotion has improved by 4.7%, whilst the rate for White staff has stayed relatively the same as last year and is slightly ahead of the national average.

Areas for improvement

- The Trust's score of 19.8% of BME staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months, is still slightly higher than the national average of 17.3%. The score for White staff has marginally improved against 2021 and the national average.

Disability Overview

Great Western Hospitals NHS Foundation Trust

Successes

- The percentage of staff with LTC or illness experiencing harassment, bullying or abuse from **managers** in the last 12 months has decreased by 1.7%. Both the Trust rates for staff with and without a LTC or illness are lower than the national average.
- 50.1% of staff with LTC or illness said the last time they experienced harassment, bullying or abuse at work they reported it which is an improvement on last year.

Areas for improvement

- The percentage of staff with LTC or illness experiencing harassment, bullying or abuse from **patients** / service users, relatives or the public in last 12 months has not improved against 2021 and is still 4% above national average.
- The percentage of staff with LTC or illness experiencing harassment, bullying or abuse from **colleagues** in last 12 months has slightly increased by 1.3% and this is above the national average.

How we will respond
Improving Together

Staff Survey Timeline

Great Western Hospitals NHS Foundation Trust

The below sets-out key planning milestones over the next seven months to build into the staff survey planning approach.

March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023
Trust wide results shared with TMC – refresh Trust A3 and countermeasures	Divisions to present at April P&CC – refreshed A3s and countermeasures	Improving Together Communication Plan – increase frequency of communications and build momentum				Staff Survey Go-Live

Progress to be monitored via divisional performance reviews, reported via TMC (monthly) and P&CC

Building Improving Together Momentum

Great Western Hospitals NHS Foundation Trust

A number of activities are planned or underway, to support organic Improving Together momentum across the organisation, acting as enablers for Question 3f. We want our staff to continue to feel excited about Improving Together, and driving an continuous improvement culture into the ethos of the organisation.

Communication Plan Refresh

Updated Improving Together communication plan under development, to support momentum and to develop case studies and best practice.

Improving Together Blog

An idea suggested by a colleague in USC, to share case studies and examples, with opportunity to colleagues to network and to develop into a newsletter. Work underway to implement this at pace

Orbital

Work planned to improve meeting room 5 into an Improving Together meeting area, for all staff to use.

Project Management Network

Dates scheduled for March and April, with a view to sharing further case studies and aligning project management with Improving Together. Over 150 staff, from project professionals to those with an interest, are currently members.

A3 Networking Events

Pipeline plans for later this year, led by Coach House, to hold A3 sharing and marketplace events in Workspace.

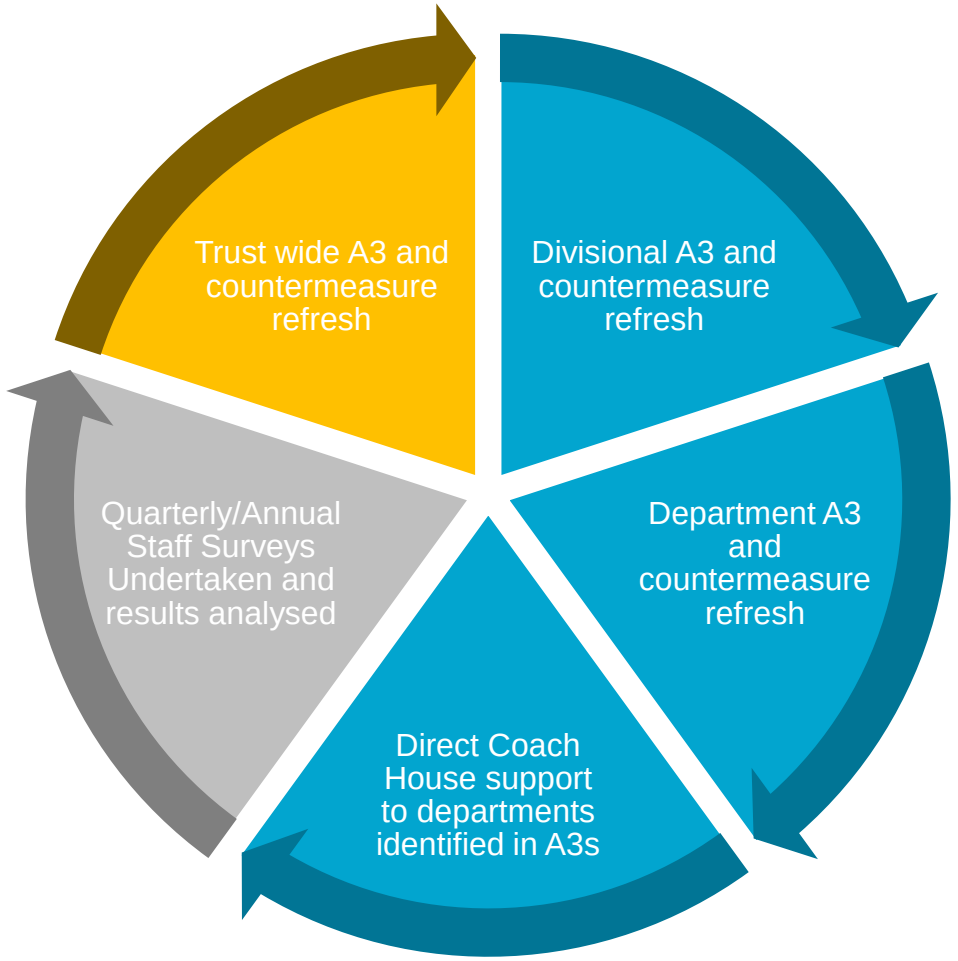
Improving Together Tea Trolley

Dedicated trolley to support the drive of Improving Together awareness, principles, and to support further engagement

Next Steps – A3 Improving Together

Q3f “I am able to make improvement happen in my area of work”

Great Western Hospitals NHS Foundation Trust



Complete | In Progress | Planned

Additional areas of focus:

In addition to Breakthrough Objective, the Committee is asked to consider extending the focus to 2 key areas.

- **Advocacy**
- **Work pressures**

** This is outside the methodology (inch wide, mile deep) and by extending the approach to other areas before achieving the desired outcome within the breakthrough objective may impact the performance of the staff survey results.*

Any questions?

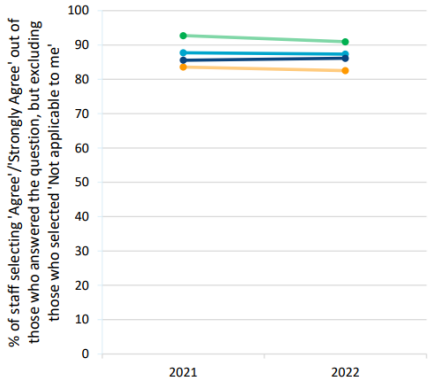
Appendices

Promise 1: We are compassionate and inclusive

Theme

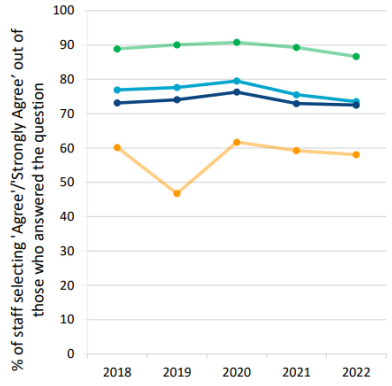
Great Western Hospitals NHS Foundation Trust

Q6a I feel that my role makes a difference to patients / service users.



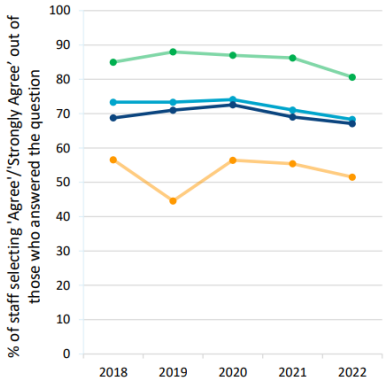
	2021	2022
Your org	85.6%	86.1%
Best	92.7%	90.9%
Average	87.7%	87.3%
Worst	83.6%	82.5%
Responses	2353	3086

Q23a Care of patients / service users is my organisation's top priority.



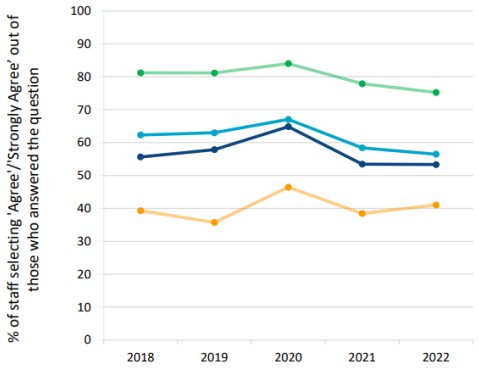
	2018	2019	2020	2021	2022
Your org	73.1%	74.0%	76.3%	72.9%	72.5%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	506	478	651	2416	3134

Q23b My organisation acts on concerns raised by patients / service users.



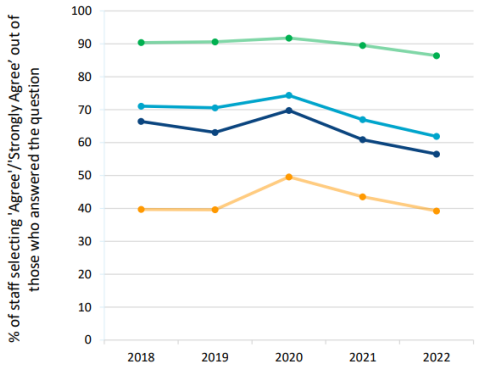
	2018	2019	2020	2021	2022
Your org	68.8%	71.0%	72.6%	69.0%	67.1%
Best	85.0%	88.0%	87.0%	86.2%	80.6%
Average	73.3%	73.3%	74.1%	71.0%	68.3%
Worst	56.6%	44.6%	56.4%	55.4%	51.5%
Responses	507	478	650	2414	3128

Q23c I would recommend my organisation as a place to work.



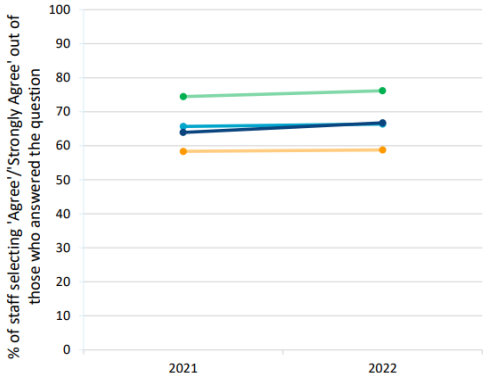
	2018	2019	2020	2021	2022
Your org	55.6%	57.9%	64.8%	53.5%	53.3%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	506	479	653	2412	3131

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



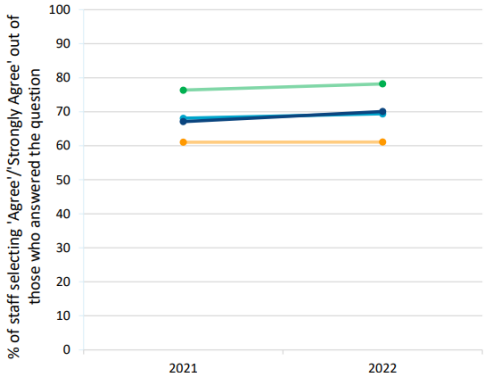
	2018	2019	2020	2021	2022
Your org	66.4%	63.1%	69.8%	60.9%	56.5%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	507	477	651	2413	3127

Q9f My immediate manager works together with me to come to an understanding of problems.



	2021	2022
Your org	63.9%	66.7%
Best	74.5%	76.2%
Average	65.7%	66.4%
Worst	58.4%	58.8%
Responses	2413	3143

Q9g My immediate manager is interested in listening to me when I describe challenges I face.



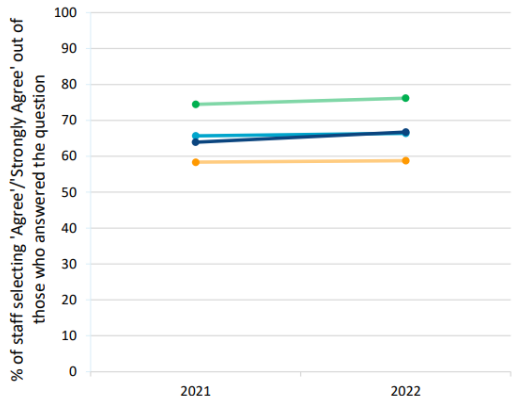
	2021	2022
Your org	67.1%	70.1%
Best	76.4%	78.2%
Average	68.1%	69.4%
Worst	61.1%	61.1%
Responses	2415	3141

Promise 1: We are compassionate and inclusive

Great Western Hospitals NHS Foundation Trust

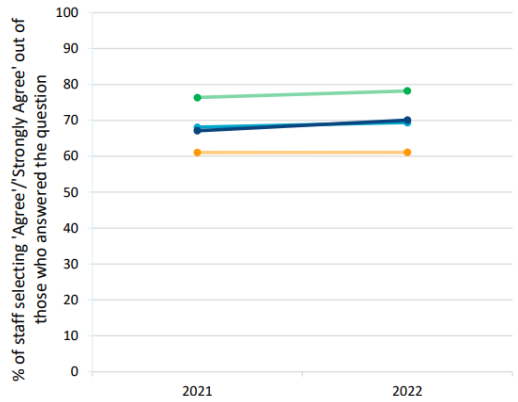
Theme

Q9f My immediate manager works together with me to come to an understanding of problems.



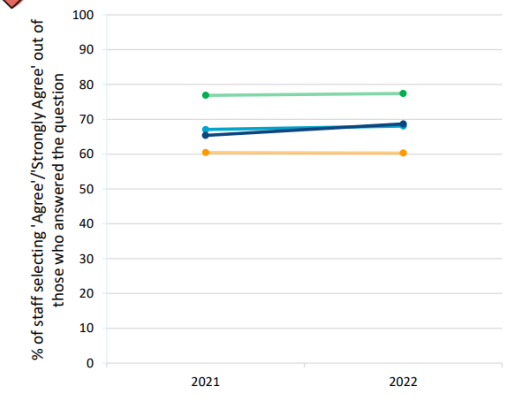
	2021	2022
Your org	63.9%	66.7%
Best	74.5%	76.2%
Average	65.7%	66.4%
Worst	58.4%	58.8%
Responses	2413	3143

Q9g My immediate manager is interested in listening to me when I describe challenges I face.



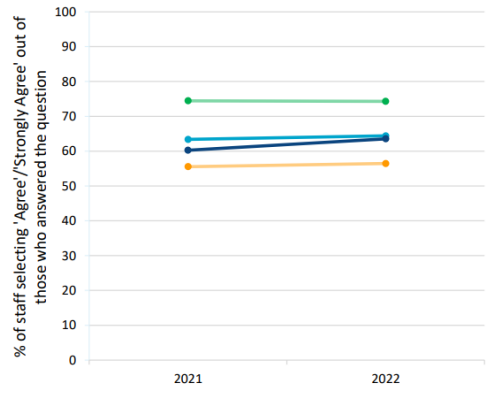
	2021	2022
Your org	67.1%	70.1%
Best	76.4%	78.2%
Average	68.1%	69.4%
Worst	61.1%	61.1%
Responses	2415	3141

Q9h My immediate manager cares about my concerns.



	2021	2022
Your org	65.4%	68.7%
Best	76.9%	77.4%
Average	67.1%	68.1%
Worst	60.5%	60.3%
Responses	2410	3133

Q9i My immediate manager takes effective action to help me with any problems I face.

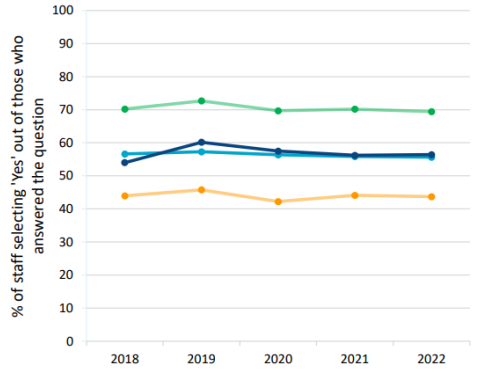


	2021	2022
Your org	60.2%	63.5%
Best	74.5%	74.3%
Average	63.4%	64.4%
Worst	55.6%	56.4%
Responses	2407	3140

Promise 1: We are compassionate and inclusive

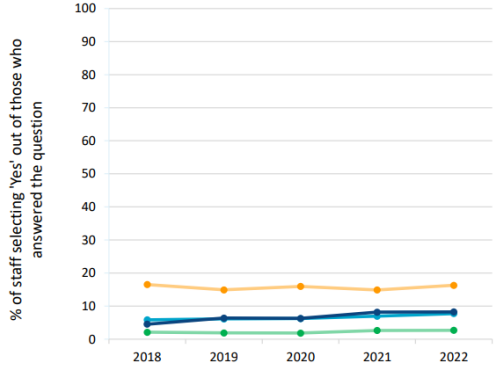
Great Western Hospitals NHS

Q15 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



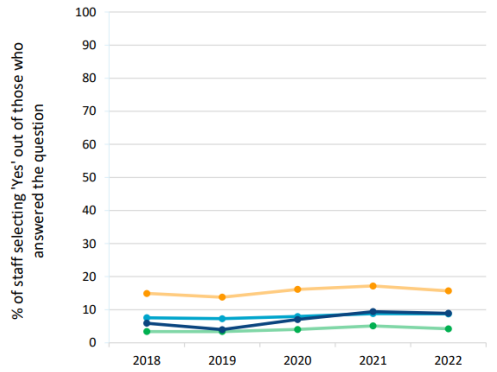
	2018	2019	2020	2021	2022
Your org	54.0%	60.2%	57.5%	56.2%	56.4%
Best	70.2%	72.7%	69.7%	70.2%	69.4%
Average	56.6%	57.3%	56.4%	55.8%	55.6%
Worst	44.0%	45.8%	42.2%	44.1%	43.7%
Responses	514	488	659	2416	3129

Q16a In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



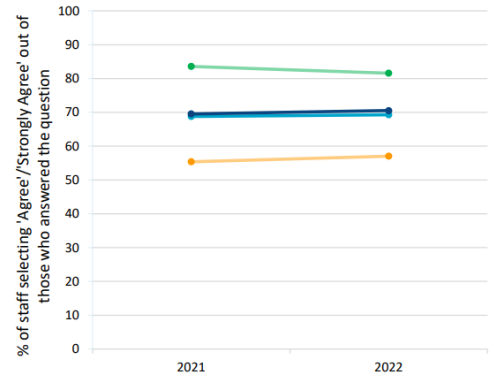
	2018	2019	2020	2021	2022
Your org	4.5%	6.4%	6.3%	8.2%	8.3%
Best	2.1%	1.9%	1.9%	2.7%	2.7%
Average	5.9%	6.2%	6.3%	7.0%	7.8%
Worst	16.5%	14.9%	16.0%	14.9%	16.3%
Responses	518	487	658	2409	3123

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



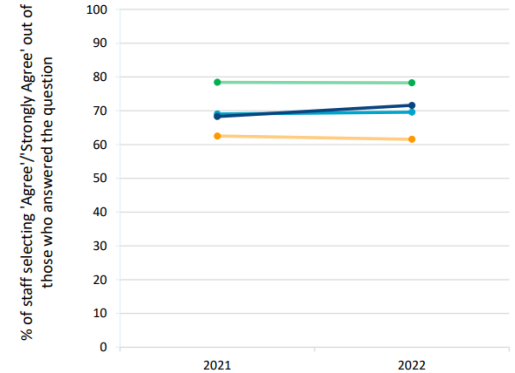
	2018	2019	2020	2021	2022
Your org	5.9%	4.0%	7.0%	9.4%	8.9%
Best	3.4%	3.4%	4.0%	5.1%	4.2%
Average	7.5%	7.3%	7.9%	8.8%	8.7%
Worst	14.9%	13.8%	16.1%	17.2%	15.7%
Responses	516	482	652	2404	3106

Q20 I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).



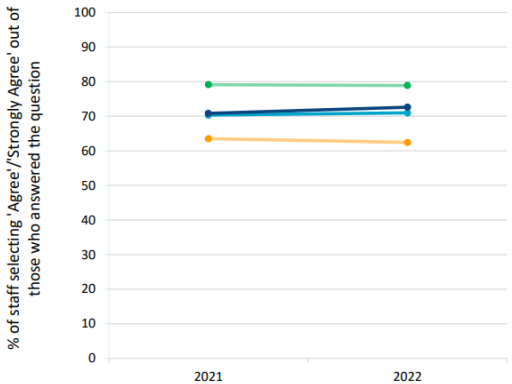
	2021	2022
Your org	69.5%	70.5%
Best	83.6%	81.6%
Average	68.8%	69.3%
Worst	55.4%	57.1%
Responses	2417	3140

Q8b The people I work with are understanding and kind to one another.



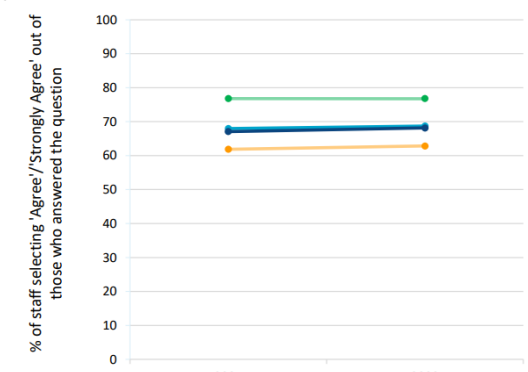
	2021	2022
Your org	68.3%	71.6%
Best	78.4%	78.3%
Average	69.0%	69.6%
Worst	62.5%	61.6%
Responses	2408	3138

Q8c The people I work with are polite and treat each other with respect.



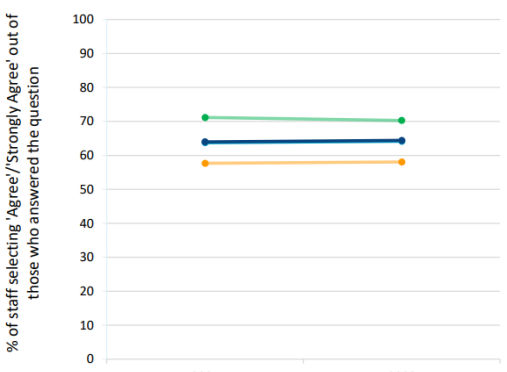
	2021	2022
Your org	70.8%	72.6%
Best	79.1%	78.9%
Average	70.3%	71.0%
Worst	63.5%	62.4%
Responses	2412	3132

Q7h I feel valued by my team.



	2021	2022
Your org	67.1%	68.1%
Best	76.8%	76.8%
Average	68.0%	68.7%
Worst	61.9%	62.8%
Responses	2411	3137

Q7i I feel a strong personal attachment to my team.



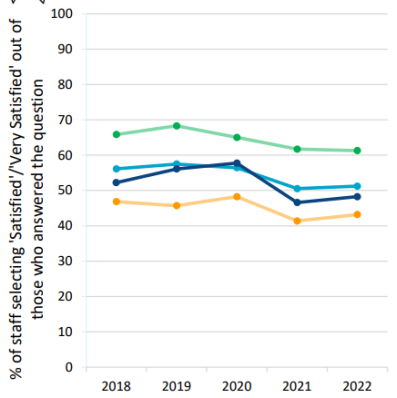
	2021	2022
Your org	64.0%	64.4%
Best	71.2%	70.3%
Average	63.7%	64.2%
Worst	57.7%	58.1%
Responses	2407	3129

Promise 2: We are recognised and rewarded

Great Western Hospitals NHS Foundation Trust

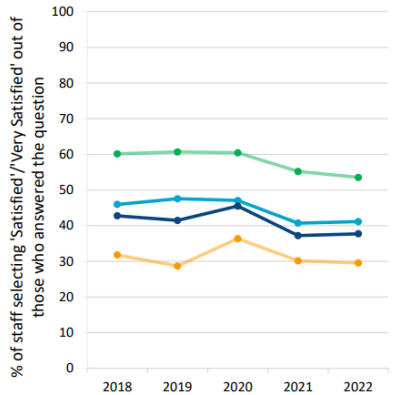
Theme

Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.



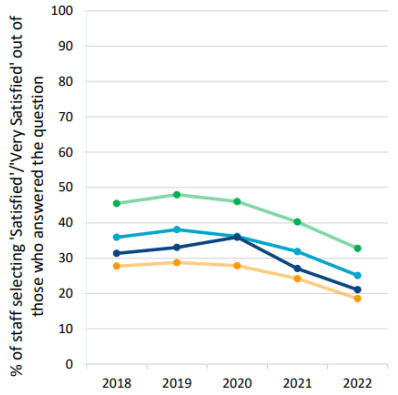
	2018	2019	2020	2021	2022
Your org	52.2%	56.1%	57.7%	46.6%	48.3%
Best	65.8%	68.3%	65.0%	61.7%	61.3%
Average	56.1%	57.5%	56.4%	50.5%	51.2%
Worst	46.8%	45.7%	48.2%	41.4%	43.2%
Responses	522	493	659	2415	3130

Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.



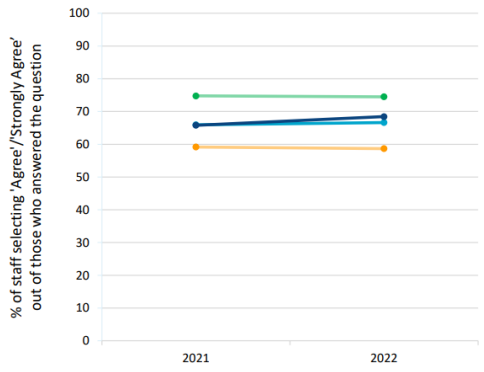
	2018	2019	2020	2021	2022
Your org	42.8%	41.5%	45.5%	37.2%	37.7%
Best	60.1%	60.7%	60.4%	55.2%	53.5%
Average	45.9%	47.5%	47.1%	40.7%	41.1%
Worst	31.8%	28.7%	36.4%	30.1%	29.5%
Responses	522	489	658	2406	3119

Q4c How satisfied are you with each of the following aspects of your job? My level of pay.



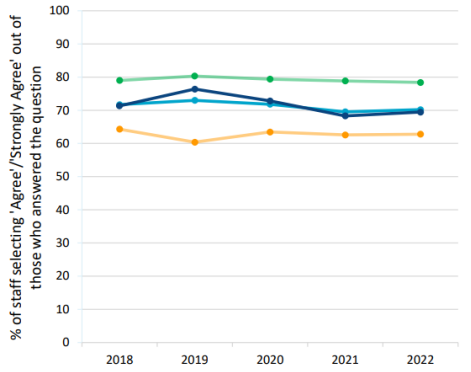
	2018	2019	2020	2021	2022
Your org	31.4%	33.0%	35.9%	27.1%	21.1%
Best	45.5%	47.9%	46.0%	40.3%	32.8%
Average	35.9%	38.1%	36.2%	31.9%	25.1%
Worst	27.7%	28.7%	27.9%	24.2%	18.5%
Responses	522	492	658	2409	3131

Q8d The people I work with show appreciation to one another.



	2021	2022
Your org	65.8%	68.4%
Best	74.8%	74.5%
Average	66.0%	66.6%
Worst	59.2%	58.7%
Responses	2404	3128

Q9e My immediate manager values my work.



	2018	2019	2020	2021	2022
Your org	71.3%	76.4%	72.8%	68.3%	69.4%
Best	79.0%	80.3%	79.4%	78.8%	78.4%
Average	71.7%	73.0%	71.8%	69.5%	70.2%
Worst	64.3%	60.4%	63.4%	62.6%	62.8%
Responses	519	490	658	2417	3145

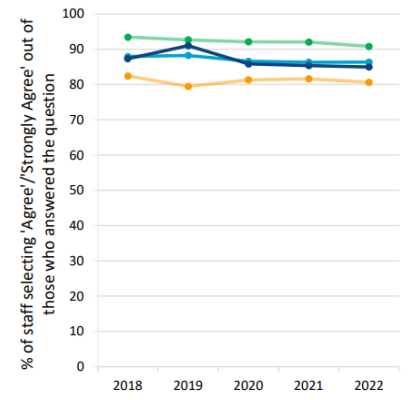
Service Teamwork Ambition

Promise 3: We each have a voice that counts

Great Western Hospitals NHS Foundation Trust

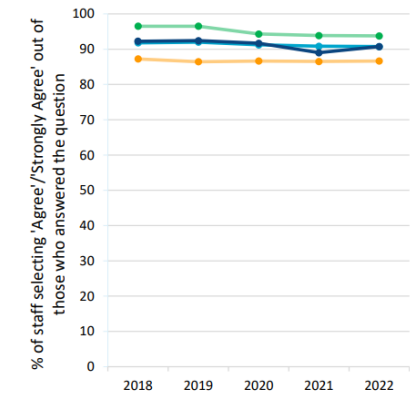
Theme

Q3a I always know what my work responsibilities are.



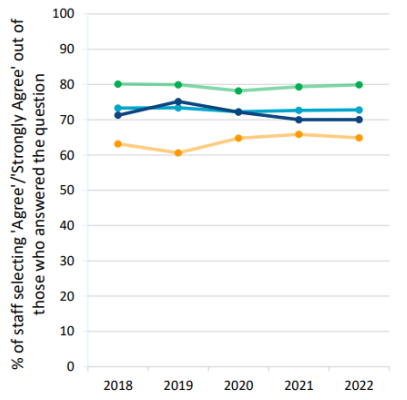
	2018	2019	2020	2021	2022
Your org	87.3%	91.0%	85.8%	85.4%	85.0%
Best	93.4%	92.7%	92.1%	92.0%	90.8%
Average	87.9%	88.2%	86.6%	86.3%	86.3%
Worst	82.4%	79.5%	81.3%	81.6%	80.6%
Responses	530	490	654	2422	3141

Q3b I am trusted to do my job.



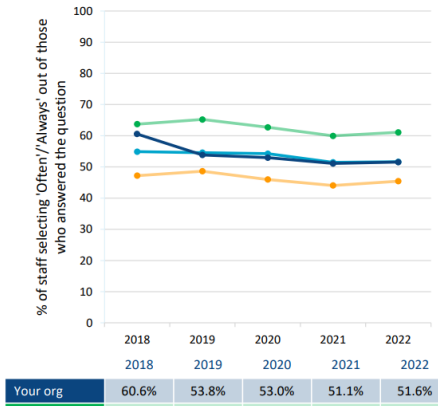
	2018	2019	2020	2021	2022
Your org	92.3%	92.4%	91.7%	89.0%	90.7%
Best	96.5%	96.5%	94.3%	93.9%	93.8%
Average	91.8%	92.0%	91.2%	90.8%	90.7%
Worst	87.3%	86.5%	86.7%	86.5%	86.7%
Responses	530	490	652	2419	3140

Q3c There are frequent opportunities for me to show initiative in my role.



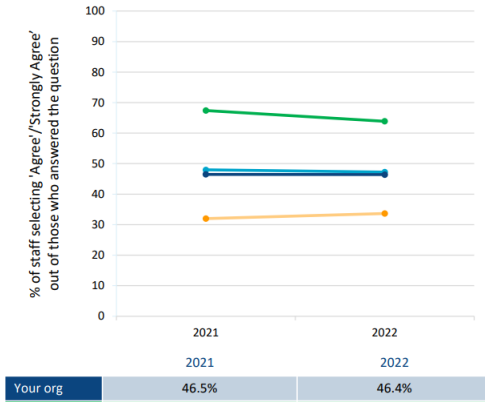
	2018	2019	2020	2021	2022
Your org	71.3%	75.2%	72.2%	70.0%	70.0%
Best	80.1%	79.9%	78.2%	79.3%	79.9%
Average	73.3%	73.4%	72.3%	72.7%	72.8%
Worst	63.2%	60.6%	64.8%	65.9%	64.9%
Responses	531	496	658	2419	3134

Q5b I have a choice in deciding how to do my work.



	2018	2019	2020	2021	2022
Your org	60.6%	53.8%	53.0%	51.1%	51.6%
Best	63.7%	65.2%	62.7%	60.0%	61.1%
Average	54.9%	54.6%	54.3%	51.5%	51.7%
Worst	47.2%	48.6%	46.0%	44.1%	45.4%
Responses	524	491	655	2411	3123

Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022
Your org	46.5%	46.4%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	2409	3120

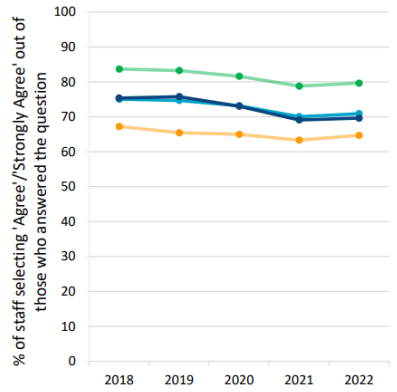
The Trust is consistently tracking the national average trend across the five year period.

Promise 3: We each have a voice that counts

Great Western Hospitals NHS Foundation Trust

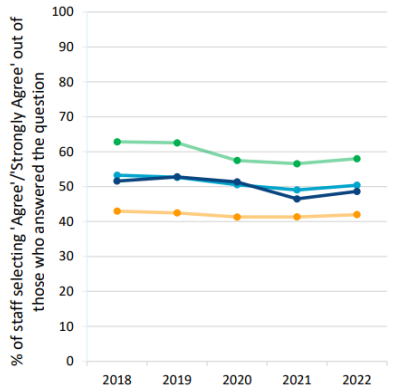
Theme

Q3d I am able to make suggestions to improve the work of my team / department.



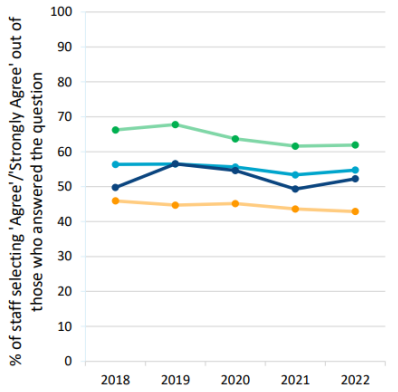
	2018	2019	2020	2021	2022
Your org	75.3%	75.8%	73.0%	69.1%	69.6%
Best	83.7%	83.3%	81.6%	78.8%	79.6%
Average	75.0%	74.7%	73.2%	70.0%	70.9%
Worst	67.2%	65.4%	65.0%	63.3%	64.7%
Responses	531	495	652	2402	3129

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



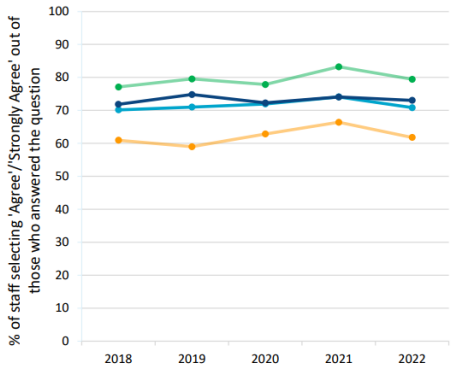
	2018	2019	2020	2021	2022
Your org	51.6%	52.8%	51.4%	46.5%	48.6%
Best	62.8%	62.5%	57.5%	56.5%	58.0%
Average	53.3%	52.7%	50.6%	49.1%	50.4%
Worst	43.0%	42.5%	41.3%	41.3%	42.0%
Responses	530	492	657	2414	3133

Q3f I am able to make improvements happen in my area of work.



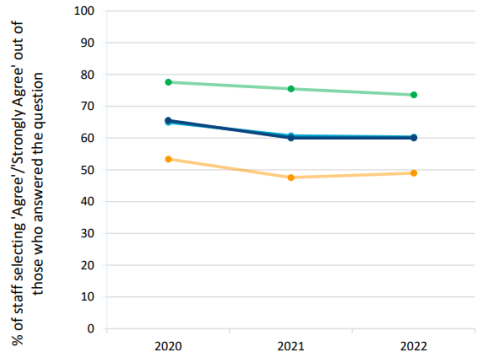
	2018	2019	2020	2021	2022
Your org	49.7%	56.5%	54.6%	49.3%	52.3%
Best	66.2%	67.8%	63.7%	61.6%	61.9%
Average	56.4%	56.5%	55.6%	53.4%	54.7%
Worst	45.9%	44.7%	45.1%	43.6%	42.9%
Responses	531	492	656	2402	3126

Q19a I would feel secure raising concerns about unsafe clinical practice.



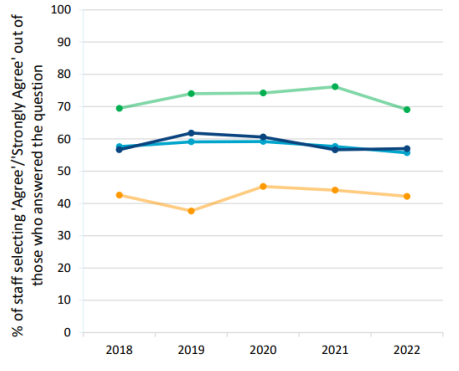
	2018	2019	2020	2021	2022
Your org	71.8%	74.8%	72.3%	74.1%	73.0%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	512	484	659	2416	3127

Q23e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022
Your org	65.5%	60.0%	60.1%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	651	2412	3122

Q19b I am confident that my organisation would address my concern.



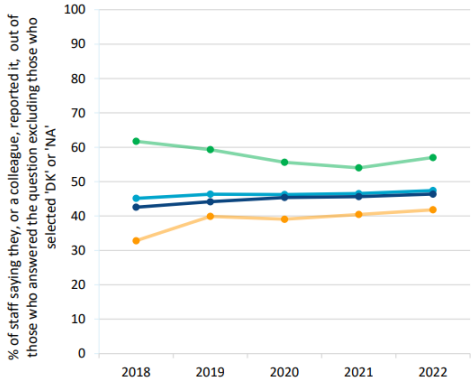
	2018	2019	2020	2021	2022
Your org	56.6%	61.8%	60.6%	56.6%	57.0%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	509	485	656	2411	3120

Promise 4: We are safe and healthy

Great Western Hospitals NHS Foundation Trust

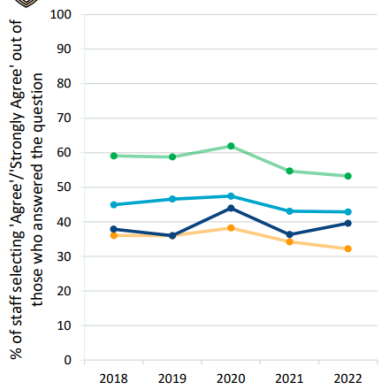
Theme

Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?



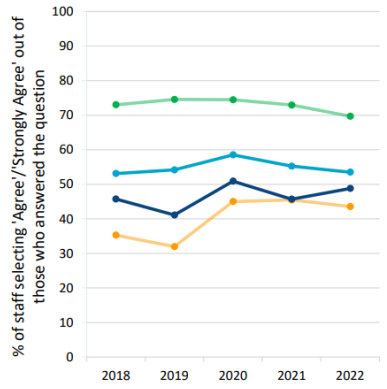
	2018	2019	2020	2021	2022
Your org	42.5%	44.2%	45.4%	45.6%	46.4%
Best	61.7%	59.3%	55.6%	54.0%	57.0%
Average	45.1%	46.4%	46.3%	46.5%	47.4%
Worst	32.8%	39.9%	39.1%	40.5%	41.8%
Responses	189	154	243	966	1153

Q3g I am able to meet all the conflicting demands on my time at work.



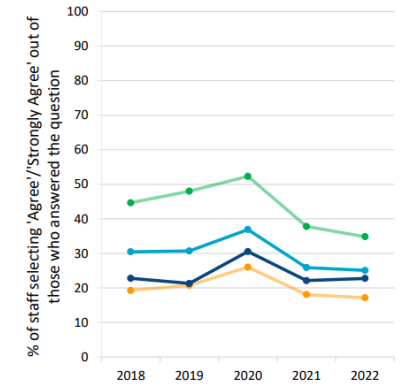
	2018	2019	2020	2021	2022
Your org	37.9%	36.0%	43.9%	36.3%	39.6%
Best	59.1%	58.8%	61.9%	54.7%	53.2%
Average	44.9%	46.6%	47.4%	43.1%	42.9%
Worst	36.0%	36.0%	38.2%	34.2%	32.2%
Responses	528	494	658	2402	3129

Q3h I have adequate materials, supplies and equipment to do my work.



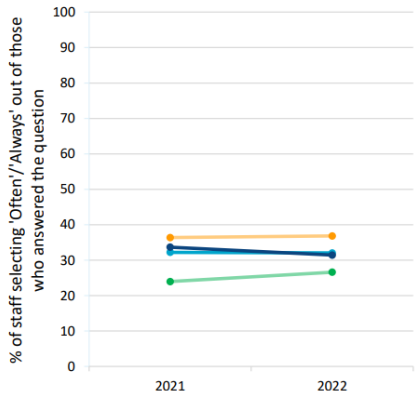
	2018	2019	2020	2021	2022
Your org	45.7%	41.1%	50.9%	45.7%	48.8%
Best	73.0%	74.6%	74.5%	72.9%	69.7%
Average	53.1%	54.2%	58.5%	55.3%	53.5%
Worst	35.3%	32.0%	45.0%	45.5%	43.6%
Responses	528	495	656	2407	3133

Q3i There are enough staff at this organisation for me to do my job properly.



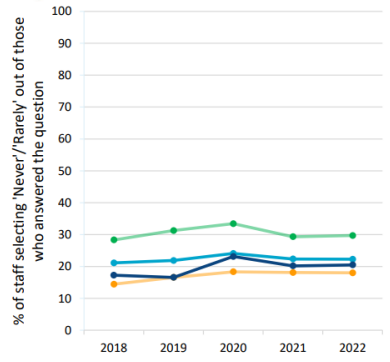
	2018	2019	2020	2021	2022
Your org	22.8%	21.3%	30.5%	22.1%	22.7%
Best	44.6%	48.0%	52.3%	37.8%	34.8%
Average	30.5%	30.7%	36.9%	25.9%	25.1%
Worst	19.3%	20.8%	26.0%	18.1%	17.2%
Responses	529	494	655	2417	3135

Q12g How often, if at all, do you not have enough energy for family and friends during leisure time?



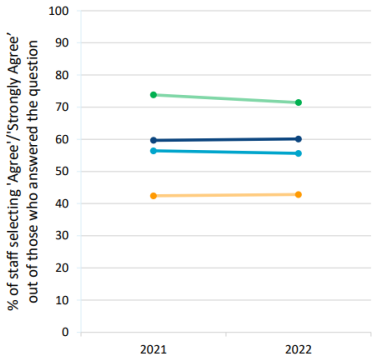
	2021	2022
Your org	33.6%	31.4%
Best	23.9%	26.6%
Average	32.2%	32.0%
Worst	36.4%	36.8%
Responses	2420	3140

Q5a I have unrealistic time pressures.



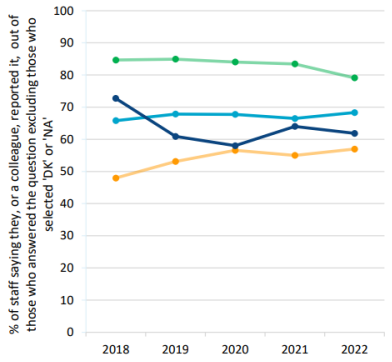
	2018	2019	2020	2021	2022
Your org	17.3%	16.6%	23.1%	20.2%	20.5%
Best	28.3%	31.3%	33.4%	29.3%	29.7%
Average	21.1%	21.9%	24.1%	22.4%	22.3%
Worst	14.4%	16.6%	18.3%	18.1%	18.0%
Responses	524	494	657	2412	3125

Q11a My organisation take positive action on health and well-being.



	2021	2022
Your org	59.6%	60.1%
Best	73.8%	71.4%
Average	56.4%	55.6%
Worst	42.4%	42.8%
Responses	2395	3120

Q13d The last time you experienced physical violence at work, did you or a colleague report it?



	2018	2019	2020	2021	2022
Your org	72.7%	60.9%	58.0%	64.0%	61.8%
Best	84.6%	84.9%	84.0%	83.4%	79.1%
Average	65.8%	67.8%	67.8%	66.5%	68.3%
Worst	47.9%	53.1%	56.6%	55.0%	57.0%
Responses	59	49	78	287	418

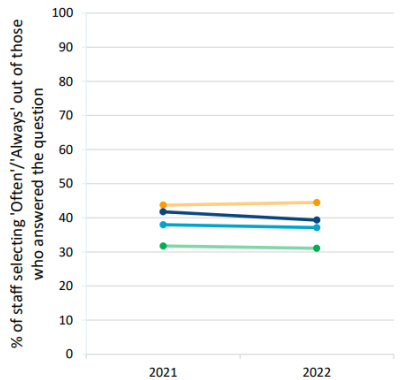
Service Teamwork Ambition Re

Promise 4: We are safe and healthy

Great Western Hospitals NHS Foundation Trust

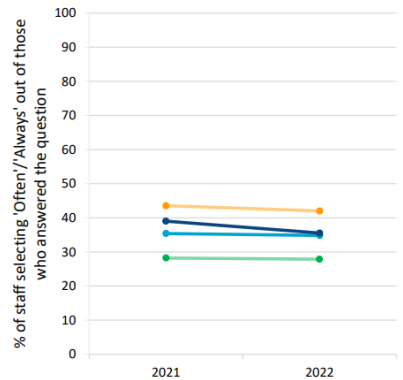
Theme

Q12a How often, if at all, do you find your work emotionally exhausting?



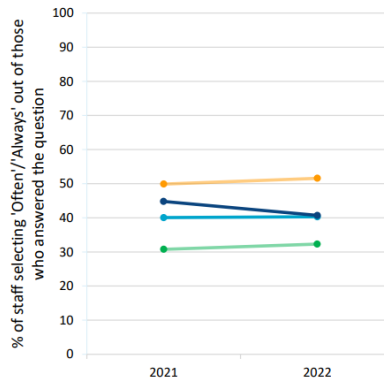
	2021	2022
Your org	41.8%	39.3%
Best	31.7%	31.0%
Average	38.0%	37.1%
Worst	43.7%	44.5%
Responses	2423	3143

Q12b How often, if at all, do you feel burnt out because of your work?



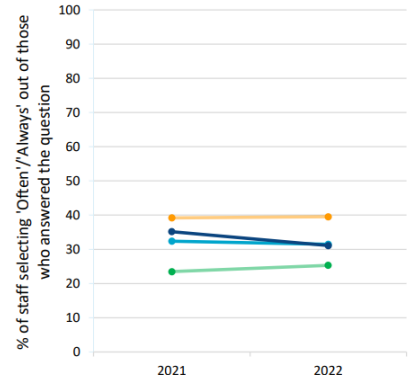
	2021	2022
Your org	39.0%	35.5%
Best	28.2%	27.9%
Average	35.4%	34.8%
Worst	43.5%	42.0%
Responses	2421	3141

Q12c How often, if at all, does your work frustrate you?



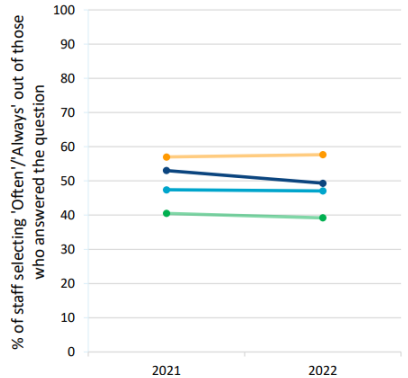
	2021	2022
Your org	44.8%	40.7%
Best	30.8%	32.3%
Average	40.1%	40.3%
Worst	49.9%	51.6%
Responses	2417	3142

Q12d How often, if at all, are you exhausted at the thought of another day/shift at work?



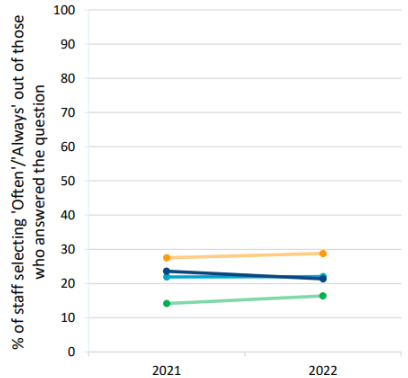
	2021	2022
Your org	35.1%	31.1%
Best	23.5%	25.3%
Average	32.4%	31.5%
Worst	39.2%	39.5%
Responses	2417	3138

Q12e How often, if at all, do you feel worn out at the end of your working day/shift?



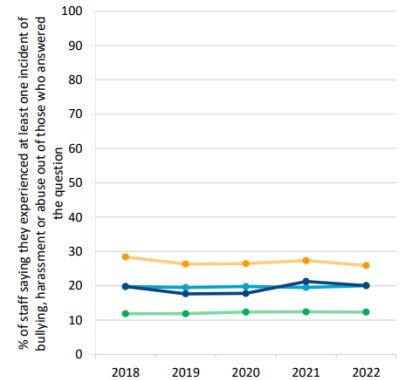
	2021	2022
Your org	53.0%	49.3%
Best	40.5%	39.2%
Average	47.4%	47.1%
Worst	57.0%	57.7%
Responses	2411	3134

Q12f How often, if at all, do you feel that every working hour is tiring for you?



	2021	2022
Your org	23.6%	21.4%
Best	14.2%	16.4%
Average	21.9%	22.0%
Worst	27.5%	28.8%
Responses	2404	3131

Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.



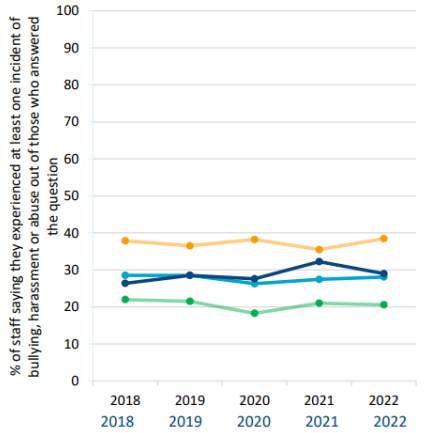
	2018	2019	2020	2021	2022
Your org	19.8%	17.6%	17.8%	21.2%	20.0%
Best	11.8%	11.9%	12.4%	12.4%	12.3%
Average	19.8%	19.5%	19.8%	19.5%	20.0%
Worst	28.4%	26.3%	26.5%	27.3%	25.9%
Responses	511	477	649	2383	3104

Promise 4: We are safe and healthy

Great Western Hospitals NHS Foundation Trust

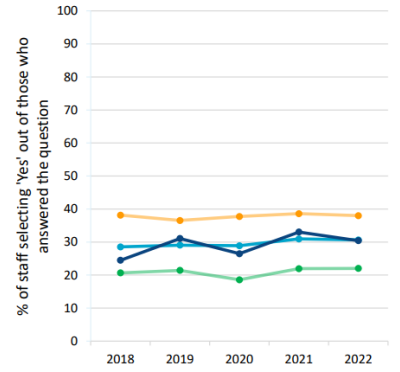
Theme

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



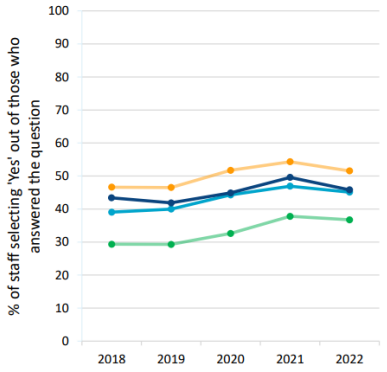
	2018	2019	2020	2021	2022
Your org	26.4%	28.5%	27.6%	32.2%	29.0%
Best	22.0%	21.5%	18.3%	21.0%	20.6%
Average	28.5%	28.5%	26.3%	27.4%	28.1%
Worst	37.9%	36.5%	38.2%	35.5%	38.5%
Responses	515	485	655	2411	3132

Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



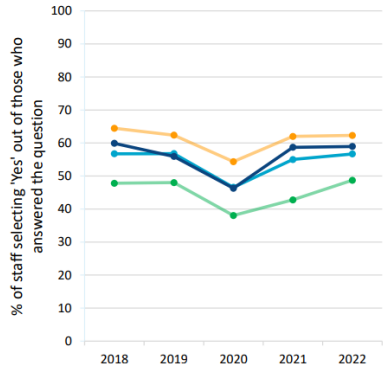
	2018	2019	2020	2021	2022
Your org	24.5%	31.1%	26.5%	33.0%	30.4%
Best	20.7%	21.4%	18.6%	21.9%	22.0%
Average	28.5%	29.1%	28.9%	31.0%	30.6%
Worst	38.1%	36.5%	37.7%	38.6%	38.0%
Responses	516	489	656	2414	3127

Q11c During the last 12 months have you felt unwell as a result of work related stress?



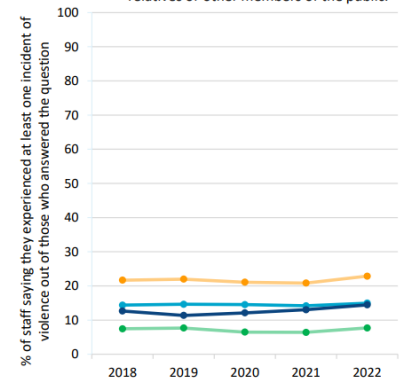
	2018	2019	2020	2021	2022
Your org	43.4%	41.9%	44.9%	49.6%	45.8%
Best	29.3%	29.3%	32.6%	37.8%	36.7%
Average	39.1%	40.0%	44.3%	46.9%	45.1%
Worst	46.6%	46.5%	51.7%	54.3%	51.5%
Responses	516	489	656	2414	3128

Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?



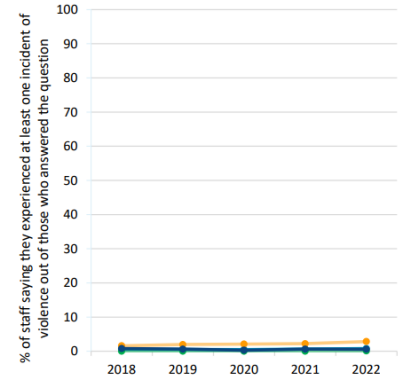
	2018	2019	2020	2021	2022
Your org	59.9%	55.9%	46.3%	58.7%	58.9%
Best	47.8%	48.0%	38.0%	42.8%	48.7%
Average	56.7%	56.8%	46.6%	55.0%	56.7%
Worst	64.5%	62.4%	54.3%	62.0%	62.3%
Responses	514	487	656	2418	3121

Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.



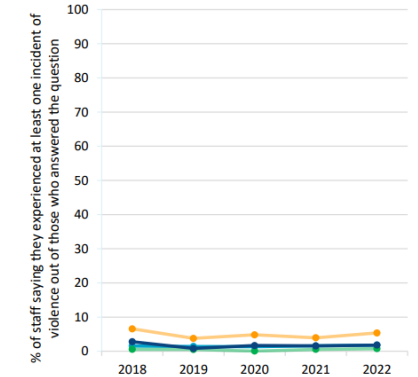
	2018	2019	2020	2021	2022
Your org	12.7%	11.4%	12.1%	13.0%	14.5%
Best	7.5%	7.7%	6.5%	6.4%	7.7%
Average	14.4%	14.6%	14.5%	14.2%	15.0%
Worst	21.7%	22.0%	21.1%	20.8%	22.8%
Responses	518	488	656	2421	3142

Q13b In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.



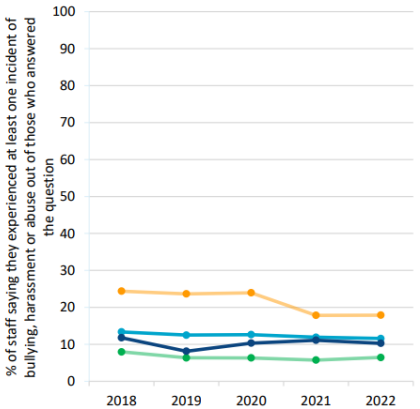
	2018	2019	2020	2021	2022
Your org	0.8%	0.6%	0.3%	0.6%	0.6%
Best	0.0%	0.0%	0.0%	0.0%	0.1%
Average	0.6%	0.6%	0.5%	0.6%	0.8%
Worst	1.6%	2.0%	2.1%	2.2%	2.9%
Responses	507	486	657	2411	3134

Q13c In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues.



	2018	2019	2020	2021	2022
Your org	2.8%	0.8%	1.7%	1.6%	1.8%
Best	0.6%	0.5%	0.1%	0.6%	0.7%
Average	1.5%	1.4%	1.4%	1.6%	1.8%
Worst	6.6%	3.8%	4.8%	4.0%	5.4%
Responses	510	478	649	2389	3113

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.



	2018	2019	2020	2021	2022
Your org	11.8%	8.1%	10.3%	11.1%	10.3%
Best	8.0%	6.4%	6.3%	5.7%	6.4%
Average	13.3%	12.5%	12.6%	11.9%	11.6%
Worst	24.4%	23.7%	23.9%	17.8%	17.9%
Responses	510	482	647	2393	3116

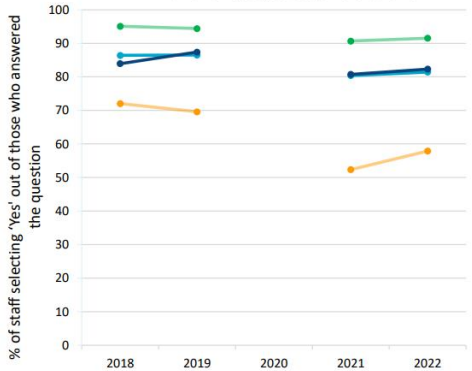
Service Teamwork Ambition Res

Promise 5: We are always learning

Great Western Hospitals NHS

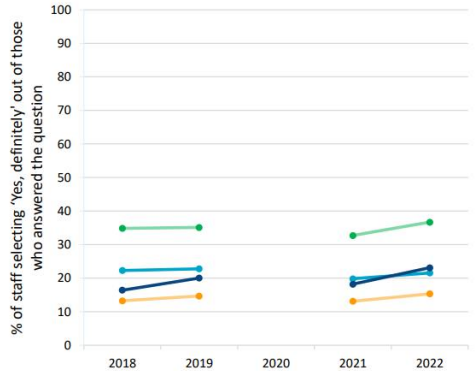
Q21a is a filter question and therefore influences the sub-score without being a directly scored question.

Q21a In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



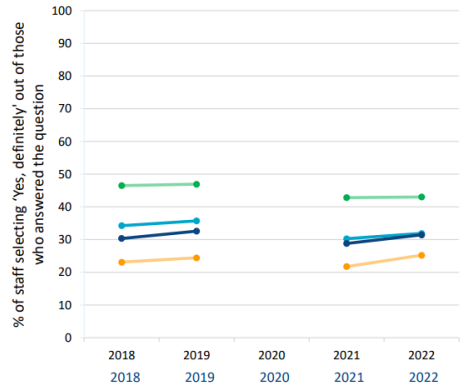
	2018	2019	2020	2021	2022
Your org	83.9%	87.4%	-	80.7%	82.3%
Best	95.1%	94.4%	-	90.7%	91.5%
Average	86.4%	86.5%	-	80.4%	81.4%
Worst	72.1%	69.6%	-	52.4%	57.9%
Responses	509	483	-	2404	3131

Q21b It helped me to improve how I do my job.



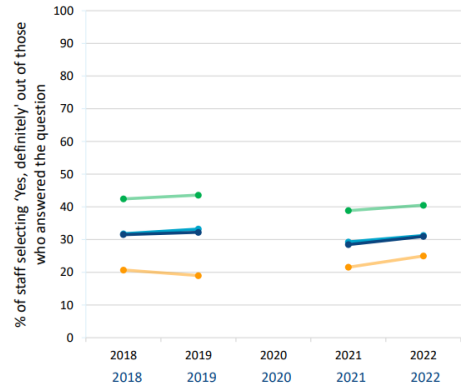
	2018	2019	2020	2021	2022
Your org	16.4%	20.0%	-	18.2%	23.1%
Best	34.8%	35.1%	-	32.7%	36.7%
Average	22.3%	22.8%	-	19.8%	21.5%
Worst	13.2%	14.7%	-	13.1%	15.3%
Responses	425	422	-	1930	2579

Q21c It helped me agree clear objectives for my work.



	2018	2019	2020	2021	2022
Your org	30.3%	32.6%	-	28.8%	31.4%
Best	46.5%	46.9%	-	42.8%	43.0%
Average	34.3%	35.7%	-	30.2%	31.9%
Worst	23.1%	24.4%	-	21.8%	25.2%
Responses	425	421	-	1935	2570

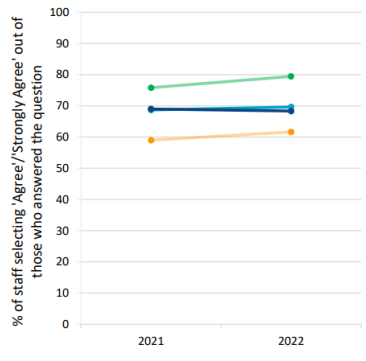
Q21d It left me feeling that my work is valued by my organisation.



	2018	2019	2020	2021	2022
Your org	31.5%	32.2%	-	28.5%	31.0%
Best	42.4%	43.6%	-	38.9%	40.5%
Average	31.8%	33.2%	-	29.3%	31.3%
Worst	20.7%	19.0%	-	21.5%	25.0%
Responses	425	419	-	1933	2570

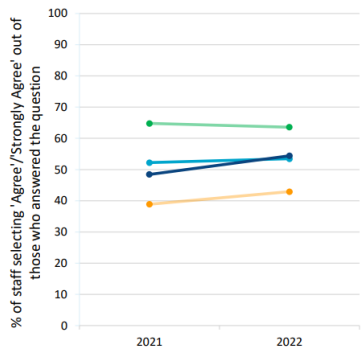
Great Western Hospitals NHS Foundation Trust Benchmark report

Q22a This organisation offers me challenging work.



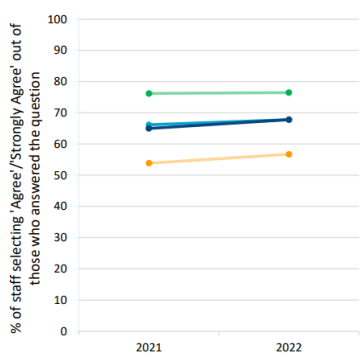
	2021	2022
Your org	69.0%	68.3%
Best	75.8%	79.4%
Average	68.7%	69.6%
Worst	59.0%	61.7%
Responses	2412	3132

Q22b There are opportunities for me to develop my career in this organisation.



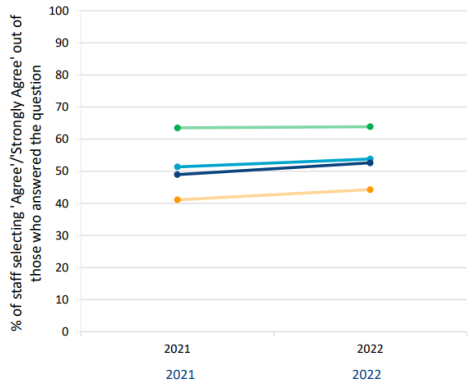
	2021	2022
Your org	48.4%	54.4%
Best	64.8%	63.6%
Average	52.2%	53.4%
Worst	38.9%	42.9%
Responses	2415	3132

Q22c I have opportunities to improve my knowledge and skills.



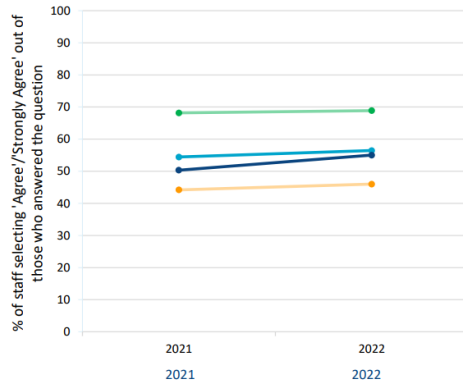
	2021	2022
Your org	65.0%	67.8%
Best	76.2%	76.5%
Average	66.2%	67.8%
Worst	53.9%	56.7%
Responses	2409	3130

Q22d I feel supported to develop my potential.



	2021	2022
Your org	49.0%	52.6%
Best	63.5%	63.9%
Average	51.4%	53.8%
Worst	41.1%	44.3%
Responses	2407	3127

Q22e I am able to access the right learning and developmei opportunities when I need to.



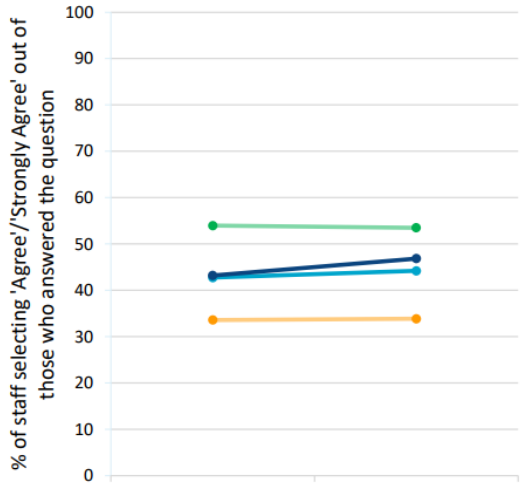
	2021	2022
Your org	50.3%	55.0%
Best	68.2%	68.9%
Average	54.4%	56.4%
Worst	44.2%	46.0%
Responses	2415	3119

Promise 6: We work flexibly

Theme

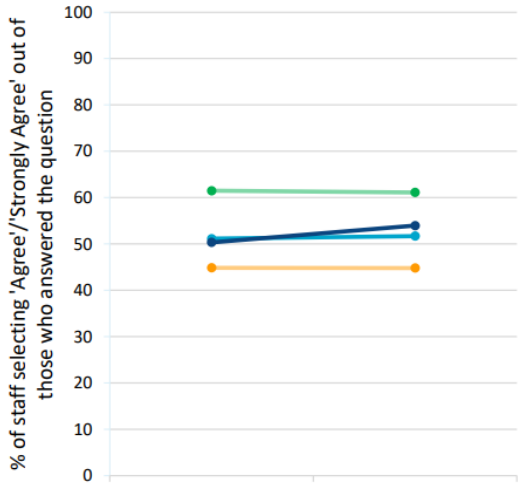
Great Western Hospitals NHS Foundation Trust

Q6b My organisation is committed to helping me balance my work and home life.



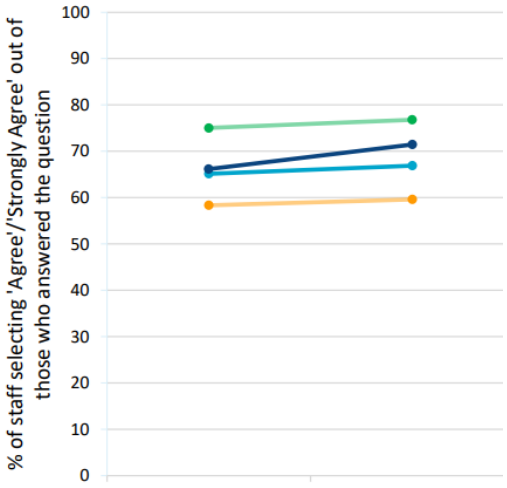
	2021	2022
Your org	43.2%	46.9%
Best	54.0%	53.5%
Average	42.7%	44.2%
Worst	33.6%	33.9%
Responses	2415	3134

Q6c I achieve a good balance between my work life and my home life.



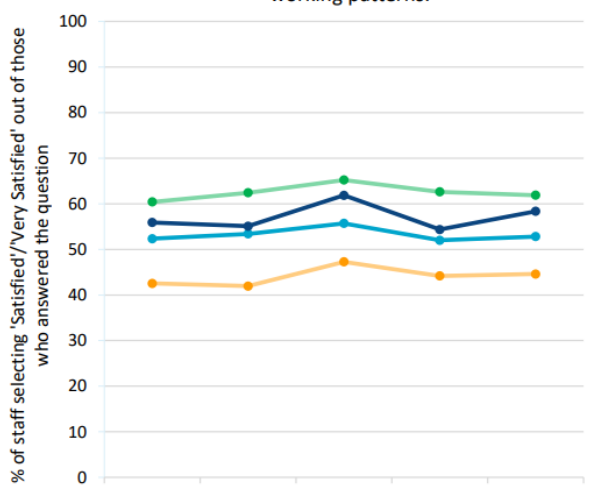
	2021	2022
Your org	50.4%	54.0%
Best	61.5%	61.1%
Average	51.1%	51.7%
Worst	44.9%	44.8%
Responses	2416	3135

Q6d I can approach my immediate manage talk openly about flexible working.



	2021	2022
Your org	66.2%	71.5%
Best	75.0%	76.8%
Average	65.2%	66.9%
Worst	58.4%	59.6%
Responses	2421	3135

Q4d How satisfied are you with each of the following aspects of your job? The opportunities for flexible working patterns.



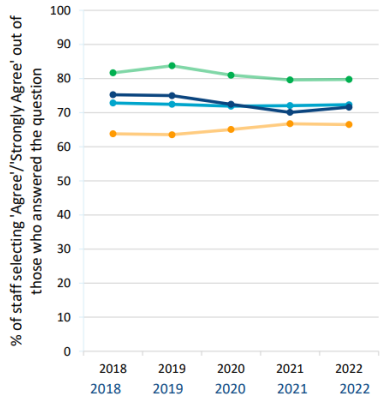
	2018	2019	2020	2021	2022
Your org	55.9%	55.1%	61.9%	54.4%	58.4%
Best	60.4%	62.4%	65.2%	62.6%	61.9%
Average	52.3%	53.4%	55.7%	52.0%	52.8%
Worst	42.5%	42.0%	47.3%	44.2%	44.6%
Responses	524	490	655	2406	3126

Promise 7: We are a team

Great Western Hospitals NHS Foundation Trust

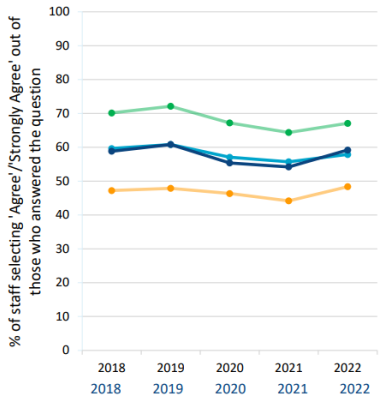
Theme

Q7a The team I work in has a set of shared objectives.



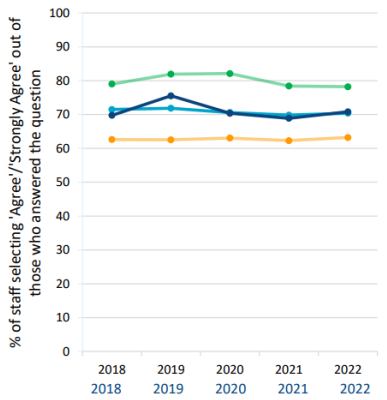
	2018	2019	2020	2021	2022
Your org	75.2%	75.0%	72.4%	70.1%	71.6%
Best	81.7%	83.8%	81.0%	79.6%	79.8%
Average	72.8%	72.5%	71.9%	72.1%	72.3%
Worst	63.8%	63.5%	65.0%	66.8%	66.5%
Responses	530	491	654	2414	3138

Q7b The team I work in often meets to discuss the team's effectiveness.



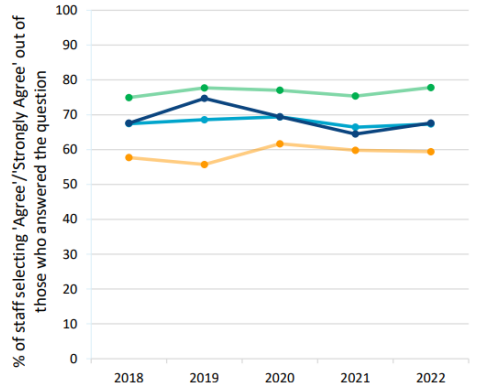
	2018	2019	2020	2021	2022
Your org	58.8%	60.8%	55.4%	54.2%	59.2%
Best	70.1%	72.1%	67.2%	64.4%	67.1%
Average	59.6%	60.8%	57.0%	55.7%	57.9%
Worst	47.2%	47.9%	46.4%	44.2%	48.4%
Responses	527	495	654	2412	3131

Q7c I receive the respect I deserve from my colleagues at work.



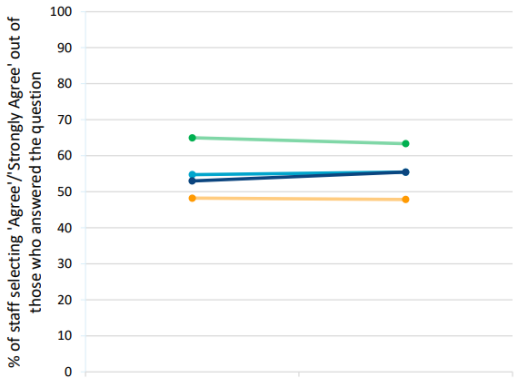
	2018	2019	2020	2021	2022
Your org	69.7%	75.5%	70.4%	68.9%	70.8%
Best	79.0%	81.9%	82.1%	78.4%	78.2%
Average	71.5%	71.8%	70.6%	69.9%	70.4%
Worst	62.6%	62.5%	63.0%	62.3%	63.2%
Responses	531	494	654	2415	3137

Q9d My immediate manager takes a positive interest in my health and well-being.



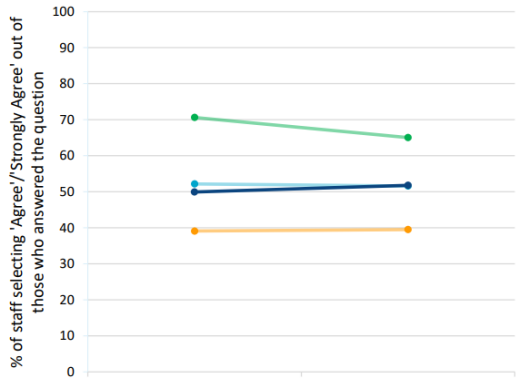
	2018	2019	2020	2021	2022
Your org	67.6%	74.7%	69.4%	64.5%	67.6%
Best	74.9%	77.7%	77.0%	75.4%	77.8%
Average	67.5%	68.6%	69.4%	66.4%	67.4%
Worst	57.7%	55.7%	61.7%	59.8%	59.4%
Responses	520	491	658	2420	3141

Q7g In my team disagreements are dealt with constructively.



	2021	2022
Your org	53.0%	55.5%
Best	65.0%	63.3%
Average	54.8%	55.5%
Worst	48.2%	47.9%
Responses	2412	3126

Q8a Teams within this organisation work well together to achieve their objectives.



	2021	2022
Your org	50.0%	51.8%
Best	70.6%	65.1%
Average	52.2%	51.6%
Worst	39.1%	39.5%
Responses	2411	3136

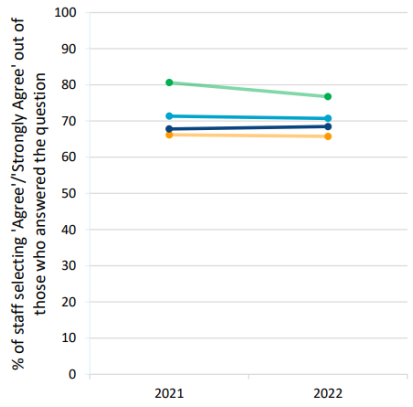
Service Teamv

Promise 7: We are a team

Theme

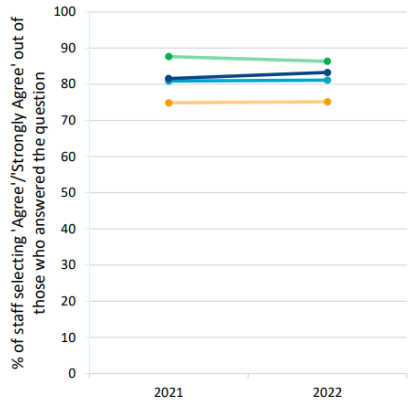
Great Western Hospitals NHS Foundation Trust

Q7d Team members understand each other's roles.



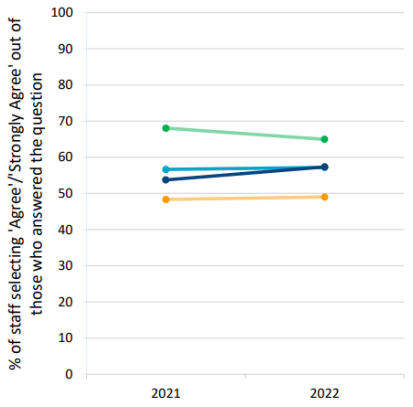
	2021	2022
Your org	67.8%	68.5%
Best	80.6%	76.8%
Average	71.4%	70.7%
Worst	66.2%	65.8%
Responses	2419	3138

Q7e I enjoy working with the colleagues in my team.



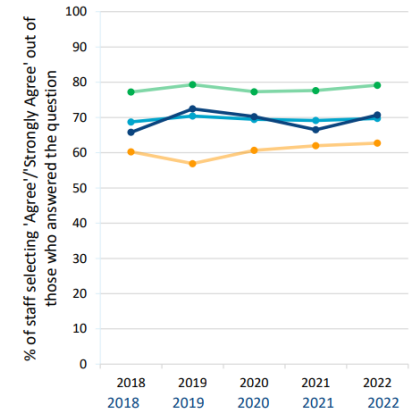
	2021	2022
Your org	81.6%	83.2%
Best	87.6%	86.3%
Average	80.9%	81.1%
Worst	74.8%	75.1%
Responses	2414	3139

Q7f My team has enough freedom in how to do its work.



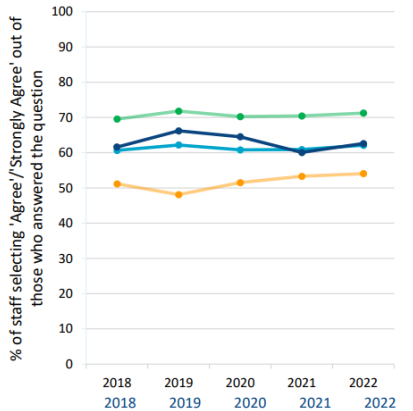
	2021	2022
Your org	53.7%	57.3%
Best	68.0%	64.9%
Average	56.6%	57.2%
Worst	48.3%	49.0%
Responses	2408	3131

Q9a My immediate manager encourages me at work.



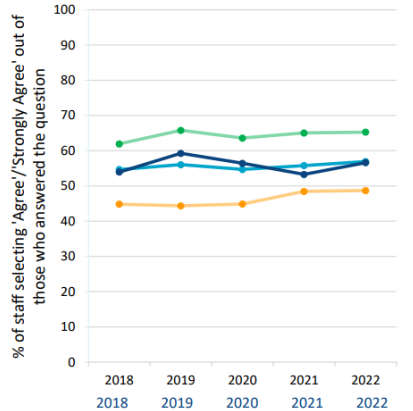
	2018	2019	2020	2021	2022
Your org	65.8%	72.5%	70.2%	66.5%	70.7%
Best	77.2%	79.3%	77.3%	77.6%	79.2%
Average	68.7%	70.4%	69.5%	69.1%	69.7%
Worst	60.3%	56.9%	60.7%	62.0%	62.7%
Responses	520	493	660	2418	3140

Q9b My immediate manager gives me clear feedback on my work.



	2018	2019	2020	2021	2022
Your org	61.6%	66.2%	64.5%	60.1%	62.6%
Best	69.5%	71.8%	70.3%	70.4%	71.3%
Average	60.7%	62.2%	60.8%	60.9%	62.1%
Worst	51.2%	48.1%	51.5%	53.3%	54.1%
Responses	520	491	658	2415	3135

Q9c My immediate manager asks for my opinion before making decisions that affect my work.



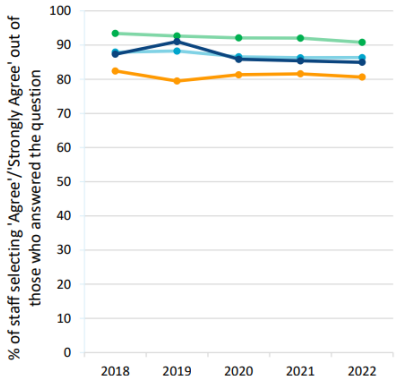
	2018	2019	2020	2021	2022
Your org	53.9%	59.3%	56.4%	53.3%	56.6%
Best	61.9%	65.8%	63.6%	65.1%	65.3%
Average	54.7%	56.0%	54.7%	55.8%	56.9%
Worst	44.8%	44.4%	44.9%	48.4%	48.7%
Responses	517	491	659	2418	3141

Theme: Morale

Theme

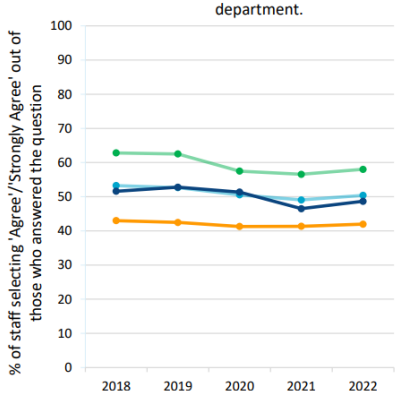
Great Western Hospitals NHS Foundation Trust

Q3a I always know what my work responsibilities are.



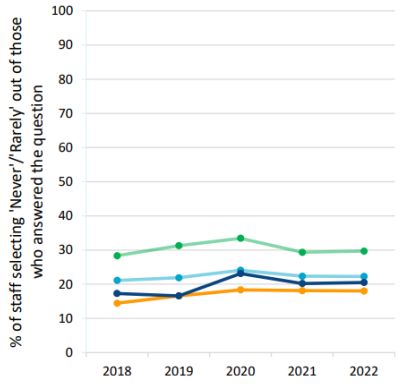
	2018	2019	2020	2021	2022
Your org	87.3%	91.0%	85.8%	85.4%	85.0%
Best	93.4%	92.7%	92.1%	92.0%	90.8%
Average	87.9%	88.2%	86.6%	86.3%	86.3%
Worst	82.4%	79.5%	81.3%	81.6%	80.6%
Responses	530	490	654	2422	3141

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



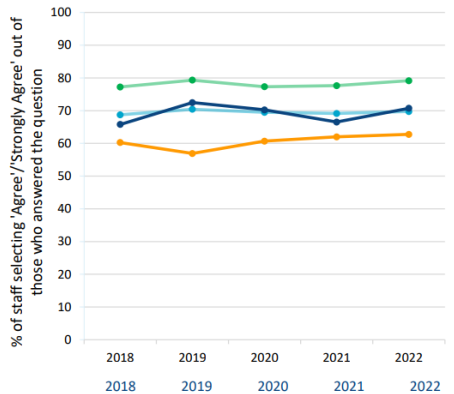
	2018	2019	2020	2021	2022
Your org	51.6%	52.8%	51.4%	46.5%	48.6%
Best	62.8%	62.5%	57.5%	56.5%	58.0%
Average	53.3%	52.7%	50.6%	49.1%	50.4%
Worst	43.0%	42.5%	41.3%	41.3%	42.0%
Responses	530	492	657	2414	3133

Q5a I have unrealistic time pressures.



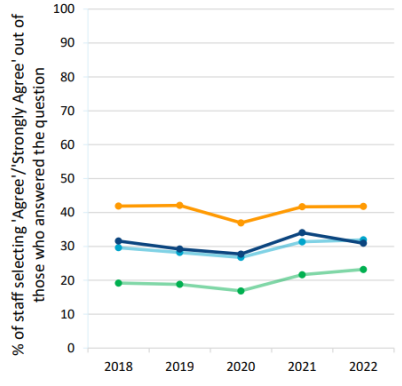
	2018	2019	2020	2021	2022
Your org	17.3%	16.6%	23.1%	20.2%	20.5%
Best	28.3%	31.3%	33.4%	29.3%	29.7%
Average	21.1%	21.9%	24.1%	22.4%	22.3%
Worst	14.4%	16.6%	18.3%	18.1%	18.0%
Responses	524	494	657	2412	3125

Q9a My immediate manager encourages me at work.



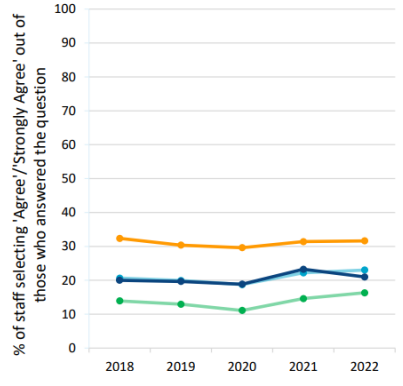
	2018	2019	2020	2021	2022
Your org	65.8%	72.5%	70.2%	66.5%	70.7%
Best	77.2%	79.3%	77.3%	77.6%	79.2%
Average	68.7%	70.4%	69.5%	69.1%	69.7%
Worst	60.3%	56.9%	60.7%	62.0%	62.7%
Responses	520	493	660	2418	3140

Q24a I often think about leaving this organisation.



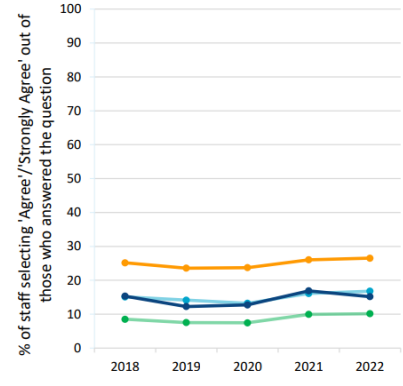
	2018	2019	2020	2021	2022
Your org	31.6%	29.2%	27.7%	34.0%	30.9%
Best	19.2%	18.8%	16.9%	21.6%	23.2%
Average	29.6%	28.2%	26.8%	31.3%	31.9%
Worst	41.9%	42.1%	36.9%	41.7%	41.8%
Responses	509	479	657	2418	3136

Q24b I will probably look for a job at a new organisation in the next 12 months.



	2018	2019	2020	2021	2022
Your org	20.0%	19.7%	18.8%	23.2%	21.0%
Best	13.9%	12.9%	11.1%	14.6%	16.3%
Average	20.6%	19.9%	18.7%	22.2%	23.0%
Worst	32.3%	30.4%	29.6%	31.4%	31.6%
Responses	508	479	656	2413	3127

Q24c As soon as I can find another job, I will leave this organisation.

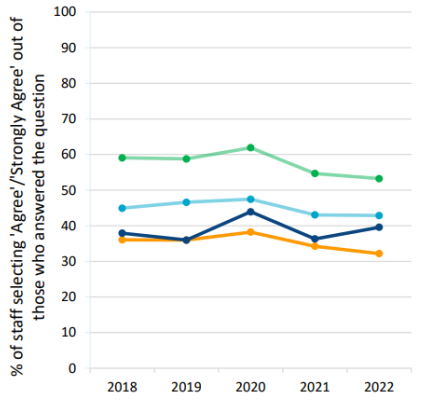


	2018	2019	2020	2021	2022
Your org	15.3%	12.3%	12.7%	16.9%	15.2%
Best	8.5%	7.5%	7.5%	9.9%	10.2%
Average	15.1%	14.1%	13.2%	16.1%	16.8%
Worst	25.2%	23.6%	23.7%	26.0%	26.5%
Responses	487	474	653	2400	3123

Theme: Morale

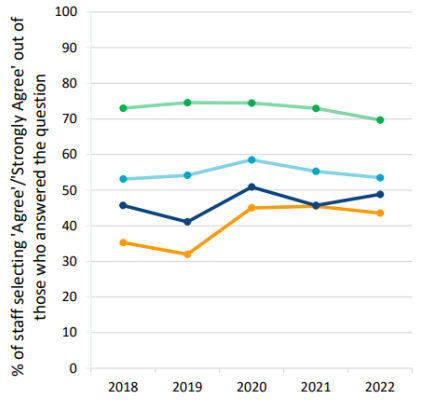
Theme

Q3g I am able to meet all the conflicting demands on my time at work.



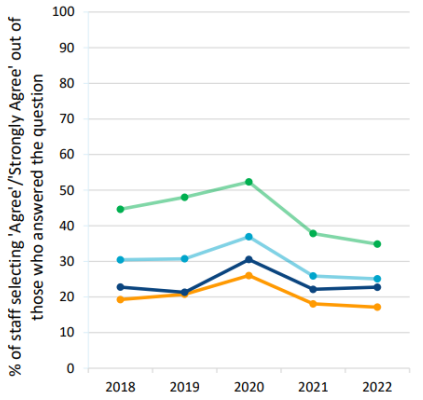
	2018	2019	2020	2021	2022
Your org	37.9%	36.0%	43.9%	36.3%	39.6%
Best	59.1%	58.8%	61.9%	54.7%	53.2%
Average	44.9%	46.6%	47.4%	43.1%	42.9%
Worst	36.0%	36.0%	38.2%	34.2%	32.2%
Responses	528	494	658	2402	3129

Q3h I have adequate materials, supplies and equipment to do my work.



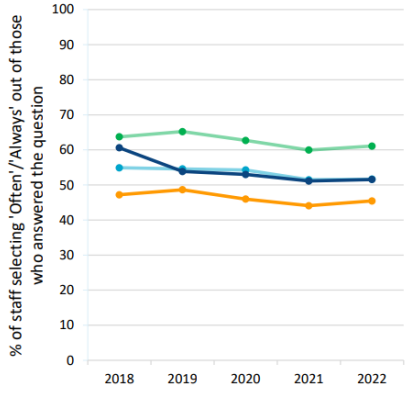
	2018	2019	2020	2021	2022
Your org	45.7%	41.1%	50.9%	45.7%	48.8%
Best	73.0%	74.6%	74.5%	72.9%	69.7%
Average	53.1%	54.2%	58.5%	55.3%	53.5%
Worst	35.3%	32.0%	45.0%	45.5%	43.6%
Responses	528	495	656	2407	3133

Q3i There are enough staff at this organisation for me to do my job properly.



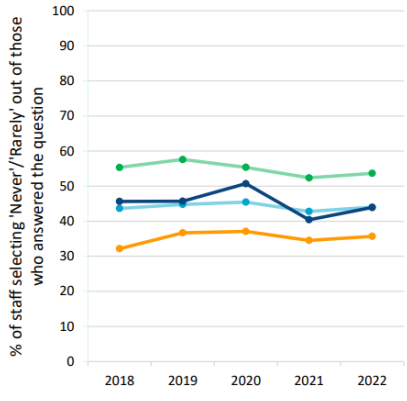
	2018	2019	2020	2021	2022
Your org	22.8%	21.3%	30.5%	22.1%	22.7%
Best	44.6%	48.0%	52.3%	37.8%	34.8%
Average	30.5%	30.7%	36.9%	25.9%	25.1%
Worst	19.3%	20.8%	26.0%	18.1%	17.2%
Responses	529	494	655	2417	3135

Q5b I have a choice in deciding how to do my work.



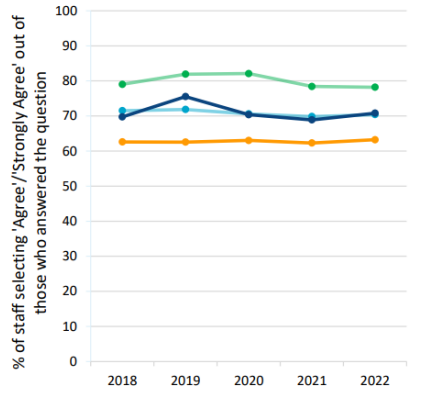
	2018	2019	2020	2021	2022
Your org	60.6%	53.8%	53.0%	51.1%	51.6%
Best	63.7%	65.2%	62.7%	60.0%	61.1%
Average	54.9%	54.6%	54.3%	51.5%	51.7%
Worst	47.2%	48.6%	46.0%	44.1%	45.4%
Responses	524	491	655	2411	3123

Q5c Relationships at work are strained.



	2018	2019	2020	2021	2022
Your org	45.7%	45.7%	50.7%	40.4%	43.9%
Best	55.3%	57.6%	55.4%	52.4%	53.6%
Average	43.6%	44.8%	45.4%	42.8%	44.0%
Worst	32.2%	36.7%	37.1%	34.5%	35.7%
Responses	522	493	656	2410	3126

Q7c I receive the respect I deserve from my colleagues at work.

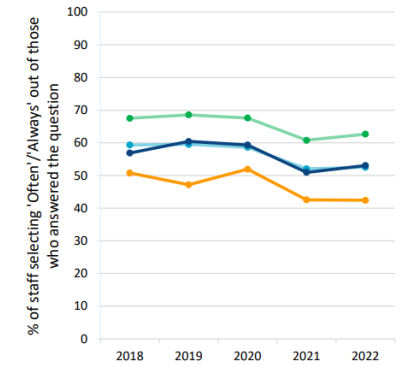


	2018	2019	2020	2021	2022
Your org	69.7%	75.5%	70.4%	68.9%	70.8%
Best	79.0%	81.9%	82.1%	78.4%	78.2%
Average	71.5%	71.8%	70.6%	69.9%	70.4%
Worst	62.6%	62.5%	63.0%	62.3%	63.2%
Responses	531	494	654	2415	3137

Theme: Staff engagement

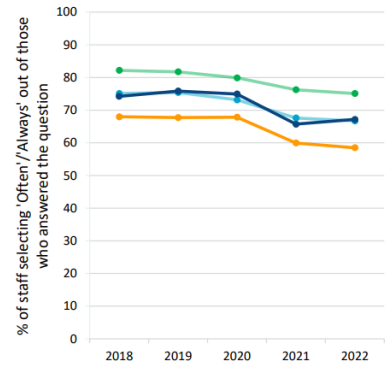
Great Western Hospitals NHS Foundation Trust

Q2a I look forward to going to work.



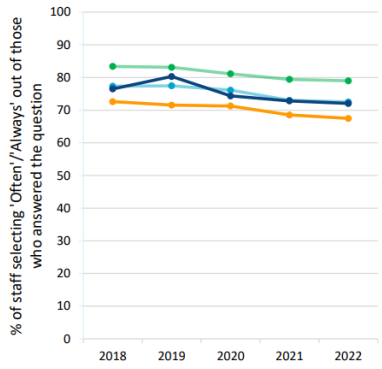
	2018	2019	2020	2021	2022
Your org	56.9%	60.4%	59.4%	51.0%	53.1%
Best	67.5%	68.6%	67.6%	60.8%	62.7%
Average	59.4%	59.5%	58.6%	52.0%	52.5%
Worst	50.8%	47.2%	51.9%	42.5%	42.4%
Responses	528	493	655	2409	3126

Q2b I am enthusiastic about my job.



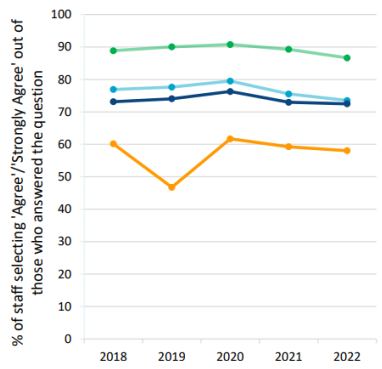
	2018	2019	2020	2021	2022
Your org	74.2%	75.9%	74.9%	65.7%	67.2%
Best	82.2%	81.7%	79.9%	76.2%	75.1%
Average	75.1%	75.4%	73.2%	67.6%	66.7%
Worst	68.0%	67.7%	67.9%	60.0%	58.5%
Responses	523	493	653	2399	3114

Q2c Time passes quickly when I am working.



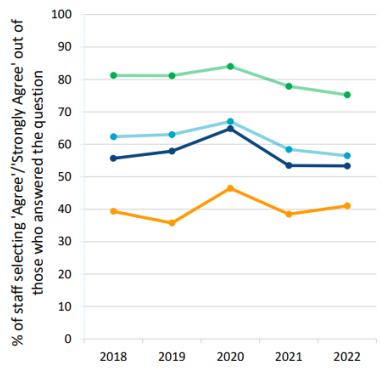
	2018	2019	2020	2021	2022
Your org	76.5%	80.3%	74.4%	72.8%	72.1%
Best	83.4%	83.1%	81.1%	79.4%	79.0%
Average	77.3%	77.4%	76.1%	73.0%	72.5%
Worst	72.6%	71.6%	71.3%	68.5%	67.5%
Responses	523	492	654	2398	3112

Q23a Care of patients / service users is my organisation's top priority.



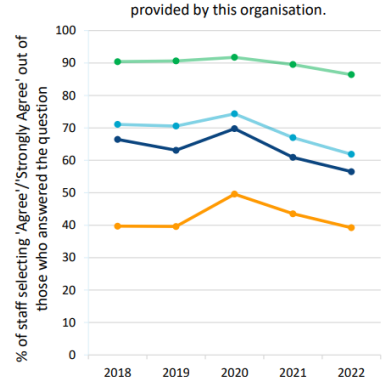
	2018	2019	2020	2021	2022
Your org	73.1%	74.0%	76.3%	72.9%	72.5%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	506	478	651	2416	3134

Q23c I would recommend my organisation as a place to work.



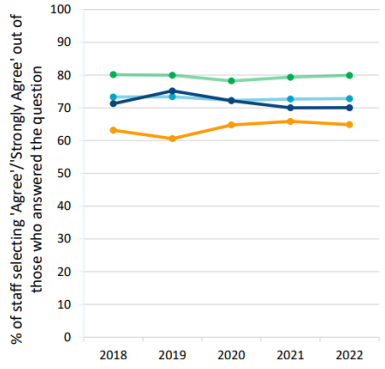
	2018	2019	2020	2021	2022
Your org	55.6%	57.9%	64.8%	53.5%	53.3%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	506	479	653	2412	3131

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



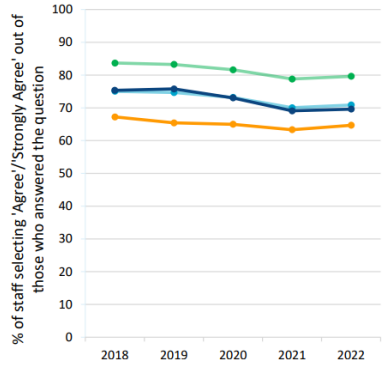
	2018	2019	2020	2021	2022
Your org	66.4%	63.1%	69.8%	60.9%	56.5%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	507	477	651	2413	3127

Q3c There are frequent opportunities for me to show initiative in my role.



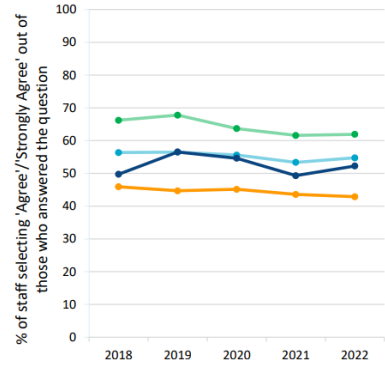
	2018	2019	2020	2021	2022
Your org	71.3%	75.2%	72.2%	70.0%	70.0%
Best	80.1%	79.9%	78.2%	79.3%	79.9%
Average	73.3%	73.4%	72.3%	72.7%	72.8%
Worst	63.2%	60.6%	64.8%	65.9%	64.9%
Responses	531	496	658	2419	3134

Q3d I am able to make suggestions to improve the work of my team / department.



	2018	2019	2020	2021	2022
Your org	75.3%	75.8%	73.0%	69.1%	69.6%
Best	83.7%	83.3%	81.6%	78.8%	79.6%
Average	75.0%	74.7%	73.2%	70.0%	70.9%
Worst	67.2%	65.4%	65.0%	63.3%	64.7%
Responses	531	495	652	2402	3129

Q3f I am able to make improvements happen in my area of work.

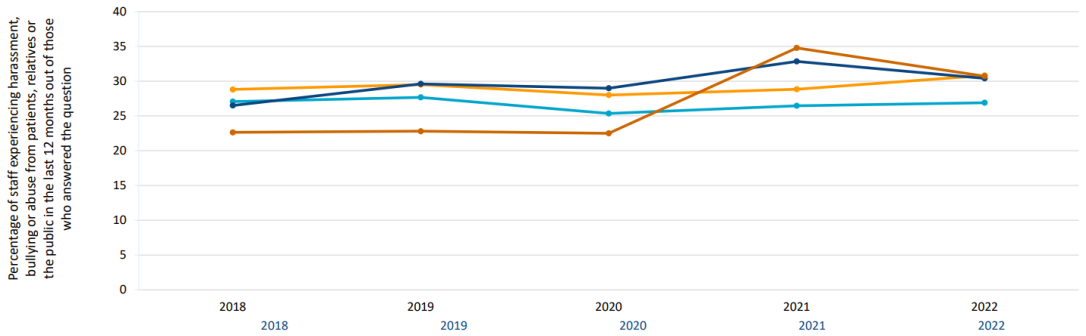


	2018	2019	2020	2021	2022
Your org	49.7%	56.5%	54.6%	49.3%	52.3%
Best	66.2%	67.8%	63.7%	61.6%	61.9%
Average	56.4%	56.5%	55.6%	53.4%	54.7%
Worst	45.9%	44.7%	45.1%	43.6%	42.9%
Responses	531	492	656	2402	3126

BME Overview

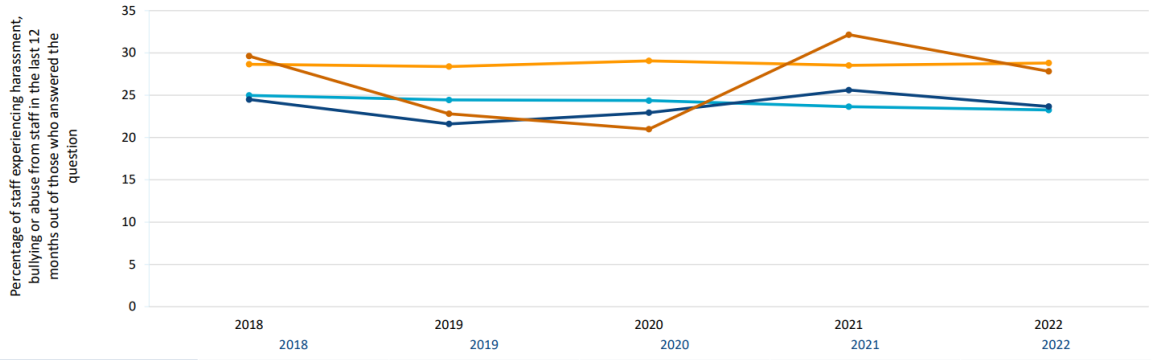
Great Western Hospitals NHS Foundation Trust

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months



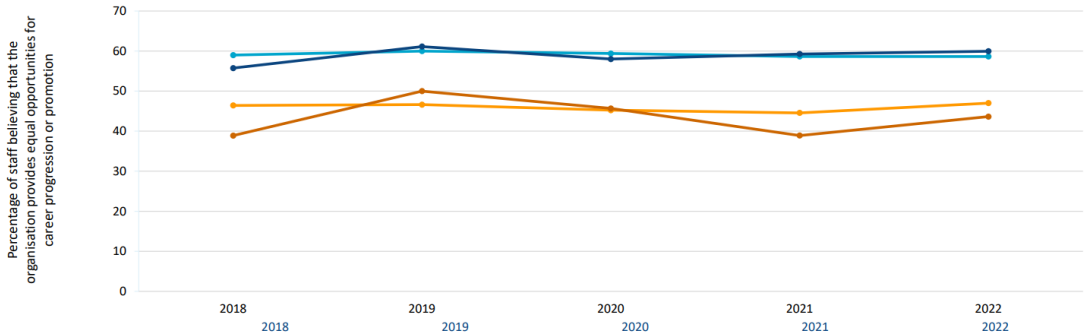
	2018	2019	2020	2021	2022
White staff: Your org	26.5%	29.6%	29.0%	32.8%	30.4%
All other ethnic groups*: Your org	22.6%	22.8%	22.5%	34.8%	30.7%
White staff: Average	27.1%	27.7%	25.4%	26.5%	26.9%
All other ethnic groups*: Average	28.8%	29.5%	28.0%	28.8%	30.8%
White staff: Responses	449	412	559	2025	2454
All other ethnic groups*: Responses	53	57	80	368	648

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months



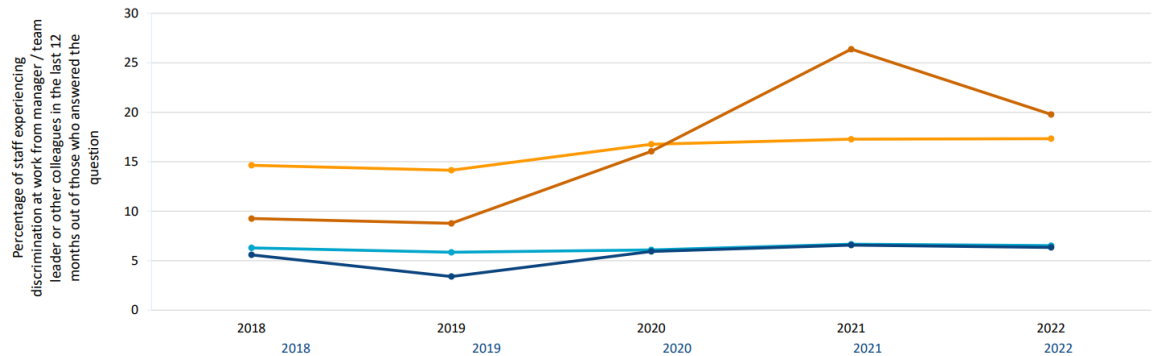
	2018	2019	2020	2021	2022
White staff: Your org	24.5%	21.6%	22.9%	25.6%	23.7%
All other ethnic groups*: Your org	29.6%	22.8%	21.0%	32.2%	27.8%
White staff: Average	25.0%	24.4%	24.4%	23.6%	23.3%
All other ethnic groups*: Average	28.7%	28.4%	29.1%	28.5%	28.8%
White staff: Responses	445	412	558	2023	2455
All other ethnic groups*: Responses	54	57	81	367	647

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.



	2018	2019	2020	2021	2022
White staff: Your org	55.7%	61.1%	58.0%	59.3%	60.0%
All other ethnic groups*: Your org	38.9%	50.0%	45.7%	38.9%	43.6%
White staff: Average	59.0%	60.0%	59.4%	58.6%	58.6%
All other ethnic groups*: Average	46.4%	46.6%	45.2%	44.6%	47.0%
White staff: Responses	445	414	562	2032	2455
All other ethnic groups*: Responses	54	58	81	365	644

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.

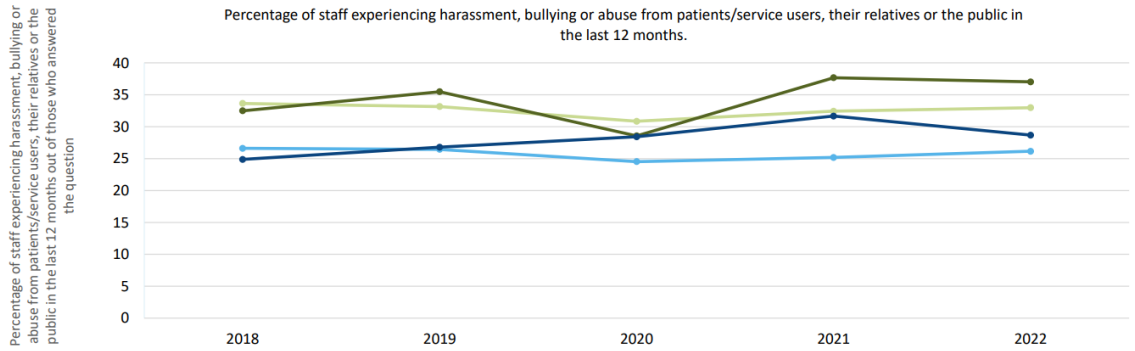


	2018	2019	2020	2021	2022
White staff: Your org	5.6%	3.4%	5.9%	6.6%	6.3%
All other ethnic groups*: Your org	9.3%	8.8%	16.0%	26.4%	19.8%
White staff: Average	6.3%	5.9%	6.1%	6.7%	6.5%
All other ethnic groups*: Average	14.6%	14.1%	16.8%	17.3%	17.3%
White staff: Responses	447	411	556	2021	2445
All other ethnic groups*: Responses	54	57	81	364	632

Disability Overview

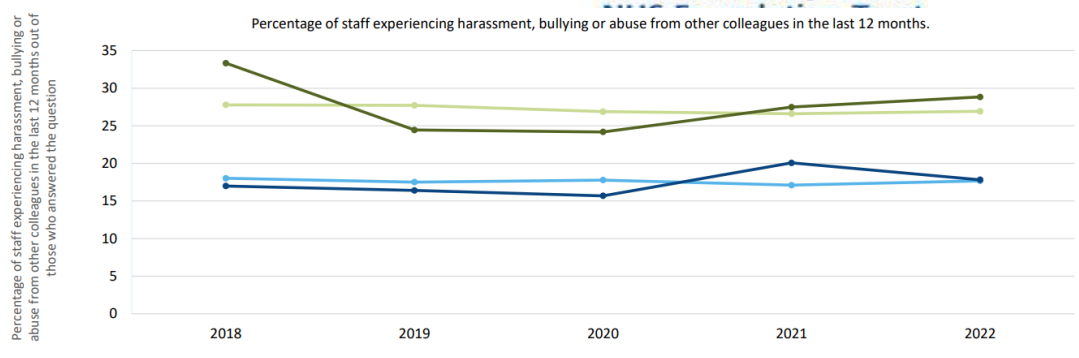
Great Western Hospitals NHS

Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.



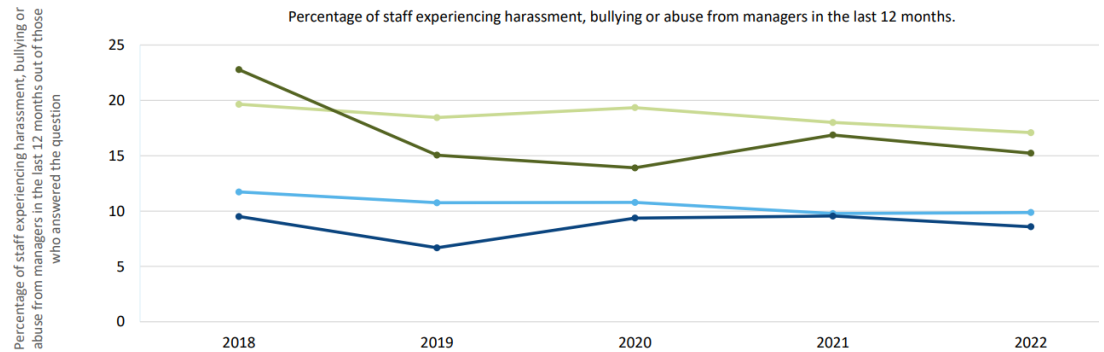
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	32.5%	35.5%	28.6%	37.7%	37.0%
Staff without a LTC or illness: Your org	24.9%	26.8%	28.4%	31.7%	28.7%
Staff with a LTC or illness: Average	33.6%	33.2%	30.9%	32.4%	33.0%
Staff without a LTC or illness: Average	26.6%	26.5%	24.5%	25.2%	26.2%
Staff with a LTC or illness: Responses	80	93	154	560	713
Staff without a LTC or illness: Responses	414	377	496	1825	2399

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.



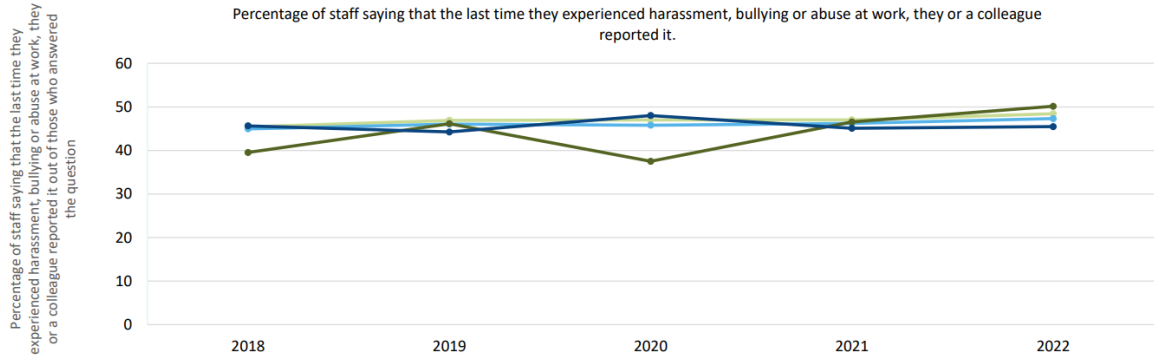
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	33.3%	24.4%	24.2%	27.5%	28.8%
Staff without a LTC or illness: Your org	17.0%	16.4%	15.7%	20.1%	17.8%
Staff with a LTC or illness: Average	27.8%	27.7%	26.9%	26.6%	26.9%
Staff without a LTC or illness: Average	18.0%	17.5%	17.8%	17.1%	17.7%
Staff with a LTC or illness: Responses	78	90	153	553	711
Staff without a LTC or illness: Responses	412	372	491	1804	2373

Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	22.8%	15.1%	13.9%	16.9%	15.2%
Staff without a LTC or illness: Your org	9.5%	6.7%	9.4%	9.6%	8.6%
Staff with a LTC or illness: Average	19.6%	18.4%	19.3%	18.0%	17.1%
Staff without a LTC or illness: Average	11.7%	10.8%	10.8%	9.8%	9.9%
Staff with a LTC or illness: Responses	79	93	151	557	709
Staff without a LTC or illness: Responses	410	374	491	1810	2388

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

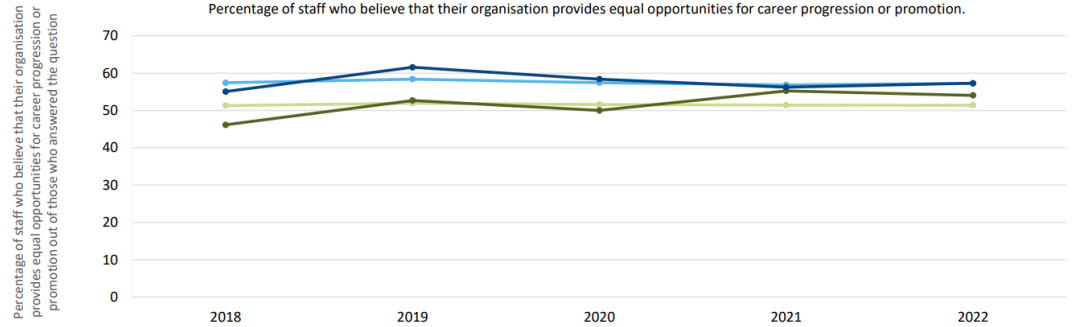


	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	39.5%	46.2%	37.5%	46.5%	50.1%
Staff without a LTC or illness: Your org	45.7%	44.2%	48.0%	45.1%	45.5%
Staff with a LTC or illness: Average	45.4%	46.9%	47.0%	47.0%	48.4%
Staff without a LTC or illness: Average	45.0%	46.1%	45.8%	46.2%	47.3%
Staff with a LTC or illness: Responses	43	39	64	260	339
Staff without a LTC or illness: Responses	138	113	177	694	805

Disability Overview

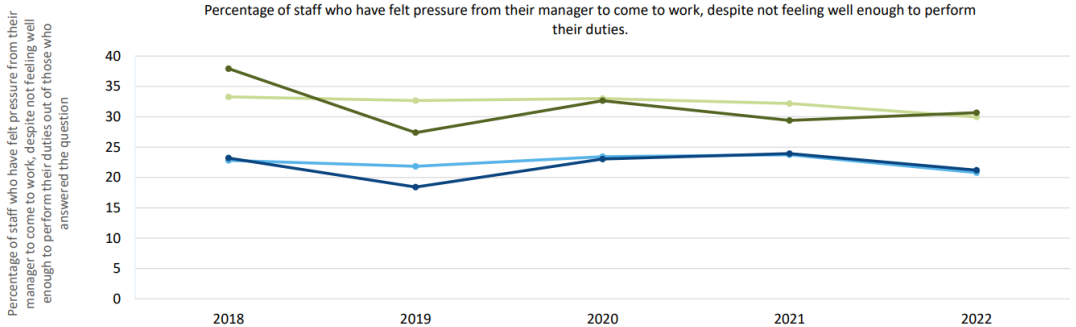
Great Western Hospitals NHS Foundation Trust

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.



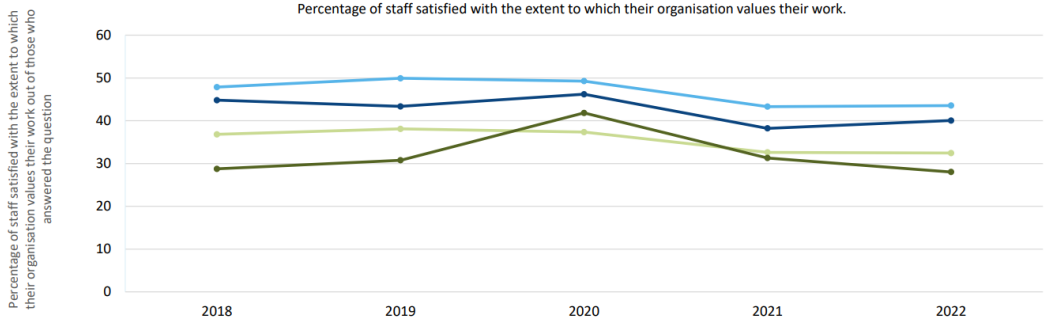
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	46.2%	52.7%	50.0%	55.3%	54.0%
Staff without a LTC or illness: Your org	55.1%	61.6%	58.4%	56.2%	57.3%
Staff with a LTC or illness: Average	51.3%	51.9%	51.6%	51.4%	51.4%
Staff without a LTC or illness: Average	57.4%	58.4%	57.4%	56.8%	57.3%
Staff with a LTC or illness: Responses	78	93	154	561	718
Staff without a LTC or illness: Responses	414	380	500	1830	2391

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



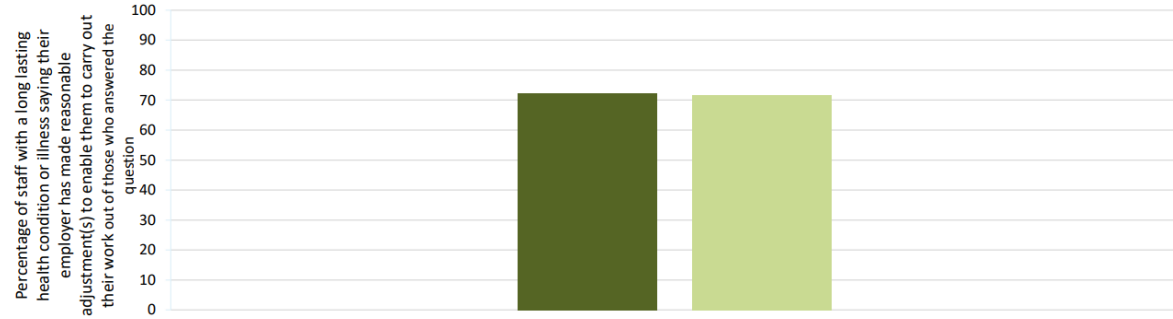
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	37.9%	27.4%	32.7%	29.4%	30.7%
Staff without a LTC or illness: Your org	23.2%	18.4%	23.0%	23.9%	21.2%
Staff with a LTC or illness: Average	33.3%	32.7%	33.0%	32.2%	30.0%
Staff without a LTC or illness: Average	22.8%	21.8%	23.4%	23.7%	20.8%
Staff with a LTC or illness: Responses	58	73	98	415	551
Staff without a LTC or illness: Responses	237	190	204	986	1283

Percentage of staff satisfied with the extent to which their organisation values their work.



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	28.7%	30.8%	41.8%	31.3%	28.0%
Staff without a LTC or illness: Your org	44.8%	43.4%	46.2%	38.2%	40.1%
Staff with a LTC or illness: Average	36.8%	38.1%	37.4%	32.6%	32.5%
Staff without a LTC or illness: Average	47.9%	49.9%	49.3%	43.3%	43.6%
Staff with a LTC or illness: Responses	80	91	153	559	710
Staff without a LTC or illness: Responses	415	376	500	1821	2389

Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.



	2022
Staff with a LTC or illness: Your org	72.3%
Staff with a LTC or illness: Average	71.8%
Staff with a LTC or illness: Responses	447

Report Title	**Committee Effectiveness Review 2022/23**				
Meeting	**Trust Board**				
Date	**4 May 2023**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Audit, Risk & Assurance Committee Terms of Reference Appendix 2 – Finance & Infrastructure Terms of Reference Appendix 3 – Quality & Safety Committee Terms of Reference Appendix 4 – Performance, Population & Place Terms of Reference Appendix 5 – Trust Management Committee Terms of Reference Appendix 6 – Mental Health Governance Committee Terms of Reference				

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

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Significant	x	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

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

A series of committee effectiveness reviews took place in February / March 2023. This was in line with year-end close down work, good governance practices, & requirements of the NHS Code of Governance. The reviews gave meeting members the opportunity to reflect on past practice & performance over the last year and consider any changes that should be enacted the following year.

This report invites the Board to refresh the Terms of Reference of the Board Committees as attached. Minor amendments only have been made to reflect feedback from committee members, or where job titles have changed, these are highlighted in yellow in each terms of reference.

There were no issues or concerns to draw to the attention of the Board about the effectiveness of the committees, the committee structure generally or the terms of reference for each committee. Each Committee has reviewed and agreed their terms of reference.

There were a number of general comments which covered committees governance as a whole as described below:-

Ref	Comment	Action
1	The need to standardise the content of Board Committee Assurance Reports	To undertake a review of the Committee Board Assurance Reports.
2	Strengthen the opportunity for members to visit services and meet teams to understand relevant issues	Review and possibly strengthen go and see schedule

Due to timing the following committees will be presented for approval at the June 2023 Board meeting:

- Remuneration Committee
- People & Culture Committee
- Charitable Funds Committee

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
Key Risks – risk number & description (Link to BAF / Risk Register)	n/a				**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Quality & Safety Committee Finance & Infrastructure Performance, Population & Place Committee Trust Management Committee Mental Health Governance Committee				
Next Steps	To align annual work plans to the terms of reference				

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

Recommendation / Action Required
The Board/Committee/Group is requested to:

The Board is requested to approve the terms of reference for the following Board committees:-

Audit, Risk & Assurance Committee
Quality & Safety Committee
Finance & Infrastructure
Performance, Population & Place Committee
Trust Management Committee
Mental Health Governance Committee

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	21 April 2023

AUDIT, RISK & ASSURANCE COMMITTEE
TERMS OF REFERENCE
2023/24

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

1. AUTHORITY

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

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

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

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

2. ROLE

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

2.2 In addition this Committee shall

- provide assurance of independence for external and internal audits;
- ensure that appropriate standards are set and compliance with them monitored, in non-financial, non-clinical areas that fall within the remit of this Committee; and
- monitor corporate governance (e.g. compliance with terms of authorisation, Constitution, Codes of Conduct, Standing Orders, Standing Financial Instructions, maintenance of registers of interest).

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

3. MEMBERSHIP

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

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

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

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

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

4. ATTENDANCE

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

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

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

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

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

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

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

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

5. QUORUM

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

6. FREQUENCY OF MEETINGS

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

7. DUTIES

7.1 Internal Control, Risk Management and Governance

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

- All risk and control related disclosure statements (including the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Trust Board.
- The structures, processes and responsibilities for identifying and managing key risks facing the organisation and controlling the same. This includes the underlying assurance processes.
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Annual Governance Statement and other relevant guidance.
- Any significant audit adjustments and changes in accounting policies and practices.
- The operational effectiveness of policies and procedures.
- Systems and processes for ensuring effective compliance with health & safety legislation and Standards for Better Health.
- Systems and processes for ensuring compliance with NHS ~~Improvement~~England, CQC and other relevant regulators.
- Arrangements for ensuring compliance with Local Security Management Directions.
- Arrangements for ensuring compliance with counter fraud standards and requirements.

- Keep under review the systems and processes of governance, assurance and their operational effectiveness and impact for the Trust.
- Oversight of systems, processes, controls and governance (compliance with Regulations, Single Oversight Framework, GIRFT & Model Hospital)
- Receive the 15+ Risk Register and Board Assurance Framework at least 2 times a year to take assurance that the processes for managing risks are effective.

7.2 Internal Audit

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

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

7.3 External Audit

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

- The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process, including the review of the work, findings and management responses to the work. This will be achieved by:
- Developing and implementing policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external auditor.
- Reporting to the Trust Board and the Council of Governors identifying any matters where action or improvement is needed and making recommendations for action.
- Reviewing and monitoring of the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.
- Discussing and agreeing with external auditors before the audit commences, the nature and scope of the audit for the Annual Audit. This includes the evaluation of audit risk, assessment of the organisation and impact on the audit work and fee.
- Approving the remuneration and terms of engagement of the external auditor, supplying information as necessary to support statutory function of the Board of Governors to appoint, or remove, the auditor.

- Reviewing all external audit reports, including those charged with governance, before submission to the Board, together with the appropriateness of management responses.

The Committee will:

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

7.4 Financial Reporting

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

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

The Audit, Risk & Assurance Committee will also:-

- Monitor the integrity of the financial statements and any formal announcements relating to financial performance, reviewing any significant financial reporting judgements.
- Ensure that the systems for financial reporting to the Board, including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

7.5 System Working, Managing Change & Transformation

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

7.6 Other Assurance Functions

The Audit Committee will refer to the work of other committees within the organisation, whose work can provide relevant assurance to the Audit, Risk & Assurance Committee's own scope of work. In particular, the Audit, Risk & Assurance Committee will refer to the work of the People & Culture Committee,

Quality & Safety Committee, Performance, Population & Place Committee and Financial & Infrastructure Committee.

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

8. REPORTING RESPONSIBILITIES

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

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

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

9. MEETING ADMINISTRATION

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

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

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

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

10. REPORTING/PROVIDING ASSURANCE

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

11. REVIEW

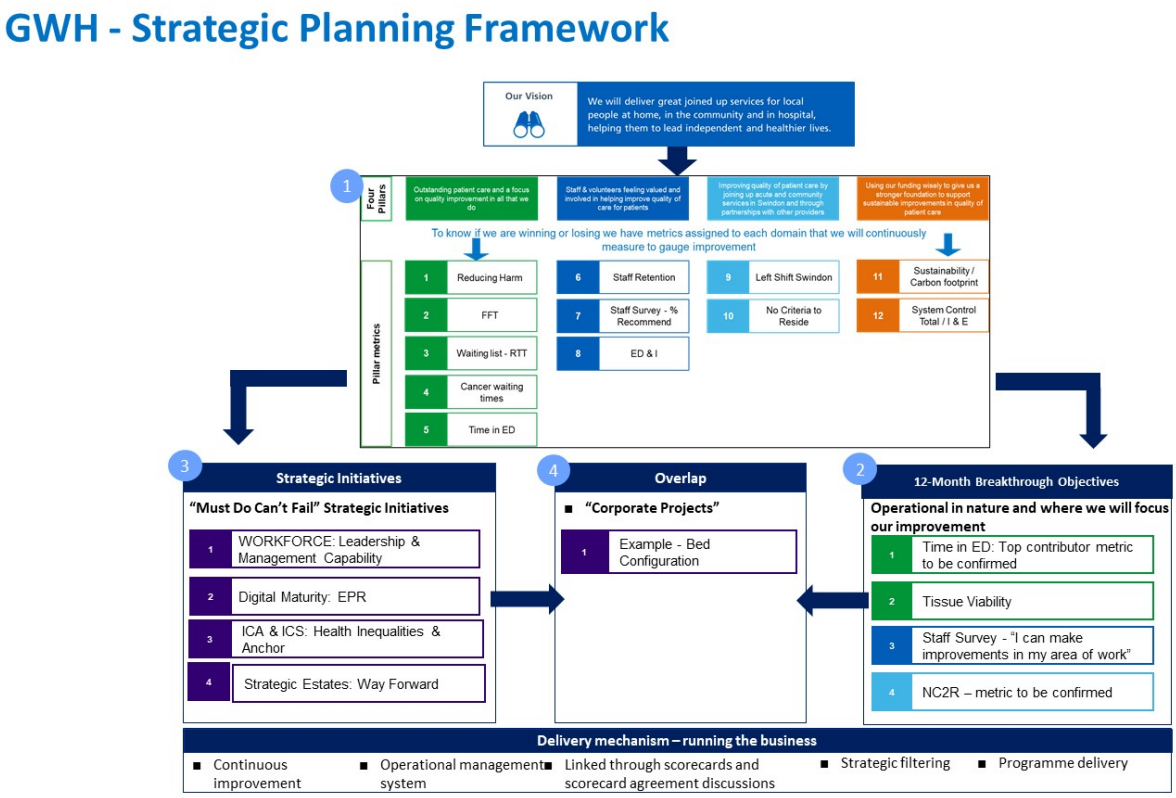
11.1 The Committee will undertake and evidence an annual review of its performance against its annual work and training plans, in order to evaluate the achievement of its duties in terms of Trust efficiency, cost improvement and value for money.

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

Appendix 1 - Summary

Committee	Audit, Risk & Assurance Committee
Chair Lead EDs	Helen Spice, Non-Executive Director Simon Wade, ~~Director of Finance & Strategy~~ Chief Financial Officer
Frequency	A minimum five times per year
Membership	3 x NEDs
Quorum	2 x NEDs
Remit	Overseeing the probity and internal financial control of the Trust, working closely with external and internal auditors. Ensuring effective internal and external audit function Ensuring effective governance, risk management and internal controls Ensure effective counter fraud provision Review of annual report accounts and associated documentation before they are submitted to the Board.
Areas of Assurance	Governance and internal control Assurance on financial & operational systems Risk Management Internal Audit Plan Oversight of internal audit recommendations External Audit Plan Counter Fraud Financial Reporting (SFIs & SofD) Assurance Framework Accounting Policies Annual Report and Financial Statements

Appendix 2 – Strategic Planning Framework



Document Control

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

FINANCE, INFRASTRUCTURE & DIGITAL COMMITTEE TERMS OF REFERENCE 2023/24

Purpose
The purpose of Finance, Infrastructure & Digital Committee is to support the Trust in achieving all its strategic objective with particular reference to: "**Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care".**

1. AUTHORITY

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

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

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

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

2. ROLE

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

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

2.3 To seek assurance on behalf of the Board that the strategic risks linked to strategic pillar (4) *"using our funding wisely to give us a stronger foundation to support sustainable improvement in quality of patient care"*, and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

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

3. MEMBERSHIP

3.1 The membership of the Finance & Investment Committee shall consist of:

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

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

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

4. ATTENDANCE

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

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

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

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

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

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

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

5. QUORUM

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

6. FREQUENCY OF MEETINGS

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

7. DUTIES

7.1 Financial Strategy and Business Planning

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

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

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

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

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

7.1.5 Review and develop reporting arrangements;

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

7.2 Income and Contract Management

7.2.1 Review the Trust contracting approach with key commissioners

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

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

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

7.3 Improvement and Efficiency

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

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

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

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

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

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

7.4 Major Capital Investment Scheme

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

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

7.4.3 In respect of major capital projects of the Trust, and to the extent necessary the wider BSW system, to consider business cases in detail and where necessary advise on strengthening prior to making recommendations to the Board for its approval or otherwise. To monitor these projects post-approval and scrutinise any cost or time variances.

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

7.5 Key Commercial Arrangements

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

7.6 Procurement

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

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

7.7 Other – Financial

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

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

7.8 Infrastructure (Estates & IT/Digital)

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

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

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

7.8.4 To review key commercial partnerships as appropriate;

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

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

7.9 Other

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

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

7.10 ICS

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

8 Other

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

8. REPORTING RESPONSIBILITIES

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

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

9. MEETING ADMINISTRATION

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

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

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

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

10. REPORTING/PROVIDING ASSURANCE

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

- Trust Investment Group
- Infrastructure Sub-Committee
- Way Forward Programme Board
- Capital Management Group
- Information Governance Steering Group

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

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

11. REVIEW

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

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

Version Control

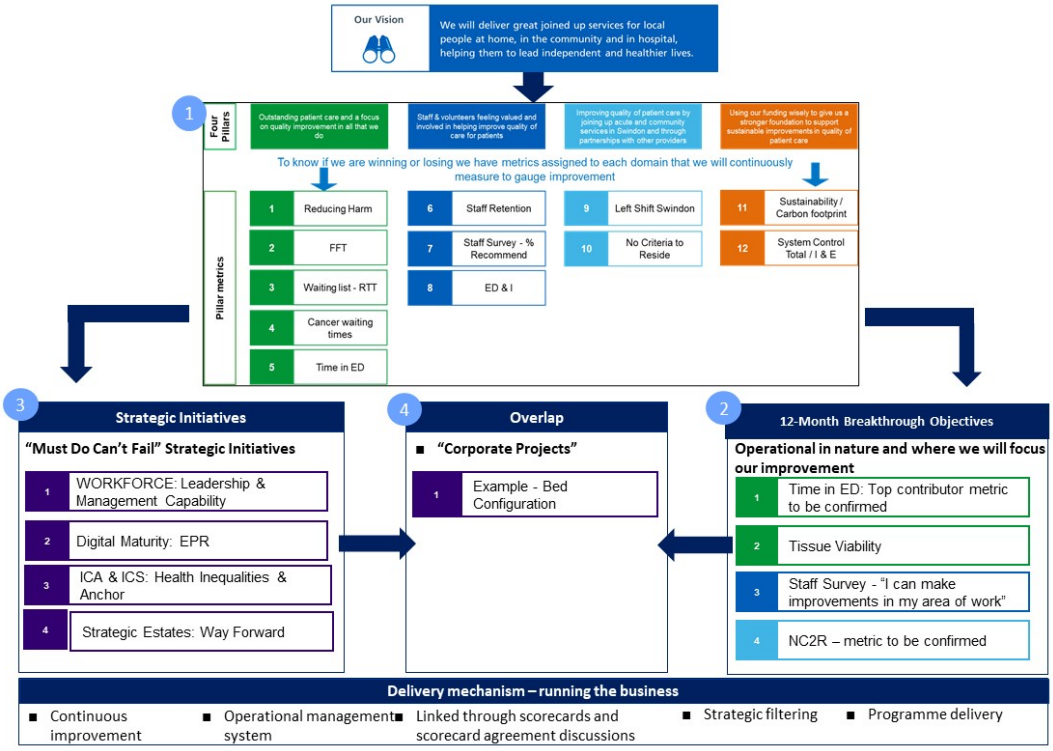
Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Finance & Investment Committee to Finance, Infrastructure & Digital Committee and expanded remit
V1.1	For review	May 2022	Finance & Investment Committee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

Appendix 1 - Summary

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

Appendix 2

GWH - Strategic Planning Framework



QUALITY & SAFETY COMMITTEE TERMS OF REFERENCE 2023-24

Purpose
The purpose of the Committee is to support the Trust in achieving all its strategic objective with particular reference to: **"Outstanding patient care and a focus on quality improvement in all that we do".**

1. AUTHORITY

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

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

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

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

2. ROLE

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

2.2 To seek assurance on behalf of the Trust Board that strategic risks linked to strategic pillar (1) "outstanding patient care and focus on quality improvement in all that we do", identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

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

3. MEMBERSHIP

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

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

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

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

4. ATTENDANCE

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

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

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

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

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

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

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

5. QUORUM

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

6. FREQUENCY OF MEETINGS

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

7. DUTIES

7.1 Patient Safety

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

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

7.2 Patient Experience

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

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

7.3 Patient Outcomes

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

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

7.4 Quality Improvement

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

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

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

7.5 Performance Monitoring

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

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

7.5.3 The Committee will regularly review ~~operational~~ quality performance where there is ongoing non-compliance ~~with referral and waiting time standards~~ as set out ~~set out~~ in the NHS Constitution or the NHS Oversight Framework.

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

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

~~7.5.6 To obtain assurance that the relevant breakthrough objectives and strategic initiatives, for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.~~

7.6 Other

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

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

8. REPORTING RESPONSIBILITIES

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

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

9. MEETING ADMINISTRATION

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

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

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

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

10. REPORTING/PROVIDING ASSURANCE

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

- Patient Quality Sub-Committee

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

11. REVIEW

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

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

Version Control

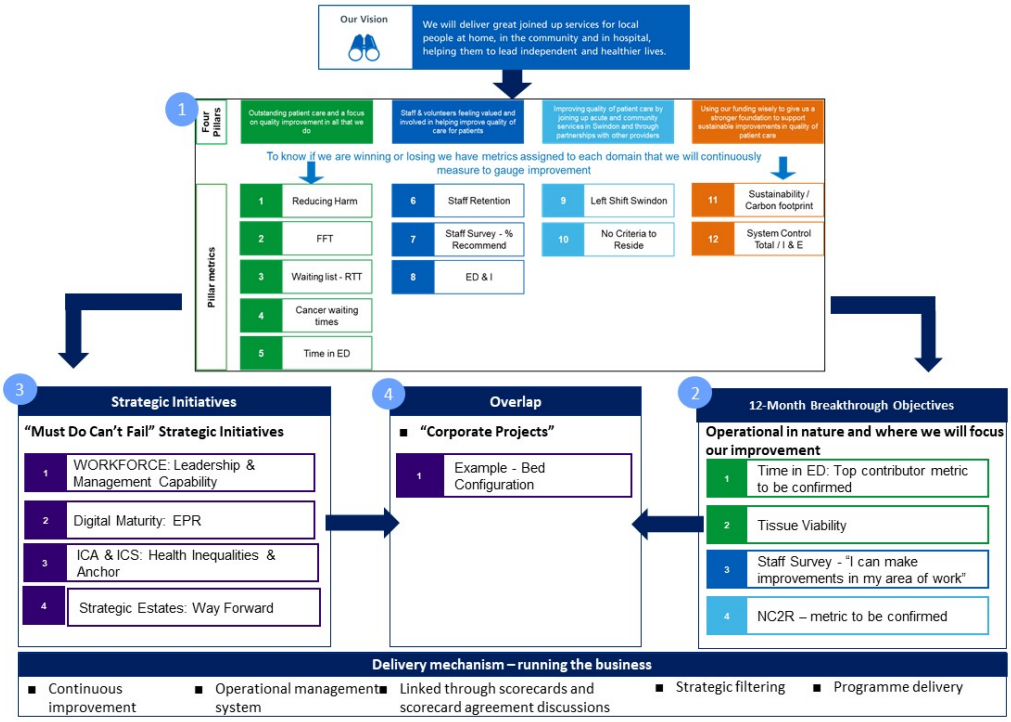
Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Quality & Governance Committee to Quality & Safety Committee and revised remit
V1.1	For review	May 2022	Quality & Governance Committee	Considered revised TofR for the Quality & Safety Committee. Amendments include: • New format • Reference to assigned strategic risk • Added deputies for Executive Directors and voting process • Clarify remit on safeguarding • Link to the Strategic Framework • Summary table of meeting remit
V2.0	Annual Review	March 2023	Company Secretary	• Job title change • Added oversight of Improving Together matrix for quality • Added reference to NHSE Oversight Framework • Added reference to corporate risk register

Appendix 1 - Summary

Committee	Quality & Safety Committee - Summary
Chair Lead EDs	Nick Bishop, Non-Executive Director Lisa Cheek, Chief Nurse Jon Westbrook, ~~Medical Director~~ Chief Medical Officer
Frequency	Monthly
Membership	3 x NEDs 2 X EDs
Quorum	2 x NEDs 1 x ED
Assurances	Quality Performance - IPR/Oversight Framework Quality Strategy Patient experience including national and local surveys Complaints performance data Incident data / Never Events Clinical Risks Quality Report GIRFT oversight Clinical Audit Plan Clinical Effectiveness including NICE Learning from Deaths Infection Prevention & Control/DIPC Research and Development Approval of Resuscitation Policy End of Life Care Children & Young People Safeguarding Adults & Young Children Mortality and Morbidity Performance Maternity & Neonatal - Ockenden Medical device/equipment safety Medication safety Performance data Safer Staffing Freedom to Speak Report ~~Quality Strategy~~ (duplication) ~~Provider Licence / Code of Governance Compliance~~ (moved to ARAC) Clinical litigation Board Assurance Framework / Corporate Risk Register
Strategic Risk	Quality (S2)

Appendix 2

GWH - Strategic Planning Framework



PERFORMANCE, POPULATION & PLACE COMMITTEE
TERMS OF REFERENCE
2023/24

Purpose
The purpose of Performance, Population & Place Committee is to support the Trust in achieving all its strategic objective with particular reference to: "**Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers"**

1. AUTHORITY

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

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

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

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

2. ROLE

2.1 Consider and advise the Board on the impact of operational management arrangements and to monitor arrangements in place for performance management.

2.2 Consider and advise the Board on the healthcare needs of the population we serve and how these are being met.

2.3 Consider and advise the Board on the development of our role at place in the ICS/ICA, Acute Hospital Alliance, networks and other (eg academic) partnerships.

2.4 To seek assurance on behalf of the Board that the strategic risks linked to strategic pillars (3) *"Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers*", and identified through the Board Assurance Framework are being appropriately managed by scrutinising and challenging mitigating action.

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

3. MEMBERSHIP

3.1 The membership of the Performance, Population & Place Committee shall consist of:

- Four Non-Executive Directors
- Two Executive Directors; the Chief Operating Officer and ~~Director of~~Chief Officer for Improvement & Partnerships.

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

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

4. ATTENDANCE

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

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

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

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

4.5 *Voting* : For voting purposes there must always be a majority of Non-Executive Directors.

4.6 The work of this Committee will be supported by the Executive Director Leads, Chief Operating Officer and ~~Director of~~ Chief Officer for Improvement & Partnerships.

5. QUORUM

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

6. FREQUENCY OF MEETINGS

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

7. DUTIES

7.1 Operational Performance

7.1.1 To seek assurance that the measures incorporated in the Integrated Performance Report and the Oversight Framework to the Trust Board meet both internal requirements and those of external stakeholders. Where performance is below the standard required, the Committee will ensure that robust recovery plans are developed and implemented.

7.1.2 To monitor delivery of the operational plan on at least a quarterly basis.

7.1.3 To review the operational performance from the wider BSW Integrated Care System to ensure the management of any performance challenges.

7.1.~~4~~2 To oversee IT service performance.

7.2 Embedding Continuous Quality Improvement & Learning

7.2.1 To oversee the delivery and embedding of Improving Together approach to continuous quality improvement and learning.

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

7.3 ICS ~~Development /~~ & Partnerships

7.3.1 To obtain assurance that Trust plans will positively impact on population health to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities.

7.3.2 To oversee the development of GWH as an anchor organisation.

7.4 Model of Care

7.4.1 To horizon scan for, be aware of, influence and respond to policy changes relating to models of care.

7.4.2 To ensure that changes in services at the Trust drive the outcomes required in the BSW model of care.

7.5 Other

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

7.5.2 Take responsibility for gaining appropriate levels of assurance for those items related to Performance, Partnerships and Improvement on the BAF for which Committee has accepted responsibility for board assurance.

8. REPORTING RESPONSIBILITIES

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

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

9. MEETING ADMINISTRATION

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

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

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

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

10. REPORTING/PROVIDING ASSURANCE

10.1 A number of sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, this Committee; and any report or briefing requested by this Committee. These include:-

- Divisional Board USC
- Divisional Board SW&C
- Divisional ICC
- Elective Care sub-committee
- Urgent care & Flow sub-committee
- Improvement sub-committee

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

11. REVIEW

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

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

Version Control

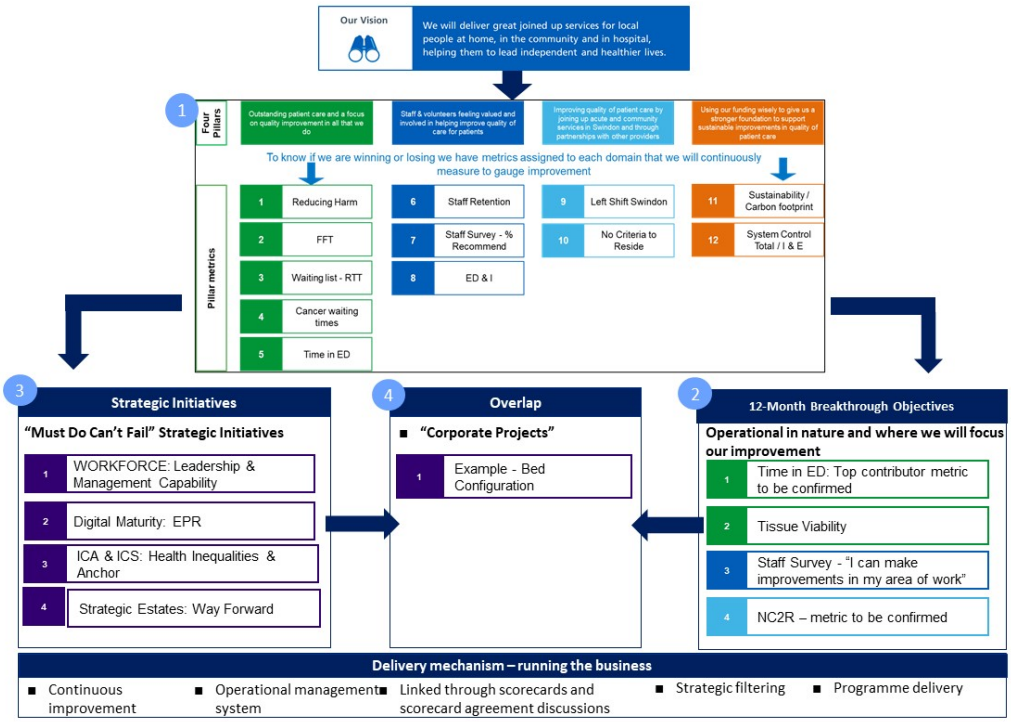
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	March 2022	Company Secretary	Revised TofR due to name change from Performance, People & Place Committee to Performance, Population & Place Committee and revised remit
V1.1	For review	June 2022	Performance, Population & Place Committee	TofR of Performance, Population & Place Committee and approved subject to the following amendments: - 2.2 add 'healthcare' before needs and change we to 'how these are being met' - 7.3.1 delete across the entire population - Add to remit; JSNA annual review, ICS work programme plan, clinical networks and EPRR
V1.2	Clarification	August 2022	Company Secretary via PPPC	Add 7.1.2 to include IT Service performance in Committee remit. To note that Finance, Infrastructure and Digital Committee to focus on Digital Strategy/Systems.
V2.0	Annual Review	March 2023	Company Secretary	• Amendment to job title • Strengthen reference to partnership working • Reference Oversight Framework • Include assurance sub committees • Transferred BSW Academy to People & Culture Committee

Appendix 1

Committee	Performance, Population & Place Committee
Chair Lead EDs	Peter Hill, Non- Executive Director Felicity Taylor- Drewe, Chief Operating Officer Claire Thompson, ~~Director~~ Chief Officer for ~~of~~ Improvement~~s~~ & Partnerships
Frequency	Monthly
Membership	4 x NEDs 2 x Eds
Quorum	2 x NEDs 1 x ED
Remit	~~Operational~~ Improving Together & Oversight Framework performance data – IPR IT Service performance Winter Plan EPRR ~~Primary Care &~~ Community Services Benchmarking & Model Hospital Report ~~Oversight of ICS/ICA development~~ Impact of ICS plans on the Trust JSNA review Population Health Management ICA work programme Clinical Networks ~~BSW Academy Development~~ (for P&CC) Integration of Services Delivery of Improving Together PMO Performance Board Assurance Framework
Strategic Risks	Patient Care Through Joined Up Services – Model of Care (S3) Patient Care Through Joined Up Services - Performance (S4) Patient Care Through Joined Up Services – Partnerships (S5)

Appendix 2

GWH - Strategic Planning Framework



TRUST MANAGEMENT COMMITTEE
TERMS OF REFERENCE
2023/24

Purpose
The purpose of the Committee is to support the Trust in achieving all its strategic objective.

1. AUTHORITY

1.1 The Trust Management 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. It is a non-statutory Committee.

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

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

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

1.5 The Committee has been constituted as the first tier executive decision-making group of the Trust. As such it is considered a strategic group which receives assurance and accepts escalation from a number of tactical sub-groups, which themselves receive assurance and escalation from a number of operational groups across the Trust.

2. ROLE / PURPOSE

2.1 The purpose of the Committee is to provide a mechanism for the Executive Directors to provide assurance to the Board concerning all aspects of delivering the Trust's strategy and supporting strategic plans, including the day to day operational management of the Trust. The Committee brings together the most senior leaders to role model our values, working in an integrated way to deliver conditions that support our colleagues to deliver our strategic objectives.

2.2 In carrying out their duties members of the TMC and any attendees must ensure that they act in accordance with the leadership framework of the Trust, which includes:

- Leadership behaviour
- Civility and respect
- Clarity about expectations (red lines)
- STAR values

The Committee will create a culture of collective leadership. It will provide a safe space to explore issues, provide solutions, and share learning.

2.3 The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from GWH's Strategic Planning Framework in doing so (appendix 2). The key driver metrics will be reported at every meeting (see section 10).

2.4 Duties include:-

- To support the Trust Board in developing and implementing the vision and strategic direction for the Trust as part of the Swindon Integrated Care Alliance (ICA) and BANES, Swindon and Wiltshire Integrated Care System (ICS).
- To develop ideas and formulate proposals that will inform the Trust Board's discussions on the future strategy of the Trust.
- To implement the strategy to the key milestones using our Improving Together approach of strategy deployment and the use of a strategic filter.
- To have oversight of/gain assurance on the overall performance of the Trust ensuring all key quality, safety and performance indicators are achieved and early corrective action is taken to prevent variation from plan.
- To drive the annual business planning processes, ensuring the Board is presented with the correct information on which to take sound decisions.
- To provide staff with clear leadership and short-, medium- and long-term direction and vision.
- To lead on the maintenance of effective processes to manage risk by triangulating management information across the Trust that enables a whole organisational view of risks and actions.

3. MEMBERSHIP AND ATTENDANCE

3.1 The membership of the TMC shall consist of:

Chief Executive
Chief Financial Officer
Chief Operating Officer
Chief People Officer
Chief Digital Officer
Chief Nurse
Chief Medical Officer
Chief Officer of Improvement & Partnerships
Divisional Directors
Associate Medical Directors
Divisional Directors of Nursing
Director of Midwifery & Neonatal Services
Director of Pharmacy & Medicine Optimisation
Director of Estates & Facilities

3.2 The following participants are required to attend meetings of the Trust Management Committee (mandatory participants):

Deputy Chief Nurse(s)
Deputy Chief Medical Officer(s)
Deputy Chief Operating Officer
Deputy Chief Financial Officer
Deputy Chief Officer of Improvement and Partnerships
Deputy Chief People Officer
Chief Information Officer
Associate Director of Organisational Development
Associate Director of Communications & Engagement
Company Secretary

3.2 **Chair** – The Chair of the Committee is the Chief Executive. In the absence of the Chair, any other Executive Director shall Chair the meeting.

4. ATTENDANCE

4.1 Non-Executive Directors will not attend meetings of the Trust Management Committee (unless otherwise agreed by the Chief Executive for a specific purpose).

4.2 *Substitutes/Deputies* - Each member of the Committee is permitted to send a substitute / deputy to attend in their absence but this will not count towards the quorum.

4.3 *Invitees* - Other persons may be invited to attend meetings of the Committee as required and agreed by the Chair of the Committee. Staff will be invited to present reports as considered appropriate.

4.4 *Compulsory Attendees* – Persons (or in their absence their representative) writing papers for this Committee are expected to attend meetings of the Committee to present their paper.

5. QUORUM

5.1 The quorum for meetings of the Committee shall be:-

- 3 Executive Directors; and,
- representation from each Division – at least one of whom will be a practicing clinician.

6. FREQUENCY OF MEETINGS

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

7. RESPONSIBILITIES

The Committee will provide a forum in which to discuss and consider strategic issues which affect operational and corporate services. It will have executive-led tactical sub-groups that will ensure that the Committee is a point of escalation for any risks or

issues that need wider operational or corporate consideration, decision, or dissemination. The main responsibilities of the Committee are to:-

7.1 To ensure the implementation of the strategic vision and direction (once agreed by the Board of Directors) in line with the timescales set out by the Board and with due consideration for the needs of the ICA/ICS.

7.2 To actively monitor achievement of the annual plan.

7.3 To carry out periodic strategic reviews of the environment and landscape to inform business planning.

7.4 To direct managers, via sub-committees and working groups, to undertake specific areas of work on its behalf.

7.5 To ensure implementation throughout the Trust of key policy actions.

7.6 To assure the Board that a quality, safety and performance management culture is embedded throughout the organisation and the external and internal targets are achieved, and where not, to implement and monitor achievement through action planning.

7.7 To develop, formulate and present ideas and proposals for the Board's consideration and approval.

7.8 To drive the annual business planning and clinical and service development cycle within the Trust.

7.9 To review and recommend business cases for onward approval to relevant committee, including business cases arising through the ICA/ICS taking into account financial, quality, workforce and operational performance considerations in line with scheme of delegation.

7.10 To authorise capital and revenue funding in line with scheme of delegation.

7.11 To provide leadership and management of the risk framework ensuring that the Assurance Framework is scrutinised and challenged and an overview is taken to check that the risks remain relevant; controls are adequate and that arrangements are in place to achieve the organisation's objectives and management of risks are effective and operating as intended and to regularly review, scrutinise and challenge risks; actions required to address those risks; and progress against actions as detailed in the Corporate risk register (al l15+ risks) and Divisional and Corporate Department risk registers. The Committee will:-

- recommend risks for escalation to the Board Assurance Framework where it is felt they have potential to materially impact upon delivery of the trust's strategy
- satisfy itself that risks scoring 15+ are being effectively managed and mitigated
- ensure that new risks scoring 15+ are accurately identified and scored and

- ensure that risks are being consistently reviewed, with timely action taken in mitigation by each Division or corporate department.

7.12 To review and approve estates, facilities management, equality and diversity and any other operational policies, procedures or other documents.

7.13 To receive minutes, notes or reports from sub-committees and groups convened to address particular issues relating to the day-to-day control and management of the organisation.

8. REPORTING RESPONSIBILITIES

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

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

9. MEETING ADMINISTRATION

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

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

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

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

10. Agendas

The content of the agenda will be agreed by the Chair of the Committee.

Standing Agenda Items
(List of items which shall normally appear on the agenda for this Committee)

The Trust Management Committee will normally receive reports for each meeting on activity under the following headings which reflect the improving together approach to drive quality improvement within the Trust:-

- **Strategic Initiatives** - Strategy Delivery, Commitments & Priorities
- **Pillar metrics** - Financial Management, Patient Safety and Quality of Care, Operational Performance, Workforce
- **Breakthrough objectives performance**
- **Strategic filter** – projects & programmes
- **Risk**

11. REPORTING/PROVIDING ASSURANCE

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

Minutes / reports from the following for **information only**: -

- Investment Committee (monthly)
- Divisional Operational Performance Review Board (monthly)
- Improvement Board
- Employee Partnership Forum (monthly)
- Equality & Diversity Group (quarterly)
- Patient Quality Committee (monthly)
- Risk Committee (monthly)

11.2 Working groups will be tasked to prepare supporting reports for the Committee.

11.3 The committee will have regular Away Day sessions to inform planning and key decision making.

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

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

12. REVIEW

12.1 The Committee should consider its effectiveness and refresh its terms of reference annually.

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

Version Control

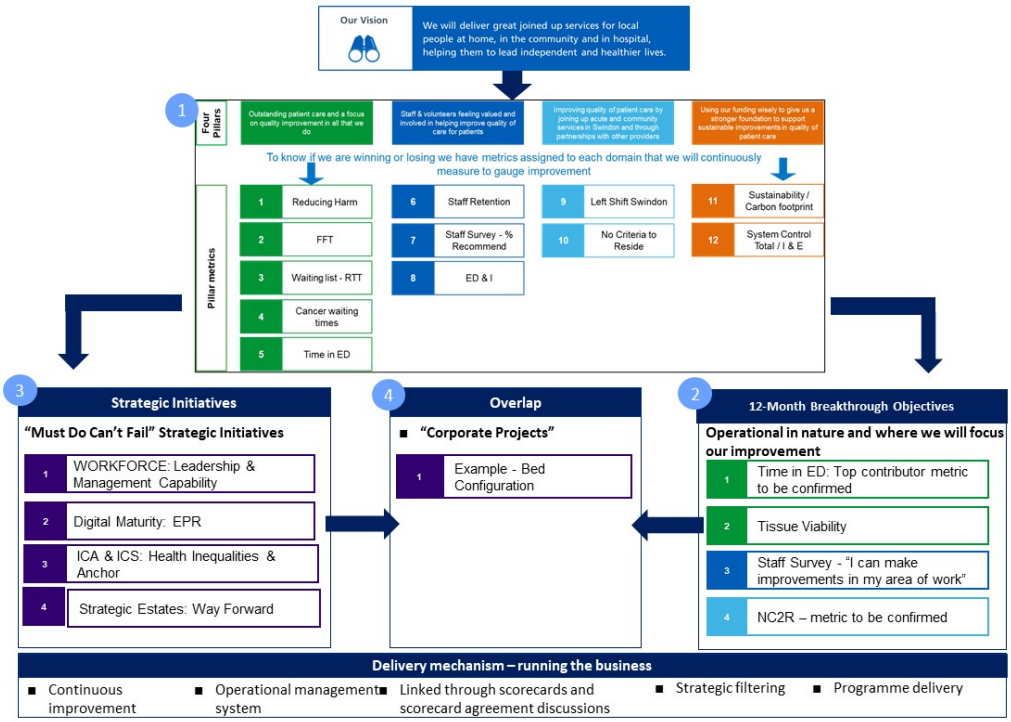
Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For review	May 2022	Company Secretary / Director of Improvement & Partnerships	Revised TofR due to the introduction to new ways of working in the form of 'Improving Together' approach and to refocus the work programme to strengthen oversight of key strategic area.
V1.1	For review	17 May 2022	Executive Committee	Comments/feedback received TofR
V1.2	Approved	23 June 2022	Trust Management Committee	Comments/feedback received TofR amended for ratification by Board
V1.3	For review	Dec-22	Trust Management Committee	It was agreed in June-22 to review in 6 months' time especially the membership. Changes agreed:- • Split membership into membership and attendees • Reference TMC Away Days • Strengthened Improving Together reference (No 10)

Appendix 1

Committee	Trust Management Committee
Chair	Kevin McNamara, Chief Executive
Frequency	Monthly
Membership	Senior Management Team
Quorum	3 Executive Directors; and, 1 x representation from each Division – at least one of whom will be a clinician
Remit	Trust Strategies Business & operational plans Corporate policies & procedures Major service developments Trust wide business cases Operational, clinical, quality and financial performance Strategic filter Improving Together ICA/ICS Strategy and Plans Risk Management Board Assurance Framework
Strategic Risks	All
Key Assurance Reports	IPR – highlight report Operational Reports Workforce reports National surveys Business Planning reports Quality Reports IT Performance Reports IG Reports Benchmarking Reports Sub committee escalation reports Estates & Facilities / H&S Report Board Assurance Framework & Risk Report

Appendix 2

GWH - Strategic Planning Framework



MENTAL HEALTH GOVERNANCE COMMITTEE
TERMS OF REFERENCE
2023/24

Purpose
The purpose of Mental Health Governance Committee is to support the Trust in achieving all its strategic objective with particular reference to: "**Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers"**

1. AUTHORITY

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

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

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

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

2. ROLE / PURPOSE

2.1 All hospitals should have governance arrangements in place to scrutinise the discharge of a range of responsibility under the Mental Health Act and the Mental Capacity Act. The Acts do not outline general requirement of governance arrangements and as such it is a matter for the Trust to determine. At GWH the Mental Health Governance Committee monitors the application of the Acts and advises the Trust Board on issues that may affect its duties under the Acts.

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).

3. MEMBERSHIP

3.1 The membership of the Committee shall consist of:

- Three Non-Executive Directors
- Two Executive Directors; the Chief Nurse and ~~Medical Director~~Chief Medical Officer

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

4. ATTENDANCE

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

4.2 The Committee may call other officers of the Trust to attend as appropriate. The following are expected to attend:

- Associate Director of Safeguarding
- Mental Health Act, Safeguarding Adults at Risk, Mental Capacity Act and Deprivation of Liberty Safeguards Administrator.

Additionally, the following external representatives may be in attendance at any meeting:

- Senior Representative from Child and Adolescent Mental Health Service (CAMHS) (Oxford Health)
- Senior Representative from Adult Mental Health Services and Older People's
  - Mental Health Services (Avon and Wiltshire Mental Health Partnership Trust)
- ~~Commissioner for Mental Health Services [BSW CCG]~~ Senior representative from BSW ICB
- Senior representatives of the DoLS Supervisory Bodies

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.

4.4 *Voting* - For voting purposes there must always be a majority of Non-Executive Directors.

4.5 The work of this Committee will be supported by the Executive Director Lead, the Chief Nurse.

5. QUORUM

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

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet quarterly.

7. DUTIES

The Mental Health Governance Committee is authorised by Trust Board to:

7.1 Make policy decisions concerning the Mental Health Act 1983 (as amended by the Mental Health Act 2007) [the MHA] and the Mental Capacity Act 2005 [the MCA] on behalf of the Board.

7.2 Monitor the implementation of the MHA and the MCA and Deprivation of Liberty Safeguards [DoLS] throughout the Trust.

7.3 Oversee compliance in relation to the MHA and the MCA throughout the Trust.

7.4 Identify matters of risk relating to the Act and develop policies and procedures to manage that risk.

7.5 Identify ongoing training needs for all staff and ensure that programmes are devised and delivered and embedded.

7.6 The Mental Health Governance Committee will monitor compliance with all relevant aspects of legislation.

7.7 Instruct the Mental Health Governance Operational Group (Sub-group of this Committee) on all necessary work required to support this committee in fulfilling its objectives and functions.

7.8 Support a culture of learning through case review and ensure the learning is disseminated throughout the organisation

7.9 Support a culture of providing parity of esteem and ensuring respect and dignity for patients with mental health needs.

8. FUNCTIONS

8.1 To initiate and manage, on behalf of the Board, the development of Trust policies and procedures in respect of current legislation.

8.2 To adopt, on behalf of the Board, Trust policies and procedures in respect of current legislation

8.3 To ensure that legislation and supporting policies and procedures are understood by staff and implemented appropriately

8.4 Through an annual audit programme provide assurance to the board regarding compliance with policy and procedures

8.5 To develop education and practice on the Acts and the Codes of Practice for all personnel involved in the application of the Acts.

8.6 To ensure that the roles and duties of Hospital Managers, as defined in the Act, are undertaken effectively and consistently throughout the Great Western Hospitals NHS Foundation Trust

8.7 To ensure that the services of Hospital Managers, as defined in the MHA are available to those detained under that Act and that those Hospital Managers exercise their duties effectively and consistently throughout the Great Western Hospitals NHS Foundation Trust.

8.8 To monitor systems in place to ensure that people who are detained under the Mental Health Act MHA in hospital are under the care of a 'responsible clinician'. (as 'approved' under section 12 of the Mental Health Act).

8.9 To monitor the use of the Acts in the Trust against national and local trends.

8.10 To prepare an Annual Report for the Trust Board and an annual work programme.

8.11 To contribute to the development of other policies and procedures as requested.

8.12 To ensure, that as required, the Department of Health returns are submitted outlining the application of the Mental Health Act.

8.13 To ensure that mental health service contracts with mental health providers meet, are robust and fulfil the requirement for an effective and efficient service.

8.14 To ensure that mental health services meet agreed quality, effectiveness and outcome measures.

9. REPORTING RESPONSIBILITIES

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

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

10. MEETING ADMINISTRATION

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

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

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

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

10. REPORTING/PROVIDING ASSURANCE

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

- Mental Health Governance Operational Group

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

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

11. REVIEW

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

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

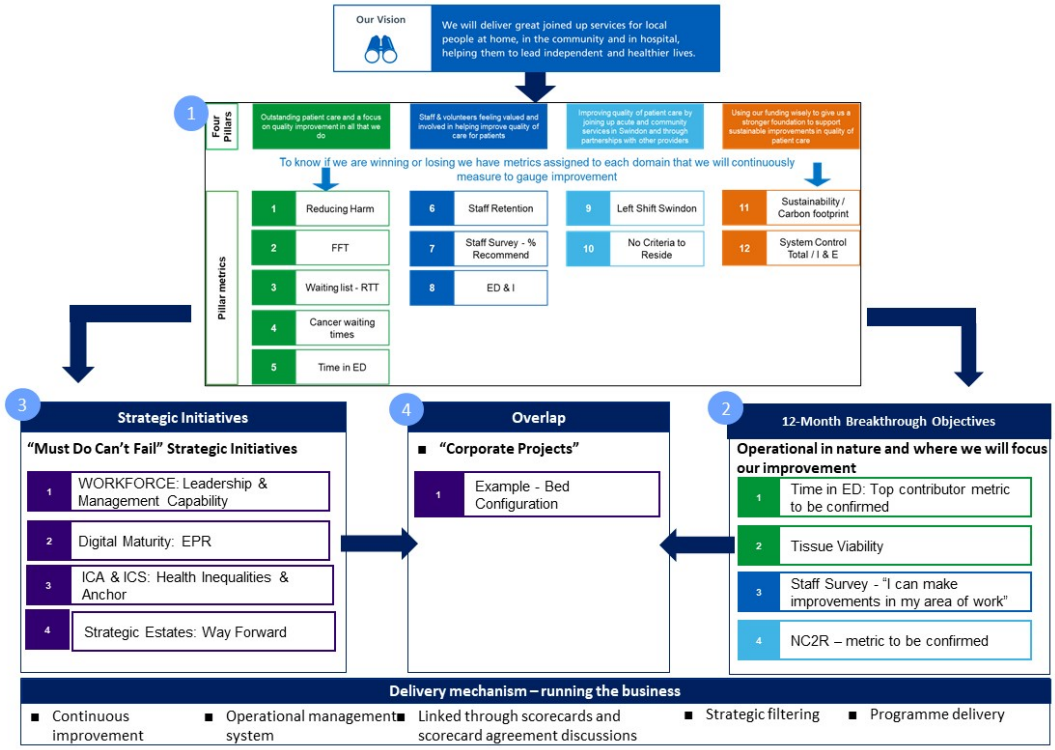
Version Control				
Version	Status	Date	Issues/Amended	Summary of Change
V1.0	For annual review	June 2022	Mental Health & Governance Committee	Amendments include:- - New format - Membership and attendance - Voting process - Deputies for NEDs and EDs - Name change of sub committee - Reword 8.7 - Delete 8.9 - Reference to strategic planning framework - Summary table of meeting remit
V2.0	Annual Review	April 2023	Company Secretary	- Change of job title - Amendment to attendee - In Summary change reporting of 12+ risks to 15+

Appendix 1 – Summary

Committee	Mental Health Governance Committee
Chair Lead EDs	Lizzie Abderrahim, Non-Executive Director Lisa Cheek, Chief Nurse Jon Westbrook, ~~Medical Director~~ Chief Medical Director
Frequency	Quarterly
Membership	3 x NEDs 2 x EDs
Quorum	2 x NEDs 1 x ED
Remit	Compliance with the Mental Health Act 1983 (as amended by the Mental Health Act 2007) [the MHA] and the Mental Capacity Act 2005 [the MCA] Monitor the implementation of the MHA and the MCA and Deprivation of Liberty Safeguards [DoLS] throughout the Trust. Changes to legislation and guidance Mental Health Governance Mental Health Risks (~~12~~ 15+) Mental Health Liaison team CAMHS Dementia Strategy

Appendix 2

GWH - Strategic Planning Framework



Report Title	**Annual Review of Trust Constitution**				
Meeting	**Trust Board**				
Date	**4 May 2023**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 – Revisions to the Trust Constitution Appendix 2 – Trust Constitution				

Purpose

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

Assurance Level

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

Process

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

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

Report

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

As part of an annual review of the Trust Constitution amendments have been proposed to cover changes since the last review. The proposed key changes reflect:-

- the establishment of Joint Committees/Committees-in-Common
- the appointments of Associate Non-Executive Directors
- the revised National Health Service Act 2006
- the changes to the Trust's Partner organisations on the Council of Governors
- holding virtual/hybrid meetings
- various 'tidying up' i.e. change of job title and gender-neutral language.

For ease of identification of key changes, appendix 1 provides a summary of the main elements of revision.

Changes to the Constitution require approval of both the Trust Board and Council of Governors.

Link to CQC Domain – select one or more	Safe	Caring	Effective	Responsive	Well Led
	x	x	x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
	None				
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					

Next Steps	Approval from the Council of Governors

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board are requested to approve the proposed amendments to the Trust's Constitution.

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	5 April 2023

Appendix 1 - Trust's Constitutional Review 2023 – the amendments are highlighted in red

Page No	Proposed Changes	Note
Various	References to:- - "Monitor" has been deleted and replaced with "NHS England" - "Director of Finance" has been replaced with "Chief Financial Officer" - "his or her" and "he or she" have been replaced with gender neutral pronouns such as "their" and "they" - Any reference to Chairman have been replaced by Chair - Any reference to the" NHS Foundation Trust Code of Governance" have been changed to "Code of Governance for NHS Providers"	Health and Care Act 2022 merging of NHS Improvement (comprising of Monitor and the NHS Trust Development Authority) into NHS England. New Code of Governance for NHS Providers came into effect from 1 April 2023.
Page 5	**Powers –** add the following paragraphs 3.6 The Trust may arrange for any functions exercisable but it to be exercised by or jointly with any one or more of the bodies set out in section S 65Z5(i) of the 2006 Act. Where such a function is exercisable jointly the bodies may arrange for the functions to be exercised by joint committees as set out in S5 65Z6 of the 2006 Act. 3.7 In exercising its powers, the Trust will have regard to: 3.7.1 S.63B of the 2006 Act (revised 2022) (duty to have regard to the wider effect of discussions), also referred to as the "Triple Aim". 3.7.2 S.63B of the 2006 Act (revised 2022) (duties in relation to climate change).	Updated to recognise joint committees and the 2006 Act (revised 2022) As specified in the Health and Care Act 2022
Page 10	**Council of Governors – duties of Governors** 13A.1.2 to represent the interests of the Members of the Trust as a whole and the interests of the public at large.	Update. To support collaboration between organisations and the delivery of better, joined-up care, councils of governors are required to form a rounded view of the interests of the 'public at large'. This includes the population of the local system of which the NHS foundation trust is part.

Page 12	**Board of Directors – appointment and removal of Chair and other Non-Executive Directors, including Associate Non-Executive Directors** 21.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors, including Associate Non-Executive Directors. 21.2 Removal of the Chair or another Non-Executive Director, including Associate Non-Executive Directors shall require the approval of three-quarters of the members of the Council of Governors.	To reflect that the Trust has appointed Associate Non-Executive Directors as part of the Board membership.
Page 24 - 28	**Interpretation and definitions** 38.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act as amended by the 2012 Act and the Health and Social Care Act 2022. ~~38.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice versa.~~ 38.5 "**2022 Act"** Means the Health & Care Act 2022; **"Associate Non-Executive Director"** means a non-voting director of the Trust who is not an employee of the Trust" **"Integrated Care Board"** An integrated care board is an organisation. Integrated Care Boards (ICB's) are statutory organisations that bring NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS. **"Integrated Care Partnership"** An 'integrated care partnership' (ICP) is a formal partnership of organisations (commissioners and providers) working together to improve the health and care of the whole population they serve. **"Integrated Care System"** An integrated care system In England, is an integrated care system (ICS) is a statutory partnership of organisations who plan, buy, and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities, voluntary and charity groups, and independent care providers **" Code of Governance for NHS Providers"** means the best practice advice published by NHS England on 27 October 2022, with effect from 1 April 2023;	Updated to reflect the Health and Care Act 2022. 38.2 deleted as the Constitution has been updated to gender neutral pronouns. New definitions added.

	" NHS England" The Health and Care Act 2022 has merged "Monitor" and the Trust Development Authority (TDA) into NHS England and removed legal barriers to collaboration and integrated care, making it easier for providers to take on greater responsibility for service planning and putting Integrated care Systems (ICSs) on a statutory footing.	
Page 35	**Composition** 1.1 The Council of Governors shall comprise: 1.1.1 13 Public Governors;	Amended to reflect the current number of public governors from 14 to 13 (this was not amended when the constituencies changed in 2022)
Page 35	**Composition** 1.1.4 **2 Other Partnership Governors** 1.3 Subject to the provisions of 1.4 below, the organisations specified as Other Partnership Organisations that may appoint members of the Council of Governors are: 1.3.1 New College Swindon, New College Drive, Swindon, SN3 1AH; and 1.3.2 Voluntary Action Swindon, 1 John Street, Swindon, SN1 1RT. 1.4 From 1 April 2020, the organisations specified as Other Partnership Organisations that may appoint members of the Council of Governors are those organisations listed in paragraphs 1.3.1 and 1.3.2 above ~~and:~~ ~~1.41. NHS Bath and North East Somerset, Swindon & Wiltshire (BSW) Clinical Commissioning Group of the Trust HQ St Martins Hospital, Clara Cross Lane, Bath BA2 5RP~~	This reflects the changes made to partner organisations.
Page 36	**2.2 Other Partnerships Governors** Other Partnership Organisations may each appoint one Other Partnership Governor ~~with the exception of the Clinical Commissioning Group Partner Organisation which may appoint two Other Partnership Governors~~ by notice in writing signed by the chief executive or chair of the organisation, or other senior member duly authorised by the organisation and delivered to the Secretary.	As above
Page 87	**Appendix 3 – Roles and Responsibilities of Governors** **1** The roles and responsibilities of the Governors are:	To reflect that the Trust now has Associate Non-Executive Directors as part of the Board membership.

	1.1 at a general meeting (which may be the annual meeting referred to in paragraph 3.1 of Appendix 4 of Annex 5 below): 1.1.1 Subject to paragraph 21 of this Constitution, to appoint or remove the Chair and the other Non-Executive Directors, including Associate Non-Executive Directors. The removal of a Non-Executive Director, including Associate Non-Executive Directors requires the approval of three-quarters of the members of the Council of Governors; 1.1.2 to decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors, including Associate Non-Executive Directors;	
Page 93	**Annex 6 – standing orders of practice and procedure of the Council of Governors** 4.2 **Calling meetings** 4.2.1 Meetings of the Council of Governors shall be held at such times and places and of such format including in person, by using electronic communication or hybrid as the Council of Governors may determine and there shall be at least 4 meetings in any year including:	Various sections of the Constitution updated to take account of holding virtual meetings.
Page 94	**Annex 6 – standing orders of practice and procedure of the Council of Governors** **4.3 Notice of Meetings and agenda** 4.3.2 Before each meeting of the Council of Governors a public notice of the time and place, and if appropriate remote access/electronic communication arrangements, of the meeting, and if possible the public part of the agenda, shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least 6 Clear Days before the meeting, save in the case of emergencies	As above
Page 97	**Annex 6 – standing orders of practice and procedure of the Council of Governors** **4.11 Voting** 4.11.5 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request. In the event of a meeting held using electronic communication, an electronic voting facility will be made available, including when appropriate, the facility for holding a secret ballot. 4.11.8 A Governor may only vote if present (either in person or by electronic communication) at the time of the vote on which the question is to be decided; no Governor may vote by proxy but a Governor is considered to	As above

	have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote.	
Page 113	**Annex 7 – standing orders of practice and procedure of the Board of Directors** 2.9.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors, including Associate Non-Executive Directors. 2.9.2 Removal of the Chair or another Non-Executive Directors, including Associate Non-Executive Directors shall require approval of three-quarters of the members of the Council of Governors. 2.10.1 The Chair and the Non-Executive Directors, including Associate Non-Executive Directors are to be appointed for a period of office determined by the Council of Governors at general meeting of the Council of Governors not exceeding 3 years. 2.10.2 At the general meeting of the Council of Governors referred to at SO 2.10.1, the Council of Governors shall decide the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors, including Associate Non-Executive Directors.	To reflect that the Trust now has Associate Non-Executive Directors as part of the Board membership.
Page 116	**Annex 7 – standing orders of practice and procedure of the Board of Directors** 3.4 **Agendas and supporting papers** Agendas will be sent to members of the Board of Directors 3 Clear Days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in emergency giving rise to the need for an immediate meeting as set out in SO 3.3.5 above. Failure to serve the agenda and (where relevant) supporting papers on more than three members of the Board of Directors will invalidate the meeting. An agenda and supporting papers shall be presumed to have been served one day after posting and in the case of by electronic communication on the day it is sent.	Various sections of the Constitution updated to take account of holding virtual meetings.
Page 120	**Annex 7 – standing orders of practice and procedure of the Board of Directors** 3.13 **Voting** 3.13.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands or by	As above

	appropriate electronic means. A paper ballot may also be used if a majority of the Directors present so request.	
Page 125	**Annex 7 – standing orders of practice and procedure of the Board of Directors** 5.1.7 The committees established by the Board of Directors are: 5.1.7.1 Audit Risk and Assurance Committee; 5.1.7.2 Remuneration Committee; and 5.1.7.3 Mental Health Governance Committee	Change in meeting title form Mental Health Act and Mental Capacity Act Committee to Mental Health Governance Committee
Page 125	**Annex 7 – standing orders of practice and procedure of the Board of Directors** 5.2 **Joint Committees** 5.2.1 Joint committees may be appointed by the Trust, by joining together with one or more other trusts, consisting of wholly or partly of the Chair and Directors of the Trust or other health service bodies, or of Directors of the Trust with non-directors of other health bodies in question. 5.2.2 Any Committee-in-Common or Joint Committee appointed under standing orders may, subject to such directions or guidance as may be given by NHS England or the Trust or any other health bodies in question, appoint sub-committees consisting wholly or partly of directors sitting on the Committee or Joint Committee (whether or not they are directors of the other health bodies in question) or wholly of persons who are not directors of the other health bodies in question, provided that the Trust is always represented by an Executive Director (or deputy nominated by the Executive Director) on such Committees, Joint Committees or sub committees.	Added to reflect the establishment of Joint Committees and Committee-in Common

Great Western Hospitals
NHS Foundation Trust

GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

CONSTITUTION

Great Western Hospitals NHS Foundation Trust Constitution

Table of Contents

INTRODUCTION

An NHS Foundation Trust is a Public Benefit Corporation which is authorised under the National Health Service Act 2006 to provide goods and services for the purposes of the health service in England. A Public Benefit Corporation is a body corporate which is constituted in accordance with Schedule 7 of the National Health Service Act 2006. The Constitution provides, inter alia, for the Trust to have Members, Governors and Directors and determines who may be eligible for membership and how Governors and Directors are elected or appointed and defines their respective roles and powers.

1 Name

1.1 The name of the Trust is to be “Great Western Hospitals NHS Foundation Trust”.

2 Principal Purpose

2.1 The Principal Purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

2.2 The Trust does not fulfil its Principal Purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Trust may provide goods and services for any purposes related to:

2.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

2.3.2 the promotion and protection of public health.

2.4 The Trust may also carry on activities other than those mentioned in paragraph 2.3 above for the purpose of making additional income available in order to better carry on its Principal Purpose.

3 Powers

3.1 The Trust is to have all the powers of an NHS Foundation Trust set out in the 2006 Act.

3.2 In the exercise of its powers the Trust shall have regard to the core principles of the National Health Service ("NHS"), as set out in Appendix 1 of Annex 8.

3.3 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

3.4 Subject to any restriction contained in this Constitution or in the 2006 Act, and to paragraph 3.5 below, any of these powers may be delegated to a committee of Directors or to an Executive Director.

3.5 Where the Trust is exercising functions of the manager pursuant to Section 23 of the Mental Health Act 1983 (as amended), those functions may be exercised by any three or more persons authorised by the Board of Directors, each of whom must be neither an Executive Director of the Trust, nor an employee of the Trust.

3.6 The Trust may arrange for any functions exercisable but it to be exercised by or jointly with any one or more of the bodies set out in section S 65Z5(i) of the 2006 Act. Where such a function is exercisable jointly the bodies may arrange for the functions to be exercised by joint committees as set out in S5 65Z6 of the 2006 Act.

3.7 In exercising its powers, the Trust will have regard to:

3.7.1 S.63A of the 2006 Act (revised 2022) (duty to have regard to wider effect of decisions), also referred to as the "Triple Aim";

3.7.2 S.63B of the 2006 Act (revised 2022) (duties in relation to climate change).

4 Other purposes

4.1 The purpose of the Trust is to provide goods and services, including education, training and research and other facilities for purposes related to the provision of health care, in accordance with its statutory duties.

4.2 The Trust may carry out research in connection with the provision of health care and make facilities and staff available for the purposes of education, training or research carried on by others.

4.3 The Trust may also undertake activities other than those mentioned in paragraphs 4.1 and 4.2 above. These activities must be for the purpose of making additional income available in order to carry out the Trust's Principal Purpose better.

5 Membership and constituencies

5.1 The Trust shall have Members, each of whom shall be a member of the following constituencies:

5.2 the Public Constituency ; or

5.3 the Staff Constituency.

6 Application for membership

6.1 An individual who is eligible to become a Member of the Trust may do so on application to the Trust as set out in paragraphs 7 and 8 below.

7 Public Constituency

7.1 Subject to the provisions of paragraphs 1 and 2 of Appendix 2 to Annex 8, an individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a Member of the Trust.

7.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the "Public Constituency".

7.3 The minimum number of Members in each area for the Public Constituency is specified in Annex 1.

7.4 An eligible individual shall become a Member upon entry to the Trust's register of Members pursuant to an application by them. The Secretary may require any individual to supply supporting evidence to confirm eligibility.

7.5 On receipt of an application for membership and subject to being satisfied that the applicant is eligible the Secretary shall cause the applicant's name to be entered in the Trust's register of Members.**8 Staff Constituency**

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member of the Trust provided:

8.1.1 they is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 theyhas been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who are employed by a designated Trust Subcontractor or who are included in a designated Volunteer Scheme and who otherwise exercise functions for the purposes of the Trust may become or continue as members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the "Staff Constituency".

8.4 The minimum number of members in each staff class within the Staff Constituency is specified in Annex 2.

8.5 An individual who is eligible to become a member of the Staff Constituency under paragraph 8.1 above and who is invited by the Trust to become a member of the Staff Constituency shall become a Member of the Trust as a member of the Staff Constituency without an application being made unless he informs the Trust that he does not wish to do so.

8.6 Any individual who is eligible to become a member of the Staff Constituency under paragraph 8.2 above shall become a member upon entry to the Trust's register of Members pursuant to an application by them.

8.7 On receipt of an application for membership as described in paragraph 8.6 above and subject to being satisfied that the applicant is eligible, the Secretary shall cause the applicant's name to be entered into the Trust's register of Members.

8.8 The Trust shall designate individuals as Trust Subcontractors and (or, as the case may be) Volunteer Schemes who exercise functions for the purposes of the Trust for the purpose of paragraph 8.2 above, and the Secretary shall maintain a register of Trust Subcontractors and Volunteer Schemes.

8.9 For the purposes of paragraphs 8.1 and 8.2 above, Chapter 1 of Part 14 of the Employments Rights Act 1996 applies for the purposes of determining whether an individual has been continuously employed by the Trust, or has continuously exercised functions for the purposes of the Trust.

8.10 Subject to the provisions of paragraphs 1.1 and 1.2 of Annex 2, the Staff Constituency shall be divided into 4 descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

9 Restriction on Membership

9.1 An individual who is a member of a constituency or of a class within a constituency may not while membership of that constituency or class continues, be a member of any other constituency or class.

9.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

9.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Appendix 2 of Annex 8.

9A Annual Members' Meeting

9A.1 The Trust shall hold an annual meeting of its Members ("Annual Members Meeting") which shall be open to members of the public.

10 Council of Governors – composition

10.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

10.2 The composition of the Council of Governors is specified in Annex 3.

10.3 The members of the Council of Governors, other than the Appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within than constituency.

10.4 The number of Governors to be elected by each constituency or where appropriate, by each class of each constituency is specified in Annex 3.

11 Council of Governors – election of Governors

11.1 Elections for Elected Governors shall be conducted in accordance with the Model Rules for Elections using the alternative rules marked "FPP" (First Past the Post), as may be varied from time to time, and are attached at Annex 4.

11.2 A variation of the Model Rules for Elections shall not constitute a variation of the terms of this Constitution.

11.3 An election, if contested, shall be by secret ballot.

11.4 A person may not vote at an election for or stand for election as an Elected Governor unless within the specified period stated in the Model Rules for Elections they have made a declaration in the form specified in paragraphs 5.1 and/or 5.2 (as appropriate) of Appendix 4 of Annex 5 of this Constitution, setting out the particulars of his qualification to vote or stand as a member of the constituency for which the

election is being held. It is an offence (other than in relation to the Staff Constituency) to knowingly or recklessly make such a declaration which is false in a material particular.

12 Council of Governors - tenure

12.1 Elected Governors

12.1.1 An Elected Governor may hold office for a period of up to 3 years.

12.1.2 No governor shall serve as a governor for more than three terms of office of up to 3 years each and no governor shall serve for more than nine years in total (whether by consecutive or non-consecutive terms) and may then not be reappointed for a further 5 years.

12.1.3 An Elected Governor shall cease to hold office if they cease to be a member of the constituency or class by which they were elected.

12.1.4 An Elected Governor shall be eligible for re-election at the end of his term.

12.2 Appointed Governors

12.2.1 An Appointed Governor shall hold office for a period of 3 years.

12.2.2 An Appointed Governor shall cease to hold office if the sponsoring organisation withdraws its sponsorship of them by notice in writing to the Secretary.

12.2.3 Subject to paragraph 12.2.4 below, an Appointed Governor shall be eligible for re-appointment at the end of his term.

12.2.4 An Appointed Governor may hold office for a maximum of 6 consecutive years and may then not be reappointed for a further 5 years.

12.3 For the purposes of the tenure provisions set out in paragraphs 12.1 and 12.2 above, a "year" means a period of 12 consecutive months commencing immediately on the date of Authorisation.

13 Council of Governors – disqualification and removal

13.1 The following may not become or continue as a member of the Council of Governors:

13.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13.1.2 a person who has made a composition or arrangement with, or granted a Trust deed for, his creditors and has not been discharged in respect of it;

13.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

13.1.4 a person who within the preceding five years has been removed from the governing body under paragraph 13 of the Constitution or has resigned or been removed from the governing body as detailed in paragraph 4.12.12 of Annex 6 Standing Orders For The Practice And Procedure Of The Council Of Governors.

13.2 Governors must be at least 18 years of age at the date they are nominated for election or appointment.

13.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Appendix 1 of Annex 5.

13.4 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary.

13.5 If a Governor fails throughout a period of six consecutive months from the date of his last attendance, to attend any meeting of the Council of Governors, its Committees, Sub-Committees or Working Groups, his tenure of office is to be terminated immediately unless a two thirds majority of the other Governors are satisfied that:

13.5.1 the absence was due to a reasonable cause; and

13.5.2 they will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

The absent Governor shall be discounted during any agreed period of absence (absences agreed by the Council of Governors) and their seat shall be discounted from voting statistics; including where special voting requirements apply.

13.6 If a Governor is considered to have acted in a manner inconsistent with:

13.6.1 the core principles of the NHS, as set out in Appendix 1 of Annex 8; or

13.6.2 the Standing Orders for the Practice and Procedure of the Council of Governors, as set out in Annex 6 (“the Standing Orders for Governors”); or

13.6.3 the Governor's Code of Conduct; or

13.6.4 they have failed to declare an interest as required by this Constitution or the Standing Orders for Governors, or they have spoken or voted at a meeting on a matter in which they have an interest contrary to this Constitution or the Standing Orders Governors, and in this paragraph "interest" includes a pecuniary and a non-pecuniary interest and in either case whether direct or indirect, and

they are adjudged to have so acted by a majority of not less than 75% of the members of the Council of Governors present and voting at a Special Meeting of the Council of Governors then the Governor shall vacate his office immediately.

13.7 The Standing Orders for Governors shall provide for the process and voting requirements to be adopted in cases relating to the termination of a Governor's tenure.

13A Council of Governors – duties of Governors

13A.1 The general duties of the Council of Governors are:

13A.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and

13A.1.2 to represent the interests of the Members of the Trust as a whole and the interests of the public at large.

13A.2 The Trust must take steps to ensure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

14 Council of Governors – meetings of Governors

14.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 21.1 below) or, in his absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 21.1 below), or as per paragraph 4.7.3 of annex 6, a Non-Executive Director shall chair the meeting shall preside at meetings of the Council of Governors and the person chairing the meeting shall have a second or casting vote.

14.2 Meetings of the Council of Governors shall be open to members of the public and Members of the Trust. Members of the public and Members of the Trust may be excluded from a meeting for special reasons by resolution of the Council of Governors on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or the proceedings.

15 Council of Governors – standing orders

15.1 The Standing Orders for Governors are attached at Annex 6.

15A Council of Governors – referral to the Panel

15A.1 In this paragraph, “the Panel” means a panel of persons appointed by NHS England to which a Governor may refer a question as to whether the Trust has failed or is failing to act in accordance with:

15A.1.1 the Constitution; or

15A.1.2 provisions made by or under Chapter 5 of the 2006 Act.

15A.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve the referral.

16 Council of Governors - conflicts of interest of Governors

16.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it.

16.2 The Standing Orders for Governors make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

17 Council of Governors – travel and other expenses

17.1 The Trust may pay travelling and other costs and expenses to members of the Council of Governors at such rates as the Trust decides from time to time.

18 Council of Governors – further provisions

18.1 Further provisions with respect to the Council of Governors are set out in Annex 5, these include:

18.1.1 Eligibility to be on the Council of Governors;

18.1.2 Council of Governors: objectives;

18.1.3 Roles and responsibilities of Governors;

18.1.4 Remuneration;

18.1.5 Vacancies;

18.1.6 Meetings;

18.1.7 Committees, sub-committees and joint committees;

18.1.8 Council of Governors: declarations.

19 Board of Directors – composition

19.1 The Trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

19.2 The Board of Directors is to comprise:

19.2.1 a Non-Executive Director Chair; and

19.2.2 a minimum of 4 (four) and a maximum of 8 (eight) other Non-Executive Directors; and

19.2.3 a minimum of 4 (four) and a maximum of 7 (seven) Executive Directors,

PROVIDED THAT the number of Non-Executive Directors plus the Chair shall exceed the number of Executive Directors.

19.3 One of the Executive Directors shall be the Chief Executive.

19.4 The Chief Executive shall be the Accounting Officer.

19.5 One of the Executive Directors shall be the Chief Financial Director.

19.6 One of the Executive Directors is to be a registered medical practitioner (within the meaning of the Medical Act 1983) or a registered dentist (within the meaning of the Dentists Act 1984).

19.7 One of the Executive Directors is to be a registered nurse or a registered midwife (within the meanings of the Nurse and Midwifery Order 2001 (SI 2002/253)).

19.8 In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in his absence, the Deputy Chair), shall have a second or casting vote at meetings of the Board of Directors in accordance with the Standing Orders for the Board of Directors attached at Annex 7.

19.9 The validity of any act of the Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Director.

19.10 Subject to the provisions of paragraphs 19.3 to 19.7 above, the Board of Directors shall determine any change in the number of Directors, PROVIDED THAT any change in the number of Directors is within the range set out in paragraph 19.2 above.

19A Board of Directors – general duty

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members of the Trust as a whole, and for the public.

20 Board of Directors – qualification for appointment as a Non-Executive Director

20.1 A person may be appointed as a Non-Executive Director only if:

20.1.1 they are a member of the Public Constituency; and

20.1.2 they are not disqualified by virtue of paragraph 24 below.

21 Board of Directors – appointment and removal of Chair and other Non-Executive Directors, including Associate Non-Executive Directors

21.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors**,** including Associate Non-Executive Directors.

21.2 Removal of the Chair or another Non-Executive Director**,** including Associate Non-Executive Directors shall require the approval of three-quarters of the members of the Council of Governors.

22 Board of Directors – appointment of Deputy Chair

22.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Deputy Chair.

23 Board of Directors - appointment and removal of the Chief Executive and other Executive Directors

23.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

23.2 The appointment of the Chief Executive is subject to the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

23.3 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

24 Board of Directors – disqualification

24.1 The following may not become or continue as a member of the Board of Directors:

24.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

24.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

24.1.3 a person who within the preceding five years has been convicted of any offence anywhere in the world and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

24.1.4 a person whose tenure of office as a chair or member or director of a Health Service Body has been terminated on the grounds that his appointment is not in the interests of the health service;

24.1.5 a person who has had his name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he has not subsequently had his name included in such a list;

24.1.6 a person who has within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

24.1.7 an executive director, non-executive director or a governor of another Health Service Body, unless approval is received from no less than 75% of the voting members of the Board of Directors (the basis of a vote against this proposal should be for justifiable reasons e.g conflicts of interest);

24.1.8 a person who is currently a governor of the Trust;

24.1.9 a person who is a member of a local authority Health Overview and Scrutiny Committee;

24.1.10 a person who is a subject of a disqualification order made under the Company Directors' Disqualification Act 1986;

24.1.11 a person who has failed without reasonable cause to fulfil any training requirement established by the Board of Directors;

24.1.12 a person who has failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the Directors' Code of Conduct;

24.1.13 a person who is an Immediate Family Member of a Director; or

24.1.14 a person who is the subject of a Sex Offenders Order and/or his name in included in the Sex Offenders Register.

24A Board of Directors – meetings

24A.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

24A.2 Before holding a meeting, the Board of Directors must send a copy of the agenda for the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

24A.3 Further provisions relating to meetings of the Board of Directors are set out in Standing Order 3 of Annex 7 to this Constitution.

25 Board of Directors – standing orders

25.1 The standing orders for the practice and procedure of the Board of Directors ("Standing Orders for the Board of Directors") are attached at Annex 7.

26 Board of Directors - conflicts of interest of Directors

26.1 The duties that a Director has by virtue of being a Director of the Trust include in particular:

26.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust (a "Conflict").

26.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

26.2 The duty referred to in sub-paragraph 26.1.1 above is not infringed if:

26.2.1 the situation cannot reasonably be regarded as likely to give rise to a Conflict; or

26.2.2 the matter has been authorised in accordance with the Constitution.

26.3 The duty referred to in sub-paragraph 26.1.2 above is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a Conflict.

26.4 In sub-paragraph 26.1.2 above and 26.10.3.5 below, "third party" means a person other than:

26.4.1 the Trust; or

26.4.2 a person acting on its behalf.

26.5 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

26.6 If a declaration under this paragraph 26 proves to be, or becomes, inaccurate or incomplete a further declaration must be made.

26.7 Any declaration required by this paragraph 26 must be made before the Trust enters into the transaction or arrangement.

26.8 This paragraph 26 does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

26.9 A Director need not declare an interest:

26.9.1 If the interest cannot reasonably be regarded as likely to give rise to a Conflict.

26.9.2 If, or to the extent that, the Directors are already aware of the interest.

26.9.3 If, or to the extent that, the interest concerns terms of the Director's appointment that have been or are to be considered:

26.9.3.1 by a meeting of the Board of Directors; or

26.9.3.2 by a committee of the Directors appointed for that purpose under the Constitution.

26.10 A matter shall have been authorised for the purposes of paragraph 26.2.2 above if:

26.10.1 The Directors, in accordance with the requirements set out in this paragraph 26.10, authorise any matter or situation proposed to them by any Director which would, if not authorised, involve a Director (an "Interested Director") breaching his duty under paragraph 26.1.1 above to avoid Conflicts.

26.10.2 Any authorisation under this paragraph 26.10 will be effective only if:

26.10.2.1 the matter in question shall have been proposed by any Director for consideration in the same way that any other matter may be proposed to the Directors under the provisions of this Constitution [or in such other manner as the Directors may determine];

26.10.2.2 any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interested Director; and

26.10.2.3 the matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

26.10.3 Any authorisation of a Conflict under this paragraph 26.10 may (whether at the time of giving the authorisation or subsequently):

26.10.3.1 extend to any actual or potential conflict of interest which may reasonably be expected to arise out of the Conflict so authorised;

26.10.3.2 provide that the Interested Director be excluded from the receipt of documents and information and the participation in discussions (whether at meetings of the Directors or otherwise) related to the Conflict;

26.10.3.3 provide that the Interested Director shall or shall not be an eligible Director in respect of any future decision of the Directors in relation to any resolution related to the Conflict;

26.10.3.4 impose upon the Interested Director such other terms for the purposes of dealing with the Conflict as the Directors think fit;

26.10.3.5 provide that, where the Interested Director obtains, or has obtained (through his involvement in the Conflict and otherwise than through his position as a Director of the Trust) information that is confidential to a third party, he will not be obliged to disclose that information to the Board of Directors, or to use it in relation to the Trust's affairs where to do so would amount to a breach of that confidence; and

26.10.3.6 permit the Interested Director to absent themselves from the discussion of matters relating to the Conflict at any meeting of the Directors and be excused from reviewing papers prepared by, or for, the Directors to the extent they relate to such matters.

26.10.4 Where the Directors authorise a Conflict, the Interested Director will be obliged to conduct themselves in accordance with any terms imposed by the Directors in relation to the Conflict.

26.10.5 The Directors may revoke or vary such authorisation at any time, but this will not affect anything done by the Interested Director, prior to such revocation or variation in accordance with the terms of such authorisation.

26.10.6 A Director is not required, by reason of being a Director, to account to the Trust for any remuneration, profit or other benefit which he derives from or in connection with a relationship involving a Conflict which has been authorised by the Directors (subject in each case to any terms, limits or conditions attaching to that authorisation) and no contract shall be liable to be avoided on such grounds.

26.11 Subject to paragraph 26.12 below, if a question arises at a meeting of Directors or of a committee of Directors as to the right of a Director to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting, be referred to the Chair whose ruling in relation to any Director other than the Chair is to be final and conclusive.

26.12 If any question as to the right to participate in the meeting (or part of the meeting) should arise in respect of the Chair, the question is to be decided by a decision of the Directors (other than the Chair) at that meeting, for which purpose the Chair is not to be counted as participating in the meeting (or that part of the meeting) for voting or quorum purposes.

27 Board of Directors – remuneration and terms of office

27.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

27.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors ("the Remuneration Committee")

28 Registers

28.1 The Trust shall have:

28.1.1 a register of Members showing, in respect of each Member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

28.1.2 a register of members of the Council of Governors;

28.1.3 a register of interests of the members of the Council of Governors;

28.1.4 a register of members of the Board of Directors; and

28.1.5 a register of interests of members of the Board of Directors.

28.2 The Secretary shall be responsible for compiling and maintaining the registers in paragraph 28.1 and the registers may be kept in either paper or electronic form. Removal from any register shall be in accordance with the provisions of this Constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 14 days of receipt.

29 Admission to and removal from the registers

29.1 **Register of Members**

The Secretary shall maintain the register of Members in two parts:

29.1.1 Part one, which shall be the register referred to in the 2006 Act, shall include the name of each Member and the constituency or class to which they belong, and shall be open to inspection by the public in accordance with paragraphs 30 and 31 below; and

29.1.2 Part two shall contain all the information from the application form and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third party.

29.1.3 Notwithstanding the provisions of paragraphs 29.1.1 and 29.1.2 above, the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual membership of the Trust is representative of those eligible for membership and for the administration of the provisions of this Constitution.

29.2 **Register of members of the Council of Governors**

The register of members of the Council of Governors shall list:

29.2.1 the name of each Governor;

29.2.2 their category of membership of the Council of Governors (public, staff, local authority, other partnership organisation); and

29.2.3 an address through which they may be contacted which may be the Secretary.

29.3 **Register of interests of members of the Council of Governors**

The register of interests of the members of the Council of Governors shall contain:

29.3.1 the name of each Governor; and

29.3.2 whether they are declared any interests and, if so, the interests declared in accordance with this Constitution or the Standing Orders for Governors.

29.4 **Register of members of the Board of Directors**

The register of members of the Board of Directors shall list:

29.4.1 the name of each Director;

29.4.2 their capacity on the Board of Directors; and

29.4.3 an address through which they may be contacted which may be the Secretary.

29.5 **Register of interests of members of the Board of Directors**

The register of interests of members of the Board of Directors shall contain:

29.5.1 the name of each Director;

29.5.2 whether they have declared any interests; and

29.5.3 if so, the interests declared in accordance with this Constitution or the Standing Orders for the Board of Directors.

30 Registers – inspection and copies

30.1 The Trust shall make the registers specified in paragraphs 29.1 to 29.5 above available for inspection by members of the public, subject to the conditions set out in paragraphs 30.2 to 30.4 or as otherwise prescribed by regulations including for the avoidance of doubt, the Public Benefit Corporation (Register of Members) Regulations 2004 (SI 2004/539).

30.2 The Trust shall not make any part of the register specified in paragraph 29.1 above (the register of Members) available for inspection by members of the public which shows details of any Member of the Trust, if the Member so requests.

30.3 So far as the registers are required to be made available:

30.3.1 they are, subject to paragraph 30.4 below, to be available for inspection free of charge at all reasonable times; and

30.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

30.4 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

31 Documents available for public inspection

31.1 Subject to paragraph 31.3 below, the Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

31.1.1 a copy of the current Constitution;

31.1.2 a copy of the latest Annual Accounts and of any report of the Auditor on them; and

31.1.3 a copy of the latest Annual Report.

31.1A Subject to paragraph 31.3 below, the Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

31.1A.1 A copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

31.1A.2 A copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

31.1A.3 A copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

31.1A.4 A copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

31.1A.5 A copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

31.1A.6 A copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS England's decision), 65KB (Secretary of State's response to NHS England 's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

31.1A.7 A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

31.1A.8 A copy of any final report published under section 65I (administrator's final report).

31.1A.9 A copy of any statement published under section 65J (power to extend time) or 65 KC (action following Secretary of State's rejection of final report) of the 2006 Act.

31.1A.10 A copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

31.2 Any person who requests a copy of or extract from any of the documents listed in paragraphs 31.1.1 to 31.1.6 above is to be provided with a copy, or extract.

31.3 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

32 Auditor

32.1 The Trust is to have an Auditor.

32.2 The Council of Governors at a general meeting shall appoint or remove the Trust's Auditor but in doing so shall consider the views of the Trust's Audit Committee.

32.3 The Accounting Officer shall ensure that the Auditor carries out his duties in accordance with Schedule 10 to the 2006 Act and in accordance with any guidance or best practice advice issued by NHS England on standards, procedures and techniques to be adopted.

33 Audit Committee

33.1 The Board of Directors shall establish a committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

34 Accounts and records

34.1 The Trust must keep proper accounts and proper records in relation to those accounts.

34.2 NHS England may with the approval of the Secretary of State for Health, give directions to the Trust as to the content and form of its accounts.

34.3 The accounts are to be audited by the Auditor.

34.4 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

34.4.1 the accounts;

34.4.2 any records relating to them; and

34.4.3 any report of the Auditor on them.

34.5 The Trust shall prepare in respect of each Financial Year Annual Accounts in such form as NHS England may with the approval of the Secretary of State direct.

34.6 NHS England may with the approval of the Secretary of State for Health direct the Trust:

34.6.1 to prepare accounts in respect of such period or periods as may be specified in the direction; and/or

34.6.2 that any accounts prepared by it by virtue of paragraph 34.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

34.7 In preparing its Annual Accounts or in preparing any accounts by virtue of paragraph 34.6.1 above, the Trust must comply with any directions given by NHS – England with the approval of the Secretary of State for Health as to:

34.7.1 the methods and principles according to which the Annual Accounts must be prepared; and/or

34.7.2 the content and form of the Annual Accounts.

34.8 The Trust must:

34.8.1 lay a copy of the Annual Accounts, and any report of the Auditor on them, before Parliament; and

34.8.2 send copies of the Annual Accounts, and any report of the Auditor on them to NHS England within such a period as NHS England may direct.

34.9 The Trust must send a copy of any accounts prepared by virtue of paragraph 34.6.1 above and a copy of any report of the Auditor to NHS England within such a period as Monitor NHS England may direct.

34.10 The functions of the Trust in respect of this paragraph 34 shall be delegated to the Accounting Officer.

35 Annual Report, Forward Plans and non-NHS Work

35.1 The Trust shall prepare an Annual Report and send it to NHS England.

35.2 Each Annual Report must give:

35.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any Public Constituency is representative of those eligible for such membership;

35.2.2 information on the impact that income received by the Trust otherwise than from the fulfilment of the Principal Purpose has had on the provision by the Trust of goods and services for those purposes; and

35.2.3 such other information as may be prescribed by NHS England.

35.3 The Trust shall give information as to its forward planning each Financial Year to NHS England.

35.4 The Forward Plan shall be prepared by the Directors.

35.5 In preparing the Forward Plan, the Directors shall have regard to the views of the Council of Governors.

35.6 Each Forward Plan must include information about:

35.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

35.6.2 the income that it expects to receive from doing so.

35.7 Where a Forward Plan contains a proposal that the Trust carry on an activity of a kind mentioned in paragraph 35.6.1 above, the Council of Governors must:

35.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its Principal Purpose or the performance of its other functions; and

35.7.2 notify the Directors of the Trust of its determination.

35.8 The Trust may implement a proposal to increase by 5% or more the proportion of its total income in any Financial Year attributable to activities other than the fulfilment of the Principal Purpose only if more than half of the members of the Council of Governors present and voting approve the implementation of the proposal.

36 Presentation of the Annual Accounts and reports to the Governors and Members

36.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

36.1.1 the Annual Accounts;

36.1.2 any report of the Auditor on them; and

36.1.3 the Annual Report.

36.2 The documents shall also be presented to the Members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

36.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 36.1 with the Annual Members' Meeting.

37 Instruments

37.1 The Trust shall have a seal.

37.2 The seal shall not be affixed except under the authority of the Board of Directors as set out in the Standing Orders for the Board of Directors.

37A Amendment of the Constitution

37A.1 The Trust may make amendments to its Constitution only if:

37A.1.1 more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors, approve the amendments; and

37A.1.2 more than half of the members of the Board of Directors present and voting at a meeting of the Board of Directors, approve the amendments.

37A.2 Amendments made under paragraph 37A.1 above shall take effect as soon as the conditions in that paragraph are satisfied, but the amendments shall have no effect in so far as the Constitution would, as a result of the amendments, not accord with Schedule 7 of the 2006 Act.

37A.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

37A.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment;

37A.3.2 the Trust must give the Members an opportunity to vote on whether they approve the amendment; and

37A.3.3 if more than half of the Members present and voting at the Annual Members' Meeting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

37A.4 Amendments by the Trust to its Constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

37B Mergers etc. and significant transactions

37B.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

37B.2 The Constitution does not contain any descriptions of the term ‘significant transaction’ for the purposes of section 51A of the 2006 Act and therefore, for the avoidance of doubt, no transactions or arrangements are 'significant transactions' for the purposes of section 51A of the 2006 Act.

38 Interpretation and definitions

38.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act as amended by the 2012 Act and the Health and Social Care Act 2022.

38.2 References in this Constitution to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder.

38.3 Headings are for ease of reference only and are not to affect interpretation.

38.4 References to paragraphs are to paragraphs in this Constitution save that where there is a reference to a paragraph in an annex or appendix to this Constitution it shall be a reference to a paragraph in that annex or appendix unless the contrary is expressly stated or the context otherwise so requires.

38.5 In this Constitution:

"2006 Act"
means the National Health Service Act 2006;

"2012 Act"
means the Health and Social Care Act 2012;

“2022 Act”
Means the Health & Care Act 2022;

"Accounting Officer"
means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;

"Annual Accounts"
means those accounts prepared by the Trust pursuant to paragraph 25 of Schedule 7 to the 2006 Act;

“Annual Members’ Meeting”
has the meaning ascribed to it in paragraph 9A.1 of this Constitution;

"Annual Report"
means a report prepared by the Trust pursuant to paragraph 26 of Schedule 7 to the 2006 Act;

"Appointed Governors"
means a Local Authority Governor, or an Other Partnership Governor;

"Area of the Trust"
means the area, consisting of all the areas, specified in Annex 1, as an area for a Public Constituency;

“Associate Non-Executive Director”
means a non-voting director of the Trust who is not an employee of the Trust”

"Audit Committee"
means a committee of the Board of Directors as established pursuant to paragraph 33 of this Constitution;

"Auditor"
means the auditor of the Trust appointed by the Council of Governors pursuant to paragraph 32 of this Constitution;

"Authorisation"
means the authorisation issued to the Trust by NHS England Monitor under section 35 of the 2006 Act and the term “Authorised” shall be construed accordingly;

"Board of Directors"
means the Board of Directors of the Trust as constituted in accordance with this Constitution;

"Certificate of Clearance"
has the meaning ascribed to it in paragraph 3 of Appendix 1 of Annex 5 of this Constitution;

"Chair"
means the Chair of the Trust. The expression "the Chair" shall be deemed to include the Deputy Chair or any other Non-Executive Director appointed if the Chair and/or Deputy Chair is absent from the meeting or otherwise unavailable, and references to "Chairship" shall be construed accordingly;

"Chief Executive"
means the Chief Executive of the Trust;

"Comptroller and Auditor General"
means the individual engaged in the position of Comptroller and Auditor General to the National Audit Office (UK government department) or its statutory successor from time to time;

“Conflict”
has the meaning ascribed to it in paragraph 26.1.1 of the Constitution;

"Constitution"
means this Constitution together with the annexes and appendices attached hereto;

"Council of Governors"
means the Council of Governors as constituted in this Constitution, which has the same meaning as the "Board of Governors" in paragraph 7 of Schedule 7 to the 2006 Act;

"Deputy Chair"
means the Deputy Chair of the Trust appointed pursuant to paragraph 22 of this Constitution;

"Director"
means a member of the Board of Directors;

"Director's Code of Conduct"
means the Code of Conduct for Directors of the Trust, as adopted by the Trust and as amended from time to time by the Board of Directors, which all Directors must subscribe to;

"Executive Director"
means an executive member of the Board of Directors of the Trust;

"Elected Governor"
means a Public Governor or a Staff Governor;

"Chief Financial Officer"
means the Finance Director of the Trust;

"Financial Year"
Means a successive period of twelve months beginning with 1 April;

"Forward Plan"
means the document prepared by the Trust pursuant to paragraph 26 of Schedule 7 to the 2006 Act;

"Governor"
means a member of the Council of Governors;

"Governor's Code of Conduct"
means the Code of Conduct for Governors of the Trust, as adopted by the Trust and as amended from time to time by the Council of Governors, which all Governors must subscribe to;

"Health Overview and Scrutiny Committee"
means a local authority overview and scrutiny committee established pursuant to section 21 of the Local Government Act 2000;

"Health Service Body"
shall have the meaning ascribed to it in Section 65(1) of the 2006 Act;

"Hospital"
means those premises set out in Article 3(2) of the Swindon and Marlborough NHS Trust (Establishment) Order 1993 (SI 1993/2637), and all associated hospitals and facilities at which the Trust provides and/or manages the provision of goods and/or services including accommodation;

"Immediate Family Member"
means either:

(a) a spouse; or

(b) a person whose status is that of "Civil Partner" as defined in the Civil Partnerships Act 2004;

“Integrated Care Board”
An integrated care board is an organisation. Integrated Care Boards (ICB’s) are statutory organisations that bring NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS.

“Integrated Care Partnership”
An ‘integrated care partnership’ (ICP) is a formal partnership of organisations (commissioners and providers) working together to improve the health and care of the whole population they serve.

“Integrated Care System”
An integrated care system In England, is an integrated care system (ICS) is a statutory partnership of organisations who plan, buy, and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities, voluntary and charity groups, and independent care providers

“Interested Director”
has the meaning ascribed to it in paragraph 26.10.1 of the Constitution;

"Local Authority Governor"
means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the Area of the Trust;

"Local Authority Partnership Agreement"
means an agreement made under section 75 of the 2006 Act;

"Member"
means a member of the Trust and the term "membership" shall be construed accordingly;

"Model Rules for Elections"
means the election rules set out in Annex 4 of this Constitution;

" Code of Governance for NHS Providers"
means the best practice advice published by NHS England on 27 October 2022, with effect from 1 April 2023;

" NHS England"
The Health and Care Act 2022 has merged “Monitor” and the Trust Development Authority (TDA) into NHS England and removed legal barriers to collaboration and integrated care, making it easier for providers to take on greater responsibility for service planning and putting Integrated care Systems (ICSs) on a statutory footing.

"Non-Executive Director"
means a non-executive member of the Board of Directors;

"Other Partnership Governor"
means a member of the Council of Governors other than: a Public Governor; Staff Governor; or Local Authority Governor;

"Other Partnership Organisation"

means an organisation that may appoint Other Partnership Governors and which is listed at paragraph 1.3 of Annex 3 of this Constitution;

“Panel”
has the meaning ascribed to it in paragraph 15A.1 of this Constitution;

Principal Purpose"
means the purpose set out in Section 43(1) of the 2006 Act;

"Public Constituency"
has the meaning ascribed to it in paragraph 7.2 of this Constitution;

"Public Governor"
means a member of the Council of Governors elected by the members of one of the Public Constituencies;

"Regulatory Framework"
means the 2006 Act and the Constitution;

"Remuneration Committee"
means the committee established by the Trust under paragraph 27.2 of this Constitution;

"Replacement Governor"
has the meaning ascribed to it in paragraph 2.3 of Appendix 4 of Annex 5 of this Constitution;

"Reserve Governor"
has the meaning ascribed to it in paragraph 2.1 of Appendix 4 of Annex 5 of this Constitution;

"Secretary"
means the Secretary of the Trust or any other person appointed by the Trust to perform the roles and responsibilities as set out in Appendix 5 of Annex 8 of this Constitution and includes a joint, assistant or deputy secretary;

"Sex Offenders Order"
means a Sexual Offences Preventative Order made under section 104 of the Sexual Offences Act 2003, or a Risk of Sexual Harm Order made under section 123 of the Sexual Offences Act 2003;

"Sex Offenders Register"
means the Register of Sex Offenders maintained under Part I of the Sex Offenders Act 1997 (as amended by the Sexual Offences Act 2003);

"Staff Constituency"
has the meaning ascribed to it in paragraph 8.3 of this Constitution;

"Staff Governor"
means a member of the Council of Governors elected by the members of the Staff Constituency;

"Trust"

means Great Western Hospitals NHS Foundation Trust;

"Trust Subcontractor"
means an organisation and/or individuals registered as such in the register of Trust Subcontractors whose employees or, in the case of an individual, who exercise functions for the purpose of the Trust;

"Voluntary Organisation"
means a body other than a public or local authority, the activities of which are not carried on for profit;

"Volunteer"
means a person who provides goods or services to the Trust, but who is not employed to do so by the Trust; and

"Volunteer Scheme"
means an arrangement designated as such by the Trust pursuant to paragraph 8.2 of the Constitution under which individuals not employed by the Trust may nevertheless exercise functions on its behalf.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraph 7)

PUBLIC CONSTITUENCIES OF THE TRUST

NAME OF CONSTITUENCY	AREA	MINIMUM NUMBER OF MEMBERS	NUMBER OF GOVERNORS
Swindon	All electoral wards within the area covered by Swindon Borough Council.	700	7
Northern Wiltshire	All electoral wards within the area covered by the following Wiltshire Council Area Boards: - • Calne Area Board • Corsham Area Board • Chippenham Area Board • Malmesbury Area Board • Marlborough Area Board • Wootton Bassett & Cricklade Area Board	200	2
Central & Southern Wiltshire Constituency	All electoral wards within the area covered by the following Wiltshire Council Area Boards: - • Amesbury Area Board • Bradford on Avon Area Board • Devizes Area Board • Melksham Area Board • Pewsey Area Board • Salisbury Area Board • Tidworth Area Board • Trowbridge Area Board • Southern Wiltshire Area Board • South West Wiltshire Area Board • Warminster Area Board • Westbury Area Board	200	2
West Berkshire, Oxfordshire, Gloucestershire and Bath and North East Somerset	All electoral wards in the areas covered by Oxfordshire County Council, West Berkshire Council, Gloucestershire County Council and Bath and North East Somerset Council.	100	1

NAME OF CONSTITUENCY	AREA	MINIMUM NUMBER OF MEMBERS	NUMBER OF GOVERNORS
Rest of England and Wales	All other electoral wards in England and Wales save those electoral wards that fall within any of the Public Constituencies set out above	100	1
	Minimum Membership	**1300**	
	Public Governors		**13**

A map showing the electoral wards for the Wiltshire Constituencies is held by the Secretary. A list of the electoral wards within the Wiltshire constituencies is listed below: -

Parishes within the Northern Wiltshire Constituency

Aldbourne	Chippenham Without	Kingston St Michael	Preshute
Ashton Keynes	Christian Malford	Lacock	Purton
Avebury	Clyffe Pypard	Langley Burrell Without	Ramsbury
Baydon	Colerne	Latton	Savenake
Berwick Bassett	Compton Bassett	Lea and Cleverton	Seagry
Biddestone	Corsham	Leigh	Sherston
Box	Cricklade	Little Somerford	Sopworth
Braydon	Crudwell	Luckington	St Paul Malmesbury without
Bremhill	Dauntsey	Lydiard Millicent	Stanton St Quintin
Brickenborough	East Kennet	Lydiard Tregoze	Sutton Benger
Brinkworth	Easton Grey	Lyneham and Bradenstoke	Tockenham
Broad Hinton	Froxfield	Marlborough	West Overton
Broad Town	Fyfield	Marston Maisey	Winterbourne Bassett
Calne	Great Somerford	Mildenhall	Winterbourne Monkton
Calne without	Grittleton	Minety	Wootton Bassett
Castle Combe	Hankerton	Nettleton	Yatton Keynell
Charlton	Heddington	Norton	
Cherhill	Hilmarton	Oaksey	
Chilton Foliat	Hullavington	Ogbourne St Andrew	
Chippenham	Kingston Langley	Ogbourne St George	

Parishes within the Central Wiltshire Constituency

Allcannings	Easton	Melksham without	Steventon
Alton	Edington	Milton Lilbourne	Trowbridge
Atworth	Erlestoke	Monkton Farleigh	Upavon
Beechingstoke	Etchilhampton	North Bradley	Urchfont
Bishops Cannings	Grafton	North Newnton	West Ashton
Bradford on Avon	Great Bedwyn	Patney	West Lavington
Bratton	Great Hinton	Pewsey	Westbury
Bromham	Ham	Potterne	Westwood
Broughton Gifford	Heywood	Poulshot	Wilcot
Bulkington	Hilperton	Roundway	Wilsford
Burbage	Holt	Rowde	Wingfield
Buttermere	Huish	Rushall	Winsley
Charlton	Keevil	Seend	Woodborough
Cheverell Magna	Limpley Stoke	Semington	Wootton Rivers
Cheverell Parva	Little Bedwyn	Shalbourne	Worton
Chirton	Manningford	South Wraxhall	
Coulston	Marden	Southwick	
Devizes	Market Lavington	Stanton St Bernard	
Dilton Marsh	Marston	Steeple Ashton	
Easterton	Melksham	Stert	

Parishes within the Southern Wiltshire Constituency

Alderbury	Collingbourne Ducis	Kilmington	Stourton with Gasper
Allington	Collingbourne Kingston	Kingston Deverill	Stratford Toney
Alvesdiston	Compton Chamberlayne	Knook	Sutton Mandeville
Amesbury	Coombe Bissett	Landford	Sutton Veny
Ansty	Corsley	Laverstock	Swallowcliffe
Barford St Martin	Dinton	Longbridge Deverill	Teffont
Berwick St James	Donhead St Andrew	Ludgershall	Tidcombe and Fosbury
Berwick St John	Donhead St Mary	Maiden Bradley with Yarnfield	Tidworth
Berwick St Leonard	Downton	Mere	Tilshead
Bishopstone	Durnford	Milston	Tisbury
Bishopstow	Durrington	Netheravon	Tollard Royal
Bower Chalke	East Knoyle	Netherhampton	Upton Lovel
Boyton	Ebbesborne Wake	Newton Tony	Upton Soudamore
Britford	Enford	Norton Bavant	Warminster
Brixton Deverill	Everleigh	Odstock	West Dean
Broad Chalke	Figheldean	Orcheston	West Knoyle
Bulford	Firsdown	Pitton and Farley	West Tisbury
Burcombe Without	Fittleton	Quidhampton	Whiteparish
Chepmanslade	Fonthill Bishop	Redlynch	Wilsford Cum Lake
Chicklade	Fonthill Gifford	Salisbury	Wilton
Chilmark	Fovant	Sedgehill and Semley	Winterbourne
Chitterne	Great Wishford	Sherington	Winterbourne Stoke
Cholderton	Grimstead	Shrewton	Winterslow
Chute	Heytesbury	South Newton	Woodford
Chute Forrest	Hindon	Stapleford	Wylye
Clarendon Park	Horningsham	Steeple Langford	Zeals
Codford	Idmiston	Stockton	

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraph 8)

1 Staff Constituency

Transitional provisions

1.1 The Staff Constituency shall be divided into Staff classes.

1.2 From 1 May 2017, there shall be four classes of staff members as follows:

1.2.1 The Nursing and Therapy Staff Class for those individuals who are employed by the Trust, or who are a Trust Subcontractor and who are employed as nurses, midwives, healthcare assistants or therapy staff at Great Western Hospitals NHS Trust ("**Nursing and Therapy Staff Class**");

1.2.2 The Allied Health Professionals Staff Class for those individuals who are employed by the Trust, or who are a Trust Subcontractor and who are employed as allied health professional staff, ("**Allied Health Professionals Staff Class**");

1.2.3 The Doctors and Dentists Staff Class for those individuals who are employed by the Trust, or who are a Trust Subcontractor and who are registered medical practitioners and registered dentists ("**Doctors and Dentists Staff Class**"); and

1.2.4 The Administrators, Maintenance, Auxiliary and Volunteers Staff Class for all other individuals who are employed by the Trust, or who are Trust Subcontractors, or members of a Volunteer Scheme, and who do not fall within the preceding classes set out in paragraphs 1.2.1 to 1.2.3 above ("**Administrators, Maintenance, Auxiliary and Volunteer Staff Class**").

1.3 The minimum number of members required for each Staff Class listed in paragraphs 1.2.1 to 1.2.4 above shall be 100.

1.4 Individuals who are eligible to be a member of the Staff Constituency may not become or continue as a member of more than one Staff Class and individuals who are eligible to join more than one Staff Class shall be allocated by the Secretary in his absolute discretion to the Staff Class for which they are primarily employed by the Trust or as a Trust Subcontractor, or through a Volunteer Scheme.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraph 10)

The composition of the Council of Governors shall be as follows:

1 Composition

1.1 The Council of Governors shall comprise:

1.1.1 **13Public Governors;**

1.1.2 **4 Staff Governors;**

1.1.2.1 1 being elected by the Nursing and Therapy Staff Class;

1.1.2.2 1 being elected by the Allied Health Professionals Staff Class;

1.1.2.3 1 being elected by the Doctors and Dentists Staff Class; and

1.1.2.4 1 being elected by the Administrators, Maintenance, Auxiliary and Volunteers Staff Class;

1.1.3 **2 Local Authority Governors; and**

1.1.4 **2Other Partnership Governors**

1.2 The number of Public Governors is to be more than half of the total membership of the Council of Governors.

1.3 Subject to the provisions of 1.4 below, the organisations specified as Other Partnership Organisations that may appoint members of the Council of Governors are:

1.3.1 New College Swindon, New College Drive, Swindon, SN3 1AH; and

1.3.2 Voluntary Action Swindon, 1 John Street, Swindon, SN1 1RT.

1.4 From 1 April 2020, the organisations specified as Other Partnership Organisations that may appoint members of the Council of Governors are those organisations listed in paragraphs 1.3.1 and 1.3.2 above and:

2 Appointed Governors

2.1 Local Authority Governors

2.1.1 Swindon Borough Council or its successor organisation may appoint 1 (one) Local Authority Governor by notice in writing signed by the leader of the Council or a member of the Council executive, and delivered to the Secretary.

2.1.2 Wiltshire Council or its successor organisation may appoint 1 (one) Local Authority Governor by notice in writing signed by the leader of the Council or a member of the Council executive, and delivered to the Secretary.

2.2 Other Partnerships Governors

Other Partnership Organisations may each appoint one Other Partnership Governor notice in writing signed by the chief executive or chair of the organisation, or other senior member duly authorised by the organisation and delivered to the Secretary.

ANNEX 4 –THE MODEL RULES FOR ELECTIONS

(Paragraph 11)

Model Rules for Elections to the Council of Governors[1]

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll

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[1] References in this annex to "board of governors" shall bear the same meaning as "Council of Governors" in the Constitution.

24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
STV44. Rejected ballot papers and rejected text voting records
FPP44. Rejected ballot papers and rejected text voting records
STV45. First stage
STV46. The quota
STV47 Transfer of votes
STV48. Supplementary provisions on transfer
STV49. Exclusion of candidates
STV50. Filling of last vacancies
STV51. Order of election of candidates
FPP51. Equality of votes

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections
STV52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll
55. Delivery of documents
56. Forwarding of documents received after close of the poll
57. Retention and public inspection of documents
58. Application for inspection of certain documents relating to election

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The Code of Governance for NHS Providers (October 2022), with effect April 2023 published by NHS England

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as they consider necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of their functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that they are not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after they have received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by them or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts their vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts their vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts their ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that they have not marked or returned any other voting information in the election, and

(c) the particulars of their qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return their declaration of identity with their ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not

duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which their voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast their vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter their voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter their voter ID number in order to be able to cast their vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that

comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide their voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unlessthey:

(a) aresatisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with their text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if they can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless they are satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before

the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unlessthey:

(a) are satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, they are also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter their voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom they wish to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once their vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast their vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain their voter ID number and the numerical voting code for the candidate or candidates, for whom they wish to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, they are to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, they are to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, they are to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, they are

to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[2]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election they shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is

[2] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting

record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by them under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by them under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that they can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that they can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had

been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until they have dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be

excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation; and

(c) give public notice of the name of each candidate whom they have declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who they have declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation, and

(c) give public notice of the name of each candidate who they have declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who they have declared elected to the chair of the corporation, and

(c) give public notice of the name of each candidate who they have declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of

the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that NHS England has declared that the vote was invalid.

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by them in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS England under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS England for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS England by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHS England will refer the application to the independent election arbitration panel appointed by NHS England.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS England shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as thye think fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom they have voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as they consider appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph 18)

APPENDIX 1

Eligibility to be on the Council of Governors

1 A person may not become or continue as a Governor of the Trust if:

1.1 in the case of an Elected Governor, they cease to be a member of the constituency he represents;

1.2 in the case of an Appointed Governor, the sponsoring organisation withdraws their sponsorship of them;

1.3 they have within the preceding five years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

1.4 they are a person whose tenure of office as the chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interest of the health service;

1.5 they are a Director of the Trust, or a governor, executive director, non-executive director, chair, chief executive officer of another Health Service Body, or a body corporate whose business involves the provision of health care services or whose business involves the provision of goods or services to the Trust (unless they are appointed by a sponsoring organisation which is a Health Service Body);

1.6 they have had their name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he has not subsequently had his name included in such a list;

1.7 they are incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs;

1.8 they have refused without reasonable cause to undertake any training which the Trust and/or Council of Governors requires all Governors to undertake;

1.9 they are a member of a local authority Health Overview and Scrutiny Committee;

1.10 they are the subject of a Sex Offenders Order and /or his name is included in the Sex Offenders Register;

1.11 they are an occupant of the same household and/or they are an immediate family member of a Governor of the Trust;

1.12 they have failed to repay (without good cause) any amount of monies properly owed to the Trust;

1.13 they have failed to sign and deliver to the Secretary a statement in the form required by the Trust confirming acceptance of the Governor's Code of Conduct;

1.14 they have demonstrated aggressive or violent behaviour at any Hospital and following such behaviour he has been asked to leave, has been removed or excluded from any Hospital or other healthcare facility in accordance with the relevant Trust policy for withholding treatment from violent/aggressive patients;

1.15 they have been confirmed as a 'vexatious complainant' in accordance with the relevant Trust policy for handling complaints;

1.16 they have been removed as a member from another NHS Foundation Trust;

1.17 they have deemed to have acted in a manner contrary to the interests of the Trust;

1.18 they have not obtained, prior to standing for election, a Certificate of Clearance, in accordance with paragraph 3 of this Appendix 1 of Annex 5; or

1.19 they have made any material misstatement in the declarations made to the Trust for the purposes of obtaining a Certificate of Clearance.

2 Where a person has been elected or appointed to be a Governor and he becomes disqualified or is removed from office under paragraph 13 of the Constitution or paragraph 1.1 of this Appendix 1 of Annex 5, or paragraph 4.12.12 of Annex 6 Standing Orders For The Practice And Procedure of the Council of Governors he shall notify the Secretary in writing of such disqualification and/or (as the case may be) removal. If it comes to the notice of the Secretary at the time of his taking office or later that the Governor is so disqualified, the Secretary shall immediately declare that the person in question is disqualified and notify them in writing to that effect. Upon despatch of any such notification;

2.1 that person's tenure of office, if any, shall be terminated and they shall cease to act as a Governor; and

2.2 The Secretary shall inform the Chair of the actions taken in respect of the person in question and the reasons for such action.

Where it is agreed that a governor shall be removed from office that governor shall be immediately suspended during any appeal period at the end of which time should the governor's appeal not be successful the governor's tenure shall terminate immediately.

3 Certificates of Clearance

3.1 Any person wishing to stand as a candidate for Governor must obtain a Certificate of Clearance from the Secretary. The Secretary shall liaise with the Trust's Director of Workforce and Education or his designated substitute in obtaining the Certificate of Clearance. The Certificate of Clearance will require the prospective candidate to declare any criminal convictions, and the Trust will then take a view as to whether, in its discretion, those convictions disqualify the individual from exercising the function of a Governor.

3.2 In developing a policy for the issuing of Certificates of Clearance the Trust shall consult with the Council of Governors.

3.3 Any offer of appointment shall be conditional subject to a Disclosure and Barring Service check and should there be any undeclared disclosure found the governors shall be removed from office at the discretion of the Company Secretary**.**

APPENDIX 2

Council of Governors: objectives

1 The Trust shall seek to ensure, subject to the requirements of the 2006 Act, that the composition of the Council of Governors meets the following objectives:

1.1 the interests of the community served by the Trust are appropriately represented and NHS core principles (as set out in Appendix 1 of Annex 8) are upheld; and

1.2 the level of representation of the Public Constituency and the Staff Constituency, and the Other Partnership Organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs and, to this end, the Council of Governors:

1.2.1 shall at all times maintain a policy for the composition of the Council of Governors which takes account of the Trust's membership strategy, and

1.2.2 shall from time to time, and not less than every three years, review the policy for the composition of the Council of Governors;

1.2.3 when appropriate, shall propose amendments to this Constitution;

1.2.4 shall provide to the Members relevant information concerning the performance and forward planning of the Trust;

1.2.5 shall act in an advisory capacity when the Board of Directors has to make challenging or difficult decisions including those that affect the strategic direction of the Trust; and

1.2.6 when appropriate, shall be entitled to appoint an independent advisor and a nominated non executive Director to assist the Council of Governors in their advisory role.

APPENDIX 3

Roles and Responsibilities of Governors

1 The roles and responsibilities of the Governors are:

1.1 at a general meeting (which may be the annual meeting referred to in paragraph 3.1 of Appendix 4 of Annex 5 below):

1.1.1 Subject to paragraph 21 of this Constitution, to appoint or remove the Chair and the other Non-Executive Directors, including Associate Non-Executive Directors. The removal of a Non-Executive Director, including Associate Non-Executive Directors requires the approval of three-quarters of the members of the Council of Governors;

1.1.2 to decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors, including Associate Non-Executive Directors;

1.1.3 subject to paragraph 32.2 of this Constitution, to appoint or remove the Auditor;

1.1.4 to be presented with the Annual Accounts, any report of the Auditor on them and the Annual Report; and / or

1.1.5 to consider disputes as to membership referred to it pursuant to paragraph 2 of Appendix 4 of Annex 8.

1.2 at a general meeting or otherwise:

1.2.1 approve (by a majority of the Council of Governors voting) an appointment (by the Non-Executive Directors) of the Chief Executive (and Accounting Officer).

1.2.2 give the views of the Council of Governors to the Directors for the purposes of the preparation (by the Directors) of the forward planning in respect of each Financial Year to be given to NHS England;

1.2.3 respond as appropriate when consulted by the Directors;

1.2.4 to consider resolutions to remove a Governor.

1.3 The Governors also have the specific role and function of:

1.3.1 providing views to the Board of Directors on the strategic direction of the Trust;

1.3.2 developing membership;

1.3.3 representing the interests of all the Members (and not just the constituency which elected them); and

1.3.4 holding the Non-Executive Directors to account in relation to the Trust's performance in accordance with the terms of the Authorisation.

1.4 Notwithstanding the provisions of paragraph 1.1 of Appendix 3 of Annex 5, the Governors may exercise other functions at the request of the Board of Directors.

1.5 The Governors are expected to bring their individual skills and knowledge to bear on the exercise of their functions, but must act collectively and not in pursuit of sectional interests or matters already reviewed and considered by the Council of Governors in the view of the chair.

APPENDIX 4

Council of Governors: further provisions

1 Remuneration

1.1 Governors are not to receive remuneration, provided that this shall not prevent the remuneration of Governors by their employer.

2 Vacancies

2.1 In the event of an Elected Governor's seat falling vacant for any reason before the end of the term of office it shall be filled by the second place candidate in the last held election for that seat provided that the second place candidate achieved at least five percent of the vote in the last held election for that seat. If that individual declines it shall be filled by the third place candidate provided that the third place candidate achieved at least five percent of the vote in the last held election for that seat (the "Reserve Governor"). If the vacancy is not filled in this way Elected Governors shall be replaced by by-elections, in accordance with the Model Rules for Election.

2.2 In the event that a Reserve Governor is not available a by-election shall be held unless an election is due within 6 months in which case the seat shall stand vacant until the following scheduled election.

2.3 In the event of an Appointed Governor's seat falling vacant for any reason before the end of the term of office, the Trust will request that the relevant Other Partnership Organisation appoint a "Replacement Governor" within 30 days. Appointed Governors shall be replaced in accordance with the processes agreed pursuant to paragraph 2.3 of Annex 3.

2.4 The validity of any act of the Council of Governors is not affected by any vacancy among the Governors or by any defect in the appointment of any Governor.

3 Meetings

3.1 The Council of Governors is to meet at least four times per year, including an annual meeting no later than 30 September in each Financial Year.

3.2 The Secretary shall call meetings in accordance with paragraph 3.1 of Appendix 4 of Annex 5 above.

3.3 Any meeting of the Council of Governors requires a quorum of one third of the total number of Governors to be present with a majority of those present being Public Governors.

4 Committees, sub-committees and joint committees

4.1 The Council of Governors may appoint committees consisting wholly or partly of its members to assist it in carrying out its functions. A committee appointed under this paragraph may appoint a sub-committee.

4.2 The Council of Governors may appoint members to serve on joint committees with the Board of Directors or committees thereof.

4.3 These committees, sub-committees or joint committees may call upon outside advisers to help them in their tasks, provided that the financial and other implications of seeking outside advisers have been discussed and agreed by the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph will be determined in accordance with paragraph 2.2 of Appendix 4 of Annex 8 (Dispute Resolution Procedures).

5 Council of Governors: declarations

5.1 The specified form of declaration referred to at paragraph 11.4 of this Constitution regarding the declaration to stand for election as an Elected Governor shall be as set out on the nomination paper referred to in the Model Rules for Elections at Annex 4 and shall state as follows:

"I, the above named candidate, consent to my nomination and agree to stand for election to the Council of Governors in the constituency indicated in Section One of this form. I also declare that I am a member of that constituency.
I, the above named candidate, declare that I am not:

(a) a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
(b) a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it
(c) a person who within the preceding 5 years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on them;
(d) a person who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986;
(e) excluded by any other provision detailed within the Trust's Constitution;
(f) An unfit and improper person and I provided at least 2 references of good character from non-family members or close acquaintances; and
(g) I have no criminal convictions to declare and note that a Disclosure and Barring Service check will be completed

I confirm that to the best of my knowledge I am eligible to become a Governor of the Trust as per the eligibility criteria noted in Section 3 of the guidance notes."

5.2 The specified form of declaration referred to at paragraph 11.4 of this Constitution regarding the declaration to vote in elections for Public Governors will be as set out in Rule 21 of the Model Rules for Elections.

ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 15)

1. INTRODUCTION

1.1 The Great Western Hospitals NHS Foundation Trust became a Public Benefit Corporation on 1 December 2008 following authorisation by NHS England pursuant to the 2006 Act.

1.2 The principal place of business of the Trust is currently at the Great Western Hospital, Marlborough Road, Swindon, Wiltshire SN3 6BB ("Trust Headquarters").

1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Council of Governors of the Trust to adopt Standing Orders ("SOs") for the regulation of its proceedings and business and to adhere at all times to the Governors' Code of Conduct.

2 INTERPRETATION

2.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SOs shall bear the same meaning as in the Constitution.

2.2 The provisions of paragraphs 38.2 to 38.5 of the Constitution apply to these SOs, save that any reference to "Constitution" shall be read as a reference to these "SOs".

2.3 In these Standing Orders:

"Clear Day"
means a day of the week not including Saturday, Sunday or a public holiday; and

"Officer"
means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

3 THE COUNCIL OF GOVERNORS

The roles and responsibilities of the Governors are set out in Appendix 3 of Annex 5 of the Constitution and have effect as if incorporated into the SOs. Certain powers and decisions may only be exercised by the Council of Governors in formal session. These powers and decisions are set out in paragraph 1 of Appendix 3 of Annex 5 of the Constitution.

4 MEETINGS OF THE COUNCIL OF GOVERNORS

4.1 Admission of the public

4.1.1 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors except where it resolves by special resolution that members of the public and representatives of the press be excluded from all or part of a meeting on the grounds that:

4.1.1.1 any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

4.1.1.2 for other reasons stated in the resolution and arising from the nature of the business or the proceedings that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the Constitution.

4.1.2 Nothing in these SOs shall require the Council of Governors to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Chair.

4.2 Calling meetings

4.2.1 Meetings of the Council of Governors shall be held at such times and places and of such format including in person, by using electronic communication or hybrid as the Council of Governors may determine and there shall be at least 4 meetings in any year including:

4.2.1.1 an annual meeting no later than the 30 September in each Financial Year; and

4.2.1.2 any other meetings required of the Governors in order to fulfil their functions in accordance with the Constitution.

4.2.2 The Secretary may call a meeting of the Council of Governors at any time. If the Secretary refuses to call a meeting after a requisition for that purpose, signed by at least one-third of Governors and specifying the business to be transacted at the meeting, has been presented to them, or if, without so refusing, the Secretary does not call a meeting within 6 Clear Days after such requisition has been presented to them at the Trust's Headquarters, such one-third or more of the Governors may forthwith call a meeting for the purpose of conducting that business.

4.2.3 The Council of Governors may invite the Chief Executive, a member of the Board of Directors or a representative of the Auditor or other advisors to attend a meeting of the Council of Governors provided that the majority of the Governors present and voting at a meeting of the Council of Governors agree.

4.2.4 The Council of Governors may agree that its Governors can participate in its meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to be exceptional but shall constitute presence in person at the meeting for the purposes of SO 4.17 (Quorum) and eligible to vote in matters raised.

4.3 Notice of meetings and agenda

4.3.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or the Secretary authorised by the Chair to sign on his behalf, shall

be delivered to, or sent by post to the usual place of residence of every Governor 6 Clear Days before the meeting save in the case of emergencies.

4.3.2 Before each meeting of the Council of Governors a public notice of the time and place, and if appropriate remote access/electronic communication arrangements, of the meeting, and if possible the public part of the agenda, shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least 6 Clear Days before the meeting, save in the case of emergencies.

4.3.3 Want of service of the notice on any one Governor shall not affect the validity of a meeting but failure to serve such a notice on more than three Governors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

4.3.4 In the case of a meeting called by Governors in default of the Secretary in accordance with SO 4.2.2, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the requisition.

4.3.5 Agendas will be sent to Governors before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than 6 Clear Days before the meeting, save in the case of emergencies.

4.3.6 In the event of an emergency giving rise to the need for an immediate meeting, failure to comply with the notice periods referred to in SOs 4.3.1 and 4.3.5 shall not prevent the calling of or invalidate such meeting provided that every effort is made to contact members of the Council of Governors who are not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

4.4 Annual meeting

4.4.1 In accordance with SO 4.2.1.1, the Council of Governors shall hold an annual meeting every Financial Year and shall present to that meeting:

4.4.1.1 A report on the proceedings of its meetings held since the last annual meeting;

4.4.1.2 A report on the progress since the last annual meeting in developing the membership strategy including the steps taken to ensure that the actual membership of the Public Constituency is representative of the persons who are eligible to be Members under the Constitution;

4.4.1.3 A report on any change to the Governors which has taken place since the last annual meeting; and

4.4.1.4 A report containing such comments as it wishes to make regarding the performance of the Trust and the accounts of the Trust for the preceding Financial Year and the future service development plans of the Trust.

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4.5 **Setting the agenda**

4.5.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted ("Standing Items").

4.5.2 A member of the Council of Governors desiring a matter other than a Standing Item to be included on an agenda, including a formal motion for discussion and voting on at a meeting, shall make his request in writing to the Chair at least 10 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

4.6 **Petitions**

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Council of Governors.

4.7 **Chair of meeting**

4.7.1 At any Council of Governors meeting, the Chair, if present, shall preside.

4.7.2 If the Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair shall preside.

4.7.3 If the Deputy Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director as shall be appointed by the Council of Governors for that meeting shall preside. If a Non-Executive Director is unavailable, the meeting shall appoint from amongst those present a member to preside.

4.7.4 If the Chair or Deputy Chair of the Trust and a Non-Executive Director is absent or unavailable to chair the meeting, those present at the meeting shall nominate a Governor to preside at the meetings of the Council of Governors and the person chairing the meeting shall have a second or casting vote.

4.8 **Motions**

4.8.1 Where a Governor has requested inclusion of a matter on the agenda in accordance with SO 4.5.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this SO 4.8 shall apply in respect of the motion:

4.8.2 The mover of the motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.8.3 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

4.8.3.1 an amendment to the motion; or

4.8.3.2 the adjournment of the discussion or the meeting; or

4.8.3.3 that the meeting proceed to the next business; or

4.8.3.4 the appointment of an ad hoc committee to deal with a specific item of business; or

4.8.3.5 that the motion be now put; or

4.8.3.6 that the public be excluded from the meeting in relation to the discussion concerning the motion under SO 4.1.1.

4.8.4 In the case of SOs 4.8.3.3 and 4.8.3.5 above, to ensure objectivity these matters may only be put by a Governor who has not previously taken part in the debate and who is eligible to vote.

4.8.5 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.8.6 The mover of a motion shall have a maximum of five minutes to move and three minutes to reply. Once a motion has been moved, no Governor shall speak more than once or for more than three minutes.

4.9 **Report from the Board of Directors**

Unless otherwise agreed in writing, at each meeting of the Council of Governors, the Board of Directors through the Chair is required to report to the Council of Governors on the Trust's general progress forward and forward planning.

4.10 **Chair's ruling**

Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.11 **Voting**

4.11.1 A Governor may not vote at a meeting of the Council of Governors unless, within 10 Clear Days prior to the commencement of the meeting he has made a declaration in the form specified within Schedule A of these SOs, that they are a member of the constituency which elected them and is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution.

4.11.2 Subject to SO 4.11.4 below, every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and the Governors present and voting on the question.

4.11.3 Whoever is chair of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal have a second or casting vote.

4.11.4 A resolution for the removal of the Chair or a Non-Executive Director shall be passed only if three-quarters of the total number of Governors vote in favour of it.

4.11.5 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request. In the event of a meeting held using electronic communication, an electronic voting facility will be made available, including when appropriate, the facility for holding a secret ballot.

4.11.6 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

4.11.7 If a Governor so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

4.11.8 A Governor may only vote if present (either in person or by electronic communication) at the time of the vote on which the question is to be decided; no Governor may vote by proxy but a Governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote.

4.11.9 In certain circumstances the Chair may specify in a notice of a meeting any matter which requires approval by a written resolution and such a matter may be approved in writing provided that at least three-quarters of the Governors, and a majority of Governors who are members of the Public Constituency of the Trust, approve the resolution in writing within the timescale imposed in such a notice having regard to paragraph 13.5 above. For the avoidance of doubt, governors who are absent due to an agreed absence (as defined in paragraph 13.5) and governors not eligible to vote because of a declared interest do not count towards the voting calculation.

4.11.10 All decisions taken in good faith at the meeting of the Council of Governors or at any meeting of a committee shall be valid, even if it is subsequently discovered that there was a defect in the calling of the meeting or the appointment of the Governors attending the meeting or any other matter.

4.12 **Special Provisions relating to termination of Governor's tenure**

4.12.1 Where a person has been elected or appointed to be a Governor and he becomes disqualified from office under this SO or under paragraph 13 or the provisions of Appendix 1 of Annex 5 of the Constitution, he shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of the first becoming aware of those matters which render them disqualified. The Secretary shall forthwith remove them from the Register of members of the Council of Governors with immediate effect subject to any other provisions.

4.12.2 If it comes to the notice of the Secretary that the Governor is disqualified pursuant to SO 4.12.1, whether at the time of the Governor's appointment or (as the case may be) election, or later, the Secretary shall immediately declare that the individual in question is disqualified and give them notice in writing to that effect as soon as practicable and in any event within 14 days of the date of the said declaration. In the event that the Governor shall dispute that they are disqualified the Governor may refer the matter to the dispute resolution procedure set out in paragraph 2.2 of Appendix 4 of Annex 8 of the Constitution within 14 days of the date upon which the notice was given to the Governor.

4.12.3 The Chair shall be authorised to take such action as may be immediately required, including but not limited to exclusion of the Governor concerned from the meeting so that any allegation made against a Governor on the following grounds can be investigated:

4.12.3.1 non-compliance with the core principles of the NHS as set out in Appendix 1 of Annex 8, the Authorisation, the Governors' Code of Conduct, or the SOs; or

4.12.3.2 failure to declare an interest as required by the Constitution or these SOs, or if the Governor in question has spoken or voted at a meeting on a matter in which he has an interest contrary to the Constitution or SOs in accordance with paragraph 13.6.5 of the Constitution.

4.12.4 Where any grounds within SO 4.12.3 are alleged, it shall be open to the Council of Governors to decide, by three-quarters of those present and voting, to lay a formal charge of non-compliance or misconduct.

4.12.5 The Governor in question will be notified in writing of the allegations and grounds upon which the charges referred to in SO 4.12.3 are made inviting his response within 14 calendar days. Any response the Governor in question makes should be submitted to the chair or the Company Secretary and not individual Governors.

4.12.6 The Governor may be invited to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence.

4.12.7 The Governors, by three-quarters majority of those present and voting and a majority of Governors who are members of the Public Constituency of the Trust, can decide whether to uphold the charge.

4.12.8 . Should the Governors uphold the charge in accordance with SO 4.12.7, the Governors can impose such sanctions as shall be deemed appropriate, such sanctions may include but are not limited to the issuing of a written warning as to the Governor's future conduct and consequences, to non-payment of expenses and suspension or removal of the Governor from office.

4.12.9 Upon disqualification, removal or termination of a Governor's office under this SO, the Secretary shall cause his name to be removed immediately from the register of members of the Council of Governors.

4.12.10 Any decision of the Council of Governors to terminate a Governor's tenure of office may be referred by the Governor concerned to the Dispute Resolution Procedure set out in paragraph 2.2 of Appendix 4 of Annex 8 of the Constitution within 14 days of the date upon which notice in writing of the Council of Governor's decision made in accordance with SOs 4.12.7 and 4.12.8 is communicated to the Governor concerned.

4.12.11 A Governor may resign from that office at any time during the term of that office by giving notice to the Secretary in writing, upon which he shall cease to hold office.

4.12.12 A Governor who resigns under SO 4.12.11 above or whose office is terminated under this SO or paragraph 13 of the Constitution shall not be eligible to stand for re-election to the Council of Governors for a period of five years from the date of his resignation or removal from office or the date upon which any appeal against his removal from office is disposed of whichever is later.

4.12.13 Where a vacancy arises on the Council of Governors, the provisions of paragraph 2 of Appendix 4 of Annex 5 of the Constitution shall apply.

4.13 Minutes

4.13.1 The minutes of the proceedings of a meeting shall be drawn up by the Secretary and submitted for agreement at the next ensuing meeting where they will be signed by the Chair.

4.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

4.13.3 Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.14 Suspension of Standing Orders

4.14.1 Except where this would contravene any provision of the Regulatory Framework or any guidance or best practice advice issued by NHS England, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Governors are present, there is a majority of Governors who are members of the Public Constituency, and that a majority of those present vote in favour of suspension.

4.14.2 A decision to suspend the SOs shall be recorded in the minutes of the meeting.

4.14.3 A separate record of matters discussed during the suspension of the SOs shall be made and shall be available to the Chair and Governors.

4.14.4 No formal business may be transacted while the SOs are suspended.

4.16 **Record of attendance**

The names of the Chair and Governors present at the meeting shall be recorded in the minutes.

4.17 **Quorum**

4.17.1 No business shall be transacted at a meeting unless at least one-third of the total number of Governors is present with a majority of those present being Public Governors.

4.17.2 If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for a minimum of 5 Clear Days to a maximum of 20 Clear Days and upon reconvening, those present shall constitute a quorum.

4.17.3 If a Governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest as provided in SO 7 he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5 LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR

5.1 The Lead Governor and/or a Deputy Lead Governor shall be elected/re-appointed by their peers at the last general meeting of the Council of Governors held prior to the expiry of the incumbent Lead Governor's term of office in their capacity as Lead Governor.

5.2 The Lead Governor and the Deputy Lead Governor must be elected governors.

5.3 Without prejudice to the rights of any Governor to communicate directly with the Chair, the lead Governor shall be responsible for receiving from Governors and communicating to the Chair any comments, observations and concerns expressed to them by Governors other than at meetings of the Council of Governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business.

5.4 The deputy lead Governor shall be responsible for supporting the lead Governor in his role and for performing the responsibilities of the lead Governor whenever they are known to be unavailable.

5.5 Each Governor shall communicate any comment, observation or concern which he may have to the lead Governor in the first instance and only to the deputy lead Governor if the lead Governor is known to be unavailable.

5.6 The appointment as Lead Governor shall be effective for two years or (if earlier):

- until that person resigns the position of Lead Governor by giving notice to the chair in writing; or

- until that person is removed from the position of Lead Governor by a resolution passed by three quarters of the remaining governors at a general meeting of the Council of Governors.

5.7 Nominations for appointment as lead Governor and deputy lead Governor shall be sent out with the papers for the annual meeting of the Council of Governors. Each nomination shall be made in writing by the Governor seeking appointment and must be returned to the Trust Headquarters addressed to the Secretary to arrive 3 Clear Days before the meeting.

5.8 There shall be separate forms of nomination for appointment to the position of lead Governor and the position of deputy lead Governor and eligible Governors may be nominated for both positions.

5.9 In the event of there being two or more nominations for either appointment a secret ballot shall be held of all the Governors present at the meeting with each Governor present having one vote for each contested appointment.

5.10 The meeting shall adjourn while the ballot is taken and the Governor whose nomination receives the largest number of votes for each position shall be appointed.

5.11 In the event of an equality of votes the Chair of the meeting shall have a second or casting vote.

5.12 If a Governor shall receive the largest number of votes for appointment as both lead Governor and deputy lead Governor that Governor shall be appointed as lead Governor and the Governor who received the second largest number of votes for the position of deputy lead Governor shall be appointed as deputy lead Governor

5.13 The result of the ballot shall be announced at the meeting.

6 COMMITTEES

6.1 Subject to any guidance or best practice advice as may be issued by NHS England, the Council of Governors may and, if directed by NHS England, shall appoint committees of the Council of Governors to assist it in the proper performance of its functions under the Regulatory Framework, consisting wholly or partly of the Chair, Governors, and others.

6.2 A committee appointed under SO 6 may, subject to such directors as may be given by the Council of Governors, appoint sub-committee consisting wholly or partly of members of the committee.

6.3 These SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms “Chair” to be read as a reference to the Chair of the committee, and the term “Governor” to be read as a reference to a member of the committee as the context permits.

6.4 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the Regulatory Framework and any best practice advice and/or guidance issued by NHS England, but the Council of Governors shall not delegate

to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.

6.5 Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

6.6 Any committee or sub-committee established under this SO 6 may call upon outside advisers to assist them with their tasks, subject to the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the Dispute Resolution Procedure as set out at paragraph 2.2 of Appendix 4 of Annex 8 of the Constitution.

6.7 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

6.8 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with best practice advice and/or guidance issued by NHS England.

6.9 Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.

6.10 The Council of Governors may appoint members to serve on joint committees with the Board of Directors or committees of the Board of Directors on the request of the Chair.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 Declaration of interests

7.1.1 The Regulatory Framework requires each Governor to declare to the Secretary:

7.1.1.1 any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust, as described in SO 7.2.1; and

7.1.1.2 any actual or potential pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, as described in SOs 7.2.2 and 7.2.3; and

7.1.1.3 any actual or potential family interest, direct or indirect, of which the Governor is aware, as described in SO 7.2.5.

7.1.2 Such a declaration shall be made either at the time of the Governor's election or appointment or as soon thereafter as the interest arises, but within 5 Clear Days of becoming aware of the existence of that interest,

and in a form prescribed by the Secretary which is in the form included as Schedule B to these SOs.

7.1.3 In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

7.1.4 Subject to SO 7.2.4, if a Governor has declared a pecuniary interest (as described in SOs 7.2.2 and 7.2.3) he shall not take part in the consideration or discussion of the matter. At the time the interests are declared, they should be recorded in the Governor's meeting minutes.

7.1.5 This SO 7 applies to any committee, sub-committee or joint committee of the Council of Governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not they are also a Governor).

7.1.6 The interests of Governors in companies likely or possibly seeking to do business with the Trust should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

7.2 **Nature of interests**

7.2.1 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by NHS England:

7.2.1.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies); or

7.2.1.2 ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust; or

7.2.1.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the Trust; or

7.2.1.4 a position of authority in a charity or Voluntary Organisation in the field of health and social care; or

7.2.1.5 any connection with a voluntary or other organisation contracting for Trust services or commissioning Trust services; or

7.2.1.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

7.2.2 A Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.2.2.1 they, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

7.2.2.2 they are a partner of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

7.2.3 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.2.3.1 of his membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

7.2.3.2 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

7.2.3.3 of any travelling or other expenses or allowances payable to a Governor in accordance with the Constitution.

7.2.4 Where a Governor:

7.2.4.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

7.2.4.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

7.2.4.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty to disclose his interest.

7.2.5 A family interest is an interest of an Immediate Family Member the spouse or partner or any parent, child, brother or sister of a Governor which if it were the interest of that Governor would be a personal interest or a pecuniary interest of his.

7.2.6 If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.3 Register of members of the Council of Governors

The register of members of the Council of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted which may be the Secretary.

7.4 Register of interests of members of the Council of Governors

The Secretary shall keep a register of interests of members of the Council of Governors which shall contain the names of each Governor, whether they have declared any interest, and if so, the interest declared.

8 STANDARDS OF BUSINESS CONDUCT

Members of the Council of Governors shall comply with the Governors' Code of Conduct and any best practice advice and/or guidance issued by NHS England. Failure to do so may result in action as defined by section 4.12.3 above.

9 APPOINTMENTS AND RECOMMENDATIONS

9.1 A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment but this paragraph of this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

9.2 Informal discussions outside nominations panels, appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

9.3 Every Governor shall disclose to the Chief Executive or his delegated officer any relationship between theirselves and a candidate of whose candidature that Governor or Officer is aware. It shall be the duty of the Chief Executive or his delegated Officer to report to the Council of Governors any such disclosure made.

9.4 On appointment, members of the Council of Governors should disclose to the Council of Governors whether they are related to any other member of the Council of Governors or holder of any office in the Trust.

9.5 Where the relationship to a member of the Council of Governors of the Trust is disclosed, SO 7 shall apply.

10 MISCELLANEOUS

10.1 The Secretary shall provide a copy of these SOs to each Governor and endeavour to ensure that each Governor understands his responsibilities within these SOs.

10.2 These SOs including all documents having effect as if incorporated in them shall be reviewed at least every three years by the Board of Directors and the Council of Governors.

10.3 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the Chair and / or the Company Secretary. Once reported, provisions within paragraph 4.12 above will apply. All Governors have a duty to disclose any non-compliance with these SOs to the Chair as soon as possible'.

Schedule A

Declaration to the Secretary of Great Western Hospitals NHS Trust Foundation Trust

I hereby declare that I am at the date of this declaration a member of the [Public/Staff] constituency, and I am not prevented from being a member of the Council of Governors by reason of any provision of paragraph 8 of Schedule 7 to the 2006 Act or the Trust's Constitution.

Schedule B

Prescribed Form of Declaration of Interests

Declaration to the Secretary of Great Western Hospitals NHS Foundation Trust

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Date [insert]

To the Secretary of Great Western Hospitals NHS Foundation Trust

Dear [insert]

In fulfilment of the obligations imposed on me by paragraph 16 of the Constitution of the Trust and the provisions of Standing Order 7 of the Standing Orders for Governors generally, and in particular Standing Order 7.1.2, I hereby give notice to the Trust of my interest in **[**insert details of the nature and extent of the relevant interest(s) (e.g. pecuniary, non pecuniary, direct, indirect, actual, potential, etc.)**]** as of the date posted above.

I require the nature and extent of my interest(s) to be recorded in the Trust's register of interests of the members of the Council of Governors.

Yours faithfully

[name]

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 25)

1 INTRODUCTION

1.1 Statutory Framework

1.1.1 The Great Western Hospitals NHS Foundation Trust became a Public Benefit Corporation on 1 December 2008 following authorisation by NHS England (formerly Monitor) pursuant to the 2006 Act.

1.1.2 The principal place of business of the Trust is at the Great Western Hospital, Marlborough Road, Swindon, Wiltshire SN3 6BB ("Trust Headquarters").

1.1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework and in particular paragraph 25 of the Constitution, requires the Board of Directors to adopt Standing Orders ("SOs") for the regulation of its proceedings and business.

1.1.4 As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.1.5 The SOs, Scheme of Delegation and SFIs provide a comprehensive business framework for the administration of the Trust's affairs, and these need to be read in conjunction with the Regulatory Framework. All Directors and Nominated Officers should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions contained within them.

1.1.6 The Trust shall deal with NHS England in an open and co-operative manner and shall promptly notify Monitor of anything relating to the Trust of which NHS England would reasonably expect prompt notice, including, without prejudice to the foregoing generality, any financial or performance thresholds which NHS England may specify from time to time.

1.1.7 The Chair, Chief Executive or any other person giving information to the public on behalf of the Trust shall ensure that they follow the principles set out by the Committee on Standards in Public Life (the Nolan Committee, now the Wicks Committee) and that they will adhere to the principles set out within the Independent Commission's Good Governance Standard for Public Service. They will also ensure that they follow the best practice advice set out in the Code of Governance for NHS Providers (October 2022) with effect from April 2023 published by NHS England.

1.2 **Delegation of Powers – Scheme of Delegation**

Under SO 4 (Arrangements for the Exercise of Functions by Delegation) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee of the Board of Directors appointed by virtue of SO 5 or by an Executive Director of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit. Delegated Powers are covered in the Scheme of Delegation.

1A INTERPRETATION

1A.1 Save as otherwise permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive and Secretary).

1A.2 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SOs shall bear the same meaning as in the Constitution.

1A.3 The provisions of paragraphs 38.2 to 38.5 of the Constitution apply to these SOs, save that any reference to "Constitution" shall be read as a reference to these SOs.

1A.4 In these SOs:

“Clear Days”
means a day of the week not including a Saturday, Sunday or Public Holiday;

"Funds Held on Trust"
means those funds which the Trust holds at its date of Authorisation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Section 47(2)(c) of the 2006 Act. Such funds may or may not be charitable;

"Nominated Officer"
means an Officer (as defined in paragraph 2.3 of Annex 6 of the Constitution) charged with the responsibility for discharging specific tasks within the SOs, Scheme of Delegation, or the SFIs;

“Scheme of Delegation”
means the Reservation of Powers to the Board of Directors and Delegation of Powers; and

"SFIs"
means the Trust's Standing Financial Instructions, which regulate the conduct of Directors and Nominated Officers in relation to all financial matters with which they are concerned.

2 THE TRUST BOARD

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee. Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees.

2.3 In relation to Funds Held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust. Accountability for charitable Funds Held on Trust is to be made to the Charity Commission.

2.4 The Trust has the functions conferred on it by the Regulatory Framework. Accountability for non-charitable Funds held on Trust is to NHS England.

2.5 The powers of the Trust established under the Regulatory Framework shall be exercised by the Board of Directors.

2.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation.

2.7 **Composition of the Board of Directors**

2.7.1 In accordance with the paragraph 19 of the Constitution, the Board of Directors is to comprise:

2.7.1.1 The following Non-Executive Directors:

2.7.1.2 the Chair, and a minimum of four and a maximum of eight other Non-Executive Directors; and

2.7.2 a minimum of four and a maximum of seven Executive Directors, including:

2.7.2.1 the Chief Executive who shall be the Accounting Officer;

2.7.2.2 theChief Financial Officxer;

2.7.2.3 a registered medical practitioner (within the meaning of the Medical Act 1983) or a registered dentist (within the meaning of the Dentists Act 1984); and

2.7.2.4 a registered nurse or midwife (within the meaning of the Nursing and Midwifery Order (SI 2002/253).

2.7.3 In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in his absence Deputy Chair) shall have a second or casting vote at meetings of the Board of Directors.

2.7.4 A person may only be appointed as a Non-Executive Director if:

2.7.4.1 they area member of the Public Constituency; and

2.7.4.2 they are not disqualified by virtue of paragraph 24 of the Constitution.

2.7.5 The validity of any act of the Board of Directors is not affected by any vacancy among the Directors or defect in the appointment of a Director.

2.7.6 The Board of Directors (in consultation with the Council of Governors) may appoint any independent Non-Executive Director as the "senior independent director", for such period not exceeding the remainder of his term as a Non-Executive Director, as they may specify on appointing them.

2.7.7 Any Non-Executive Director so appointed may at any time resign from the office of "senior independent director" by giving notice in writing to the Chair. The Board of Directors (in consultation with the Council of Governors) may thereupon appoint another independent Non-Executive Director as "senior independent director" in accordance with the provisions in SO 2.7.6.

2.7.8 The “senior independent director” shall perform the role set out in the best practice advice in the Code of Governance for NHS Providers (2022, effective April 2023) (issued by NHSEngland).

2.8 **Register of members of the Board of Directors**

In accordance with paragraph 29.4 of the Constitution, the Trust shall keep and maintain a register of members of the Board of Directors, which shall list the names of the Directors, their capacity on the Board of Directors and an address through which they may be contacted which may be the Secretary.

2.9 **Appointment and removal of the Chair and other Non-Executive Directors**, including Associate Non-Executive Directors

2.9.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors, including Associate Non-Executive Directors.

2.9.2 Removal of the Chair or another Non-Executive Directors, including Associate Non-Executive Directors shall require approval of three-quarters of the members of the Council of Governors.

2.10 **Remuneration and terms of office of the Chair and Non-Executive Directors**, including Associate Non-Executive Directors

2.10.1 The Chair and the Non-Executive Directors, including Associate Non-Executive Directors are to be appointed for a period of office determined by the Council of Governors at general meeting of the Council of Governors not exceeding 3 years.

2.10.2 At the general meeting of the Council of Governors referred to at SO 2.10.1, the Council of Governors shall decide the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors, including Associate Non-Executive Directors.

2.11 Appointment and powers of Deputy Chair

2.11.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors may appoint a Non-Executive Director to be Deputy Chair for such a period, not exceeding the remainder of his term as a Non-Executive Director, as the Council of Governors may specify on appointing them.

2.11.2 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Council of Governors. The Council of Governors may thereupon appoint another Non-Executive Director as Deputy Chair in accordance with the provisions of SO 2.11.1.

2.11.3 Where the Chair of the Trust has died or has ceased to hold office, or where he has been unable to perform his duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes his duties, as the case may be; and references to the Chair in these SOs shall, so long as there is no Chair able to perform his duties, be taken to include references to the Deputy Chair. Where both the Chair and Deputy Chair are unable to perform their duties owing to illness, conflict of interest or any other cause, another Non-Executive Director as may be appointed by the Council of Governors shall act as Chair.

2.12 Appointment and removal of Chief Executive and other Executive Directors

2.12.1 Subject to the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors, the Non-Executive Directors shall appoint or remove the Chief Executive.

2.12.2 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

2.13 Remuneration and terms of office of the Chief Executive and Executive Directors

2.13.1 The Trust shall establish a committee of Non-Executive Directors in accordance with SO 5 to decide the remuneration and allowances, and the other terms and conditions of office of the Chief Executive and other Executive Directors.

2.14 Disqualification

Directors are subject to the disqualification criteria included at paragraph 24 of the Constitution.

3 MEETINGS OF THE TRUST

3.1 Admission of the public and the press

3.1.1 Meetings of the Board of Directors shall be held in public and the public and representatives of the press shall be afforded facilities to attend such meetings of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

"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".

3.1.2 The Chair shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public".

3.1.3 Nothing in these SOs shall require the Board of Directors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board of Directors.

3.2 Calling meetings

3.2.1 Subject to SO 3.2.2 below, meetings of the Board of Directors shall be held at such times and places and in such format as the Board of Directors may, in its absolute discretion, determine.

3.2.2 The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Board of the Directors, and this has been presented to them, or if, without so refusing, the Chair does not call a meeting within 6 days after such requisition has been presented to them, at the Trust's Headquarters, such one-third or more members of the Board of Directors may forthwith call a meeting for the purpose of conducting that business.

3.3 Notice of meetings

3.3.1 Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair, or by an Officer of the Trust authorised by the Chair to sign on his behalf, shall be delivered to every Director, or sent by post to the usual

place of residence of every Director, so as to be available to them at least 3 Clear Days before the meeting, save in the case of emergencies.

3.3.2 Want of service of the notice on any member of the Board of Directors shall not affect the validity of a meeting, but failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

3.3.3 In the case of a meeting called by the Directors in default of the Chair in accordance with SO 3.2.2 above, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the requisition.

3.3.4 In the event of an emergency giving rise to the need for an immediate meeting of the Board of Directors, failure to comply with the notice periods in SOs 3.3.1 to 3.3.4 shall not prevent the calling of, or invalidate, such a meeting provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.3.5 Before a public meeting of the Board of Directors, a public notice of the time and place and format of the meeting, and the public part of the agenda, shall be displayed at the Trust's Headquarters and advertised on the Trust's website at least 3 Clear Days before the meeting, save in the case of emergencies.

3.4 **Agendas and supporting papers**

Agendas will be sent to members of the Board of Directors 3 Clear Days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in emergency giving rise to the need for an immediate meeting as set out in SO 3.3.5 above. Failure to serve the agenda and (where relevant) supporting papers on more than three members of the Board of Directors will invalidate the meeting. An agenda and supporting papers shall be presumed to have been served one day after posting and in the case of by electronic communication on the day it is sent.

3.5 **Setting the agenda**

3.5.1 The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors.

3.5.2 A Director desiring a matter to be included on an agenda, other than a Standing Item, or a motion under SO 3.10 (emergency motion), including a formal motion for discussion and voting, shall make his request in writing to the Chair at least 10 days before the meeting. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

3.6 **Petitions**

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Board of Directors.3.7 **Chair of meeting**

3.7.1 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and they are present, shall preside. If the Chair and Deputy Chair are absent, such Non-Executive Director as the members of the Board of Directors present shall choose, shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such Non-Executive Director as the members of the Board of Directors present shall choose, shall preside.

3.8 **Chair's ruling**

Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.9 **Notices of motion**

3.9.1 Notwithstanding the provisions of SO 3.5 above, and subject to the provisions of SO 3.11 (Motions: procedure at and during a meeting) and SO 3.12 (motion to rescind a resolution) below, a member of the Board of Directors wishing to move or amend a motion shall send a written notice to the Chair.

3.9.2 The notice shall be delivered at least 10 days before the meeting. The Chair shall include in the agenda for the meeting all notices so received that are in order and permissible under these SOs. Subject to SO 3.3.3, this SO shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meeting.

3.10 **Emergency motions and written motions**

3.10.1 **Emergency motions**

Subject to the agreement of the Chair, and subject also to the provisions of SO 3.11 (Motions: Procedure at and during a meeting), a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.10.2 **Written motions**

3.10.2.1 In urgent situations and with the consent of the Chair, business may be affected by a Director's written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.

3.10.2.2 If all members of the Board of Directors have been notified of the proposal and a simple majority of Directors entitled to attend and vote at a meeting of the Board of Directors confirms acceptance of the written motion either in writing or electronically to the Secretary within 5 Clear Days of dispatch then the motion will be deemed to have been resolved notwithstanding that the Directors have not gathered in one place.

3.10.2.3 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date a Director who has previously indicated acceptance can withdraw and the motion shall fail.

3.10.2.4 Once the resolution is passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

3.11 **Motions: procedure at and during a meeting**

3.11.1 **Who may propose**

A motion properly notified under SO 3.9 above may be proposed by the Chair of the meeting or any member of the Board of Directors present at the meeting. It must also be seconded by another member of the Board of Directors.

3.11.2 **Contents of motions**

The Chair may exclude from the debate at his discretion any motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

3.11.2.1 the reception of a report;

3.11.2.2 consideration of any item of business before the Board of Directors;

3.11.2.3 the accuracy of minutes;

3.11.2.4 that the Board of Directors proceed to next business;

3.11.2.5 that the Board of Directors adjourn;

3.11.2.6 that the question be now put.

3.11.3 **Amendments to motions**

3.11.3.1 A motion for amendment shall not be discussed unless it has been proposed and seconded.

3.11.3.2 Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors.

3.11.3.3 If there are a number of amendments proposed and seconded to a motion, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.11.4 **Rights of reply to motions**

3.11.4.1 **Amendments**

The mover of an amendment to a motion may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

3.11.4.2 **Substantive/original motion**

The member of the Board of Directors who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.11.5 **Withdrawing a motion**

A motion, or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.11.6 **Motions once under debate**

3.11.6.1 When a motion is under debate, no motion may be moved other than:

3.11.6.1.1 an amendment to the motion; or

3.11.6.1.2 the adjournment of the discussion, or the meeting; or

3.11.6.1.3 that the meeting proceed to the next business; or

3.11.6.1.4 that the motion should be now put; or

3.11.6.1.5 the appointment of an 'ad hoc' committee to deal with a specific item of business;

3.11.6.1.6 (where relevant) a motion under SO 3.1.2 above resolving to exclude the public (including the press); or

3.11.6.1.7 that a member of the Board of Directors be not further heard.

3.11.6.2 In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

3.11.6.3 If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.11.6.4 The mover of a motion shall have a maximum of 5 minutes to move and 3 minutes to reply. Once a motion has been moved, no member of the Board of Directors shall speak more than once or for more than 3 minutes.

3.12 **Motion to rescind a resolution**

3.12.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of four other members of the Board of Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate committee of the Board of Directors or the Chief Executive for recommendation.

3.12.2 When any such motion has been dealt with by the Board of Directors, it shall not be competent for any member of the Board of Directors, other than the Chair, to propose a motion to the same effect within 6 calendar months. However the Chair may do so if he considers it appropriate. This SO shall not apply to motions moved in pursuance of a report or recommendations of a committee of the Board of Directors or the Chief Executive.

3.13 **Voting**

3.13.1 Subject to SO 3.15 (Suspension of Standing Orders) or as otherwise provided under these SOs, every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

3.13.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands or by

appropriate electronic means. A paper ballot may also be used if a majority of the Directors present so request.

3.13.3 If at least one-third of the members of the Board of Directors present so request, the voting (other than by paper ballot), on any question may be recorded to show how each Director present voted or abstained.

3.13.4 If a Director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

3.13.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.13.6 An Officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.14 Minutes

3.14.1 The minutes of the proceedings of a meeting of the Board of Directors shall be drawn up by the Secretary and submitted for agreement at the next scheduled meeting of the Board of Directors.

3.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting. Minutes shall be retained in the Chief Executive's office.

3.14.3 Board minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public save for items discussed by the Directors following the exclusion of the public and representatives of the press under SOs 3.1.1 and 3.1.2.

3.15 Suspension of Standing Orders

3.15.1 Except where this would contravene any provision of the Regulatory Framework or any guidance or best practice advice issued by NHS England, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

3.15.2 A decision to suspend the SOs shall be recorded in the minutes of the meeting.

3.15.3 A separate record of matters discussed during the suspension of the SOs shall be made and shall be available to the Directors.

3.15.4 No formal business may be transacted while the SOs are suspended.

3.15.5 The Audit Risk and Assurance Committee shall review every decision to suspend the SOs.

3.17 **Record of attendance**

The names of the Directors present at a meeting of the Board of Directors shall be recorded in the minutes together with the names of any Nominated Officers, Officers, and others invited by the Chair to be in attendance, save for members of the public or representatives of the press.

3.18 **Quorum**

3.18.1 No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors is present including at least one Executive Director and one Non-Executive Director.

3.18.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.18.3 Subject to paragraphs 26.10, 26.11 and 26.12 of the Constitution, if a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict (see S O7) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Remuneration and Terms of Service Committee).

3.19 **Meetings: electronic communication**

3.19.1 In this SO “communication” and “electronic communication” shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

3.19.2 A Director in electronic communication with the Chair and all other parties to a meeting of the Board of Directors or of a committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.19.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically

present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

3.19.4 Meetings held in accordance with this SO are subject to SO 3.18 (Quorum). For such a meeting to be valid, a quorum MUST be present and maintained throughout the meeting.

3.19.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to SO 2.6, the Regulatory Framework and such guidance or best practice advice as may be given by NHS England, the Board of Directors may make arrangements for the exercise of any of its functions by a committee appointed by virtue of SO 4.3 below or by an Executive Director in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

4.2 Emergency powers

The powers which the Board of Directors has retained to itself within these SOs may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 Delegation to committees

The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees of the Board of Directors, which it has formally constituted. The constitution and terms of reference of these committees and their specific executive powers shall be approved by the Board of Directors.

4.4 Delegation to Nominated Officers

4.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate Officers to undertake the remaining functions for which he will still retain accountability to the Board of Directors.

4.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his proposals, which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Finance Director or

other Executive Director to provide information and advise the Board in accordance with any statutory requirements.

4.4.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these SOs.

4.5 Duty to report non-compliance with Standing Orders

If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors and Officers have a duty to disclose any non-compliance with these SOs to the Secretary as soon as possible.

5 COMMITTEES

5.1 Appointment of committees

5.1.1 Subject to SO 2.6, the Regulatory Framework and such guidance or best practice advice issued by NHS England, the Board of Directors may and, if directed by NHS England, shall appoint committees of the Trust consisting wholly or partly of Directors or wholly of persons who are not Directors of the Trust.

5.1.2 A committee appointed under SO 5.1.1 may, subject to such guidance and/or best practice advice as may be issued by NHS England or the Board of Directors, appoint sub-committees consisting wholly or partly of Directors (whether or not they are Directors of the Trust in question) or wholly of persons who are not Directors of the Trust.

5.1.3 The SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees (and any sub-committees appointed under SO 5.1.2) established by the Board of Directors, in which case the term “Chair” is to be read as a reference to the Chair of the committee (or sub-committee) as the context permits, and the term “member" is to be read as a reference to a member of the committee also as the context permits.

5.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide in accordance with any legislation and/or regulations and such guidance or best practice advice issued by NHS England. Such terms of reference shall have effect as if incorporated into the SOs.

5.1.5 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

5.1.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms

of such appointment shall be within the powers of the Board of Directors as defined by the Regulatory Framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses.

5.1.7 The committees established by the Board of Directors are:

5.1.7.1 Audit Risk and Assurance Committee;

5.1.7.2 Remuneration Committee; and

5.1.7.3 Mental Health Governance Committee

5.1.8 The terms of reference of those committees shall be agreed by the Board of Directors.

5.1.9 Notwithstanding the provisions of SO 5.1.7 above, the Board of Directors may establish other committees from time to time at its discretion.

5.2 **Joint Committees**

5.2.1 Joint committees may be appointed by the Trust, by joining together with one or more other trusts, consisting of wholly or partly of the Chair and Directors of the Trust or other health service bodies, or of Directors of the Trust with non-directors of other health bodies in question.

5.2.2 Any Committee-in-Common or Joint Committee appointed under standing orders may, subject to such directions or guidance as may be given by NHS England or the Trust or any other health bodies in question, appoint sub-committees consisting wholly or partly of directors sitting on the Committee or Joint Committee (whether or not they are directors of the other health bodies in question) or wholly of persons who are not directors of the other health bodies in question provided that the Trust is always represented by an Executive Director (or deputy nominated by the Executive Director) on such Committees, Joint Committees or sub committees.

5.3 **Confidentiality**

5.3.1 A member of a committee (including sub-committees or joint committees) shall not disclose a matter dealt with by, or brought before the committee, sub-committee or joint committee without its permission until the committee, sub-committee or joint committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.3.2 A Director or a member of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, sub-committee or joint committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee, sub-committee or joint committee shall resolve that it is confidential.

6 INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

6.1 The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the Regulatory Framework in all respects and in

particular in relation to the following matters which are set out specifically within the Constitution:

6.1.1 The Directors, having regard to the views of the Council of Governors, are to prepare Forward Plan in respect of each Financial Year to be given to NHS England;

6.1.2 The Directors are to present to the Council of Governors at a general meeting the Annual Accounts, any report of the Auditor on them, and the Annual Report;

6.2 The Annual Report is to give:

6.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its Public Constituency is representative of those eligible for such membership; and

6.2.2 any other information which NHS England requires.

6.3 In order to comply with the Regulatory Framework in all respects and in particular in relation to the matters which are set out above, the Council of Governors may request that a matter which relates to paragraphs 35 and 36 of the Constitution is included on the agenda for a meeting of the Board of Directors.

6.4 If the Council of Governors so desires such a matter as described within SO 6.3 to be included on an agenda item, they shall make their request in writing to the Chair at least 10 days before the meeting of the Board of Directors, subject to SO 3.3. The Chair shall decide whether the matter is appropriate to be included on the agenda. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS OF THE MEMBERS OF THE BOARD OF DIRECTORS

7.1 Subject to paragraphs 26.8 and 26.9 of the Constitution members of the Board of Directors are required to declare:

7.1.1 any pecuniary interest in any contract, proposed contract or other matter which is under consideration or is to be considered by the Board of Directors; and

7.1.2 any interests including but not limited to any personal or family interests which are relevant and material to the business of the Trust,

irrespective of whether those interests are direct or indirect, actual or potential.

7.2 All members of the Board of Directors must declare such interests as soon as the Director in question becomes aware of it. Any members of the Board of Directors appointed subsequently to the date of Authorisation must do so on appointment.

7.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the Constitution or the SOs and delivering it to

the Secretary on appointment or as soon thereafter as the interest arises, but within 5 Clear Days of becoming aware of the existence of a relevant and material interest.

7.4 In addition, if a Director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting, and as soon as practicable after its commencement, disclose the fact and he must then withdraw from the meeting and play no part in the relevant discussion and he shall not vote on any question with respect to the matter. The requirements of this SO 7.4 are subject to paragraphs 26.8, 26.9 and 26.10 of the Constitution.

7.5 If a Director has declared a pecuniary interest in accordance with SO 7.9 below, he shall not take part in the consideration or discussion of the matter in respect of which an interest has been disclosed and shall be excluded from the meeting whilst that proposed contract is under consideration. At the time the interests are declared, they should be recorded in the Director's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

7.6 Subject to paragraphs 26.8 and 26.9 of the Constitution and any guidance or best practice advice issued by NHS England, interests which should be regarded as "relevant and material" for the purposes of these SOs are:

7.6.1 directorships, including non-executive directorships held in private companies or public listed companies (with the exception of those of dormant companies);

7.6.2 ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust;

7.6.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the Trust;

7.6.4 a position of authority in a charity or Voluntary Organisation in the field of health and social care;

7.6.5 any connection with a voluntary or other organisation contracting for Trust services or commissioning Trust services;

7.6.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

7.7 Members of the Board of Directors who hold directorships in companies likely or possibly seeking to do business with the Trust should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

7.8 Subject to paragraphs 26.8 and 26.9 of the Constitution a Director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.8.1 they, or a nominee ofthem, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to

be made or which has a direct pecuniary interest in the other matter under consideration; or

7.8.2 they are partner of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

7.9 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.9.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

7.9.2 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.10 Where a Director:

7.10.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

7.10.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

7.10.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class.

the Director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty to disclose his interest in accordance with the Constitution.

7.11 In the case of persons living together, the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of the Constitution and the SOs to be also an interest of the other.

7.12 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.13 Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 of Schedule 7 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this SO.

7.14 SO 7 applies to any committee, sub-committee or joint committee of the Board of Directors and applies to any member of any such committee, sub-committee or joint committee (whether or not they are also a Director).

7.15 **Register of interests of the members of the Board of Directors**

7.15.1 The register of interests of the members of the Board of Directors shall contain the names of each Director, whether he has declared any interests and, if so, the interests declared in accordance with the Constitution or these SOs.

7.15.2 In accordance with SO 7.3 above, it is the obligation of the Director to inform the Secretary in writing within 5 Clear Days of becoming aware of the existence of a relevant or material interest. The Secretary must then amend the register of interests of members of the Board of Directors upon receipt of new or amended information as soon as is practical and, in any event, within 14 days of receipt.

7.15.3 The register of interests of the members of the Board of Directors will be available to the public in accordance with paragraph 30 of the Constitution.

8 STANDARDS OF BUSINESS CONDUCT

8.1 **Policy**

8.1.1 Directors and (where relevant) Nominated Officers should comply with the Directors' Code of Conduct and any guidance or best practice advice issued by NHS England. This section of SOs should be read in conjunction with these documents.

8.2 **Interest of Directors and Officers in contracts**

8.2.1 If it comes to the knowledge of Director or an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or Secretary of the fact that they are interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.2.2 A Director or Officer must also declare to the Chief Executive or Secretary any other employment or business or other relationship of his, or of an Immediate Family Member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust in accordance with SO 7. The Trust shall require such interests to be recorded in the register interests of members of the Board of Directors.

8.2.3 The provisions of this SO 8.2 are subject to paragraphs 26.8 and 26.9 of the Constitution.

8.3 **Canvassing of, and recommendations by, Directors in relation to appointments**

8.3.1 Canvassing of Directors or members of any committee, sub-committee or joint committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these SOs shall be included in application forms or otherwise brought to the attention of candidates.

8.3.2 A Director shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.3.3 Informal discussions outside nomination panels, appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

8.4 Relatives of Directors or Officers

8.4.1 Directors and Officers shall bear in mind that candidates for any staff appointment shall when making an application disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4.2 Directors and Officers shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

8.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) must disclose to the Secretary whether they are related to any other member of the Board of Directors or holder of any office in the Trust.

8.4.4 Where the relationship to an Officer or another Director to a Director of the Trust is disclosed, SO 7 shall apply.

8.5 External consultants

SO8 will apply equally to all external consultants or other agents acting on behalf of the Trust.

9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 Custody of Seal

The common seal of the Trust shall be kept by the Secretary or his Nominated Officer in a secure place.

9.2 Sealing of documents

9.2.1 The common seal of the Trust shall not be affixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee thereof, or where the Board of Directors has delegated its powers in accordance with the Scheme of Delegation. The Board has resolved that the seal may be used between Board meetings, based on business need, at the discretion of the Chief Executive or Chief Financial Officer.

9.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Financial Officer(or his Nominated Officer) and authorised and countersigned by the Chief Executive (or his Nominated Officer who shall not be within the originating directorate).

9.2.3 Where it is necessary that a document shall be sealed, the common seal of the Trust shall be affixed in the presence of two Officers duly authorized by the Chief Executive, and also not from the originating department, and shall be attested by them.

9.3 Register of sealing

The Secretary shall make an entry of every sealing (numbered consecutively) in a book maintained for that purpose, and shall ensure that each entry is signed by the persons who shall have approved and authorised the document and those who attested the seal. The Secretary shall make a report of all sealings to the Audit Risk and Assurance Committee at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

10 SIGNATURE OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or his Nominated Officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee of the Board of Directors to which the Board of Directors has delegated appropriate authority in accordance with the SOs.

11 MISCELLANEOUS

11.1 Standing Orders to be given to Directors and Nominated Officers

It is the duty of the Chief Executive to ensure that existing Directors and Nominated Officers and all new appointees are notified of and understand their responsibilities within the SOs.

11.2 Documents having the standing of Standing Orders

The SFIs and the Scheme of Delegation shall have the effect as if incorporated into these SOs.

11.3 **Review of Standing Orders**

The SOs shall be reviewed at least every three years by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated into these SOs.

ANNEX 8 - FURTHER PROVISIONS

(Paragraphs 3, 7, 9, 13 and 21)

APPENDIX 1

NHS Core Principles

1 NHS Core Principles

1.1 The NHS will provide a universal service for all based on clinical need, not ability to pay.

1.2 The NHS will provide a comprehensive range of services.

1.3 The NHS will shape its services around the needs and preferences of individual patients, their families and their carers.

1.4 The NHS will respond to different needs of different populations.

1.5 The NHS will work continuously to improve the quality of services and to minimise errors.

1.6 The NHS will support and value its staff.

1.7 The NHS will work together with others to ensure a seamless service for patients.

1.8 The NHS will help keep people healthy and work to reduce health inequalities.

1.9 The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

2 Representative Membership

2.1 The Trust shall at all times strive to ensure that, taken as a whole, its actual membership of the public constituencies is representative of those eligible for membership. To this end:

2.1.1 The Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors and shall be reviewed by them from time to time and at least every year.

2.1.2 The Trust shall present to each annual meeting of the Council of Governors:

2.1.2.1 a report on steps taken to secure that, taken as a whole, the actual membership of its constituencies and the classes of constituencies is representative of those eligible for such membership;

2.1.2.2 the progress of the membership strategy;

2.1.2.3 any changes to the membership strategy.

3 Co-operation with health service and other bodies

3.1 In exercising its functions the Trust shall co-operate with Health Service Bodies and any local authority with which the Trust has a Local Authority Partnership Agreement.

3.2 Notwithstanding the provisions of paragraph 3.1 above, the Trust shall co-operate with any specific third party body that it has a duty (statutory, contractual, or otherwise) to co-operate with.

4 Respects for rights of people

4.1 In conducting its affairs, the Trust shall respect the rights of the members of the community it serves, its employees and people dealing with the Trust as set out in the Human Rights Act 1998.

APPENDIX 2

Membership

1 Disqualification from membership of the Trust

1.1 A person may not be a Member of the Trust if they are under 12 years of age.

1.2 A person may not become or remain a member if they do not meet the requirements of eligibility under this Constitution

1.3 A person may not become a member of the Trust if they have been removed from membership by the Council of Governors within the preceding 5 years.

1.4 Where the Trust is on notice that a Member may be disqualified from membership, or may no longer be eligible to be a Member the Secretary shall give the Member 14 days written notice to show cause why his name should not be removed from the Trust's register of Members. On receipt of any such information supplied by the Member, the Secretary may, if he considers it appropriate, remove the Member from the register of Members. Any dispute about entitlement to membership will be resolved in accordance with the procedure set out at paragraph 2.1 of Appendix 4 of this Annex.

1.5 All Members of the Trust shall be under a duty to notify the Secretary of any change in their particulars which may affect their entitlement as a Member.

2 Expulsion from membership of the Trust

A Member may be expelled by a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors on the following grounds:-

2.1 if they have demonstrated aggressive or violent behaviour at any Hospital and following such behaviour he has been asked to leave, has been removed or excluded from any Hospital or other healthcare facility in accordance with the relevant Trust policy for withholding treatment from violent/aggressive patients;

2.2 if they have been confirmed as a ‘vexatious complainant’ in accordance with the relevant Trust policy for handling complaints;

2.3 if they have been removed as a member from another NHS Foundation Trust; or

2.4 if they are deemed to have acted in a manner contrary to the interests of the Trust.

2.5 The following procedure is to be adopted:

2.5.1 Any Member may complain to the Secretary that another Member has acted in a way which would justify expulsion in accordance with paragraphs 2.1 to 2.4 of this Appendix 2 to Annex 8.

2.5.2 If a complaint is made, the Council of Governors may itself consider the complaint, having taken such steps as it considers appropriate, to ensure that each Member's point of view is heard and may either:

2.5.2.1 dismiss the complaint and take no further action; or

2.5.2.2 arrange for a resolution to expel the Member complained of to be considered at the next meeting of the Council of Governors.

3 Termination of Membership

3.1 A Member shall cease to be a Member on:

3.1.1 death;

3.1.2 resignation by notice in writing to the Secretary;

3.1.3 ceasing to fulfil the requirements of paragraphs 7 or 8 of this Constitution, as the case may be; or

3.1.4 being disqualified pursuant to paragraph 1 above, or being expelled pursuant to paragraph 2 above.

APPENDIX 3

Further Provisions – general

1 Indemnity

1.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

1.2 The Trust may take out insurance either through the NHS Litigation Authority or otherwise in respect of directors and officers liability, including liability arising by reason of the Trust acting as a corporate trustee of an NHS charity.

2 Dispute Resolution Procedures

2.1 In the event of any dispute about the entitlement to membership the dispute shall be referred to the Secretary who shall make a determination on the point in issue. If the Member or applicant (as the case may be) is aggrieved at the decision of the Secretary he may appeal in writing within 14 days of the Secretary's decision to the Council of Governors whose decision shall be final.

2.2 In the event of dispute between the Council of Governors and the Board of Directors or between a Governor and the Council of Governors:

2.2.1 in the first instance the Chair on the advice of the Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

2.2.2 if the Chair is unable to resolve the dispute he shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute;

2.2.3 if the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

3 Amendment of the Constitution

3.1 The Trust may make amendments to this Constitution.

3.2 No proposals for amendment of this Constitution will be approved unless more than half of the members of the Board of Directors who vote and more than half of the members of the Council of Governors who vote approve the change.

4 Dissolution of the Trust

4.1 The Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the provisions of the 2006 Act.

APPENDIX 4

The Role and Responsibilities of the Secretary

1 Notwithstanding the specific functions of the Secretary, as set out in this Constitution, the Secretary will be expected to:

1.1 Ensure good information flows within the Board of Directors and its committees and between senior management and the Council of Governors;

1.2 Ensure that the procedures of the Board of Directors (as set out in this Constitution and the Standing Orders for Directors) are complied with;

1.3 Ensure that the procedures of the Council of Governors (as set out in this Constitution and the Standing Orders for Governors) are complied with;

1.4 Advise the Board of Directors and the Council of Governors (through the Chair or the Deputy Chair, as the case may be) on all governance matters; and

1.5 Be available to give advice and support to individual Directors and assistance with professional development.

Report Title	**Annual Self Certification – G6 / FT4 / CoS7**				
Meeting	**Trust Board**				
Date	**4 May 2023**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 : Self Certificate Template FT4 Appendix 2 : Self Certificate Template G6				

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

Assurance Level

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

Process

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

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

Report

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

NHS providers are required to complete self-certifications for publication which provides assurance that providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

Declaration	Detail
G6 (3)	Providers must certify that their Board has taken all necessary precautions to comply with the licence, NHS Act and NHS Constitution.
FT4	Providers must certify compliance with required governance standards and objectives
Cos7 (3)	Providers providing Commissioner Requested Services (CRS) have to certify that they have a reasonable expectation that required resources will be available to deliver designated services. (For NHS Foundation Trusts only)
Certification for Training for Governors	Providers have provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

The Audit, Risk & Assurance Committee have reviewed and agreed compliance with the Code of Governance and Provider Licence at their meeting held in March 2023 and the Council of Governors reviewed and agreed that the training received by governors during 2022/23 met the requirements of the S151(5) of the Health & Social Care Act 2012.

The Trust is compliant against its Provider Licence.

To note:

1. The NHS Foundation Trust Code of Governance has been updated and will be replaced by the Code of Governance for NHS Providers with effect from 1 April 2023. The Provider Licence is currently being updated and will be re-issued sometime in 2023 (date to be confirmed).
2. This will be the last year for foundation trusts to submit self-certifications to reduce duplication with the Annual Report.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks – select one or more					
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
	n/a				
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	• Provider Licence and code of governance compliance report to Audit, Risk & Assurance Committee – Mar-23 • Governor Training Report to Council of Governors Feb-23				
Next Steps	For Chief Executive and Chief Financial Officer to sign and to publish on the website and to inform the Annual Governance Statement in the Annual Report.				

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to approve the annual self certifications	
Accountable Lead Signature	Caroline Coles, Company Secretary
Date	16 April 2023

Annual Declarations 2022/23

1. Introduction and Purpose

All NHS Foundation Trusts are required to complete annual self-certifications under the terms of the NHS provider licence.

The purpose of this paper is to provide the Audit, Risk & Assurance Committee with a high-level schedule of compliance against its Provider Licence (appendix 1) and a detailed response for those annual declarations that are required to be made by the Trust as follows:-

Declaration	Detail
G6 (3)	Providers must certify that their Board has taken all necessary precautions to comply with the licence, NHS Act and NHS Constitution.
Cos7 (3)	Providers providing Commissioner Requested Services (CRS) have to certify that they have a reasonable expectation that required resources will

	be available to deliver designated services. (For NHS Foundation Trusts only)
FT4	Providers must certify compliance with required governance standards and objectives
Training for Governors	Providers have provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

2. Self-certification G6 (3)

Declaration	
Following a review for the purpose of paragraph 2(b) of licence condition G6 (*regular review of whether those processes and systems have been implemented and of their effectiveness*), the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Compliant**

Response

The effectiveness of internal control systems and processes are reviewed on an annual basis and documented within the Annual Governance Statement as presented to the Audit & Risk Committee and incorporated within the Annual Report. In addition, assurance to the Board is supported by opinions from Internal Auditors and External Auditors.

3. Self-certification Cos7 (3)

Declaration	
After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Compliant**

Response

- Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the cost improvement plans are achieved.
- The long- and medium-term financial position as detailed in the Trust's Finance Plan 2022/23 was considered and approved by the Board of Directors in May 2022.
- The year to date and the annual financial position are detailed in the following reports presented to the Trust Board and relevant Board committee and Executive Led Groups:
  - Monthly Financial Performance Report
  - Monthly Integrated Performance Report
  - The 2022/23 annual accounts were prepared on a going concern basis
- The financial position within 2023/24 is challenging and a Trust and ICS plan remains to be finalised. The Trust position is influenced by a number of factors including system funding regime, the transition out of Covid and inflation above planning guidance.
- The Trust is working to achieve the best possible financial position in agreement with the ICS and NHSE.
- CIP will be maximised in 2023/24 however additional resources are likely required if the Trust is to achieve balance.

4. Self-certification FT4

Declaration - **FT4 - 1**	
The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Compliant**
Response	
• Compliance with NHS Foundation Trust Code of Governance (NHS Code of Governance for NHS Providers from 1 April 2023) is regularly assessed and reported, both to the Audit, Risk & Assurance Committee and within the annual report. • The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Company Secretary who has accountability for its maintenance). • There are no material conflicts of interest in the Board. • All governors' elections and by-elections are held in accordance with election rules. • Systems and controls assurances are obtained via the Audit, Risk & Assurance Committee. • An independent review of leadership and governance using the well-led framework is completed every 3-5 years. • The most recent CQC inspection report (published June 2020) rates the foundation trust as "requires improvement" in two areas, and all other areas "good" including well-led • More complete explanations about systems of corporate governance are set out in the annual governance statement and the foundation trust's annual report. • The Company Secretary maintains an overview of corporate governance developments within the NHS and across wider sectors, and good practice is shared through established regional and national Company Secretaries Networks.	

Declaration - FT4 - 2	
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Compliant**
Response	
• Compliance with NHS Foundation Trust Code of Governance (NHS Code of Governance for NHS Providers from 1 April 2023) is assessed each year as part of the annual reporting process. • Any guidance requirements are routinely assessed and implemented as necessary - overview of guidance provided by auditors in updates received at each Audit, Risk & Assurance Committee meeting. • Assurance and advice is provided as required by the Audit, Risk & Assurance Committee.	

Declaration - FT4 - 3	
The Board is satisfied that the Licensee has established and implements: **(a) Effective board and committee structures;** **(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and** **(c) Clear reporting lines and accountabilities throughout its organisation.**	**Compliant**
Response	
• Board committees established with clear lines of reporting, and recently reviewed • Terms of reference in place for Board and all other committees and groups within the Trust which are regularly reviewed and updated where necessary. These set out the remit of each type of meeting, membership, attendance by others, quorum requirements and reporting responsibilities.	

- Chairs report to the board to report assurance and escalate concerns in line with reporting structure.
- Clear delegation of actions to committees.
- Annual Governance Statement in place which identifies areas of potential risk and mitigating actions.
- Scheme of Delegation and robust Standing Financial Instructions in place

Declaration - FT4 - 4	
The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: **(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;** **(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;** **(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the CQC, the NHS Commissioning Board and statutory regulators of health care professions;** d) **For effective financial decision making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);** **(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision making;** **(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;** **(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and** **(h) To ensure compliance with all applicable legal requirements.**	**Compliant**

Response

- Risk Management Strategy in place and recently reviewed
- Board Assurance Framework used extensively at each committee and board meeting
- Datix risk management system in place
- Use of internal and external audit services to investigate any areas of concern
- Contracts for services agreed with commissioners
- Finance, Infrastructure & Digital Committee considers detailed financial performance report at each meeting
- Performance report considered at each Board meeting. Detailed performance discussed at monthly divisional performance reviews.
- Comprehensive agendas for Board meetings circulated to directors in advance of each meeting
- Cost Improvement Plans in place which are risk assessed for quality
- Standing Financial Instructions and Standing Orders in place
- Counter Fraud specialist reports to the Audit, Risk & Assurance Committee
- In relation to point (f) and (g), the Trust's annual report and operational plan have set out a number of high-level risks facing the Trust and ways in which these are being mitigated.
- Points as set out in 1), 2) and 3) above apply.

Declaration - FT4 - 5	
The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: **(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;** **(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;** **(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;** **(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;** **(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and** **(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.**	Compliant

Response

- The Chief Medical Officer and the Chief Nurse are both appropriately professionally qualified and accountable to their professional body (in addition to the Trust).
- NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce and governance
- Collectively, the NED component of the Board is suitably qualified to discharge its functions.
- Quality reports presented to Quality & Safety Committee and shared with the Board.
- Quality and Safety Committee, chaired by a NED with terms of reference which include reporting from Patient Safety Group, Safeguarding Groups and IPC.
- Clinical Audits – the Trust participates in national audits and also local audits. Audit reports are submitted to relevant committees or groups.
- Learning from national reports with comparative reports undertaken and action plans devised and implemented.
- National reports and benchmarking e.g. NICE guidelines and patient safety alerts.
- Monthly leadership safety walk rounds undertaken by Executive directors and Non- Executive Directors
- The executive team is supported by a cadre of appropriately-qualified and capable deputies

Declaration - FT4 - 6	
The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Compliant

Response

- The Medical Director, Chief Nurse and Chief Financial Officer are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust).
- All Executive Directors' performance and competencies are reviewed through annual appraisals.
- Collective & individual skill-sets reviewed as part of board succession planning
- The Trust Chair receives an annual performance appraisal from the Senior Independent Director
- NEDs receive an annual performance appraisal from the Trust Chair who advises the governors

- NEDs have been appointed/re-appointed by the Council of Governors as advised by the governors' Nominations and Remunerations Committee
- NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, IT, commerce, governance, and OD. Collectively, the NED component of the Board is suitably qualified to discharge its functions
- Once in post, each NED undergoes an internal induction to facilitate an understanding of the Trust, its operations and strategic direction
- Thereafter, on-going training to develop existing and new skills relevant to the NED role is undertaken by attendance at external conferences and workshops as required.
- NED progress is monitored by the Trust Chair at a formal annual appraisal session at which achievements against objectives for the preceding year are evaluated and new goals for the forthcoming year and a personal development plan are established.
- This is supplemented by a number of Board away days throughout the year to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues.
- Divisions are led by experienced and capable teams consisting of a Divisional Director of Operations, Divisional Medical Director and Divisional Director of Nursing.
- Safer staffing levels on wards are reported to Board at each meeting and monitored

5. Training of Governors

Declaration	
The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Compliant
Response	
The Council of Governors considered and approved the training provided to Governors during 2022/23 (appendix 2) at its meeting on 8 February 2023.	

Report Title	**New Code of Governance for Provider Trusts**				
Meeting	**Trust Board**				
Date	**4 May 2023**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

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

Assurance Level Assurance in respect of: process/outcome/other (please detail):							
Process							
Significant	x	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

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

This paper will provide an overview of the Code of Governance for NHS Provider Trusts that has been issued by NHS England.

The report sets out the key headlines from the Code, implications for the Trust, proposal for monitoring compliance and next steps.

It is proposed that a formal report, detailing the 'comply and explain' position against the provisions of the Code is provided in April, on an annual basis, as is the current practice. The report will be considered by the Audit, Risk & Assurance Committee.

In recognition that 2023/24 is the first year of the new code it is proposed that in September the Audit, Risk & Assurance Committee receive a mid-year 'comply and explain' report providing details of the position against the provisions of the Code.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	x	x	x	x	x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)	-				**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement					
Next Steps	Mid-year report to Audit, Risk & Assurance Committee in September 2023				

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the update.	
Accountable Lead Signature	Caroline Coles, Company Secretary
Date	17 April 2023

1 Introduction

1.1 This paper will provide an overview of the new Code of Governance for NHS Provider Trusts that has been issued by NHS England, and was effective from 1 April 2023.

1.2 The report will set out the key headlines from the Code, implications for the Trust, proposal for monitoring compliance and next steps.

2. Background

2.1 The revised Code of Governance from NHS England https://www.england.nhs.uk/long-read/code-of-governance-for-nhs-provider-trusts/ has been produced to help Trusts deliver effective corporate governance, contribute to better organisational and system performance and improvement and enable them to discharge our duties in the best interests of patients, service users and the public.

2.2 The Code brings together best practice form the NHS and private sector, including the UK Corporate Governance Code, the last version of which dates from 2018 UK Corporate Governance Code https://www.frc.org.uk/getattachment/88bd8c45-50ea-4841-95b0-d2f4f48069a2/2018-UK-Corporate-Governance-Code-FINAL.pdf . The Code is an overarching framework for the corporate governance of trusts and complements the statutory and regulatory obligations.

2.3 The last Code was dated from 2014. A great deal has changed since then, including the formal establishment of Integrated Care Boards and the merging of NHS Improvement (comprising of Monitor and the NHS Trust Development Authority) into NHS England.

2.4 To support the shift to collaboration and system working a new single framework for overseeing NHS systems and organisations, the NHS Oversight Framework has replaced the NHS System Oversight Framework. Under this framework all providers in comparable circumstances will be treated in a similar way. And therefore, the updated Code applies to both NHS Foundation Trusts and for the first time NHS Trusts.

3. Code of Governance of NHS providers trusts

3.1 The Code has five sections that set out how to ensure there are clear and consistent systems and practice for good corporate governance across organisations. Each section details the provisions of the code which are best practice and do not represent mandatory guidance. However, non-compliance may form part of a wider regulatory assessment of adherence to the provider licence.

Section A: **Board leadership and purpose**
Details the role of the Board, with particular reference to establishing the trust's vision, values and strategy, emphasising the need for alignment with the ICP's integrated care strategy.

Section B: Division of responsibilities
Details the role of Board, Council of Governors and need for division of responsibilities between leadership of the Board and executive leadership of trust's operations.

Section C: Composition, succession and evaluation
Details expectations regarding appointments to the Board, diversity of skills, experience and knowledge on Boards and Committees. Development and support needing to be provided to Directors and Governors.

Section D: Audit, risk and internal control
Arrangements to ensure independence and effectiveness of internal and external audit functions. Procedures in place to manage risk, oversee internal control framework.

Section E: Remuneration
Principles when setting level of remuneration and governance framework that should be in place to manage this aspect of directors' remuneration.

3.2 A review of the new Code by the Company Secretary has not identified any significant changes from the code that is in place for Foundation Trusts. The Code does introduce the need for providers to have good governance to underpin collaboration. Also, it highlights the need for boards to retain oversight of system and their partnership activities and effectively delegate authority for decision making but does not prescribe specific structures or processes.

3.3 The new emphasis on collaboration does raise the need for directors to navigate the tension between their duties as directors of their organisations and their responsibilities within systems and partnerships.

4. Fulfilment of Code's requirements

4.1 As stated previously the provisions of the code are best practice and do not represent mandatory guidance and accordingly non-compliance is not itself a breach of Condition FT4 of the NHS provider licence.

4.2 The Code sets out that Directors and Governors both have a responsibility for ensuring that 'comply and explain' remains an effective basis for the Code.

4.3 To meet the 'comply and explain' requirements each trust must comply with each of the provisions of the code or where appropriate explain why the trust has departed from the Code. The Trust is already using this approach in line with requirements for Foundation Trusts.

4.4 In some cases to comply will require a statement of information in the annual report, or provision of information to the public, or for Foundation Trusts, Governors or members. Schedule A of the Code sets out which provisions fall into which category and where there is a requirement to include information in the trust annual report. The NHS Foundation Trust Annual Reporting Manual will also detail this and will be used by the Trust to ensure compliance.

5. Next Steps

5.1 The Company Secretary is linked with other trust corporate governance leads to identify any further intelligence and identify good practice that could be adopted.

5.2 It is proposed that a formal report, detailing the 'comply and explain' position against the provisions of the Code is provided in Q1, on an annual basis, as is the current practice. The report is considered by the Audit, Risk & Assurance Committee as is current practice.

5.3 In recognition that 2023/24 is the first year of the new code it is proposed that in September the Audit, Risk & Assurance Committee receive a mid-year 'comply and explain' report providing details of the position against the provisions of the Code.

Report Title	**Register of Interests and Declaration of Interests at Meetings**				
Meeting	**Trust Board**				
Date	**4 May 2023**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 - Register of Interest Board April 2023				

Purpose

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

Assurance Level

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

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

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

Report

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

This report provides an annual reminder to members of the Board of their obligation to register any relevant and material interests as soon as they arise or within 7 clear days of becoming aware of the existence of the interest and to also make amendments to their registered interests as appropriate.

The report also reminds of the requirement to declare interests at meetings when matters in which there is an interest are being considered and the requirement to withdraw from the meeting during their consideration.

Furthermore, this report asks the Board to receive a copy the Register of Interests of the Board of Directors for review, which best practice suggests should be undertaken on at least an annual basis.

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

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

Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			x
Explanation of above analysis:			

Recommendation / Action Required

The Board/Committee/Group is requested to:

(a) that the requirement of directors to register their relevant and material interests as they arise or within 7 clear days of becoming aware of the existence of an interest be noted;

(b) that the requirement to keep the register up to date by making amendments to any registered interests as appropriate be noted;

(c) that the requirement to declare the existence of registered interests or any other relevant and material interests at meetings be noted including the requirement to leave the meeting room whilst the matter is discussed; and

(d) that the Director's Register of Interests be received and it be agreed that the Board is assured that the requirements of the Constitution to maintain a register of interest of Board Directors are being met.

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	21 April 2023

Declarations of Interest Trust Board of Director - April 2023

	Date Confirmed	First Name	Last Name	Position Title	Interests to declare	Description of interest	Dates To	Dates From	Type of interest: Clinical Private Practice	Strategic Decision Making	Outside Employment / Directorships	Gifts and Hospitality	Loyalty	Shareholdings	Membership of Committees / Charites / Networks etc	Personal connections
6	**Voting Board Members**															
7	19-Apr-23	Elizabeth	Abderrahim	Non Executive Director	Y	Employed as Company Secretary by Anawim, Birmingham's Centre for Women	28-Jun-19	Present			X					
8	05-Apr-22	Nicholas	Bishop	Non Executive Director from August 2018	Y	Distant family member work for BDO (not in any department which undertakes NHS work)	Ongoing									X
9	29-Apr-22	Lisa	Cheek	Chief Nurse from March 2021	N											
10	29-Apr-22	Liam	Coleman	Trust Chair from February 2019	Y	Deferred Member of Nationwide Building Society membership scheme Non Executive Director / Chair of Audit Committee - The Financial Conduct Authority Non Executive Director of Vivid Housing Ltd from Nov 2021	Ongoing				X					
11	18-Apr-23	Judith	Gray	HR Director from July 2019	Y	Trustee for ICP Support. ICP is a charity which supports women and their families who develop intrahepatic cholestasis of pregnancy Son is a Senior Manager for our external auditors, Deloitte	Ongoing								X	X
12	06-Apr-22	Peter	Hill	Non Executive Director from April 2017	Y	Trustee Salisbury Hospice Trust	Ongoing								X	
13	09-May-22	Paul	Lewis	Non Executive Director from April 2018	N											
14	06-Dec-22	Kevin	McNamara	Chief Executive from March 2020	Y	Board member for West of England Academic Health Science Network Chair of Westof England Patient Safety Collaborative (part of AHSN)	01/12/2022 1/4/2023	ongoing ongoing							X	
320	29-Apr-22	Claire	Thompson	Director of Improvement and Partnerships from 19 April 2021	N											
321	06-Apr-22	Simon	Wade	Director of Finance & Strategy from November 2020	N											
322	14-Apr-23	Jon	Westbrook	Medical Director from September 2021	N											
323	14-Apr-23	Felicity	Taylor-Drewe	Chief Operating Officer from August 2021	Y	Non-Executive Director Wiltshire Health and Social Care (GWH nominated)	Ongoing				X					
324	28-Apr-22	Faried	Chopdat	Non Executive Director from April 2021	Y	Trustee and Chair of the Audit Committee of WorldSkills UK Non Executive Director Grant Thornton UK	Ongoing				X				X	
325	17-Apr-23	Helen	Spice	Non Executive Director from April 2021	Y	Make a Wish Foundation -Non Executive Director Trustee Mental Health and Employment Partnership Ltd, Non-Executive Director Non-Executive Director Barts Health NHS Trust	Ongoing				X					
326	06-May-22	Claudia	Paoloni	Non-Executive Director from April 2021	Y	Director of Calm Water Ltd Lecrahurst Ltd HCSA Executive Committee - Executive Members Consultant Anaesthetist, University Hospital Bristol & Weston Trust Hospital Medical Committee (Chair), University Hospital Bristol & Weston Trust	Ongoing				X					
327	12-Apr-23	Will	Smart	Non Executive Director from	Y	Council Member, Health and Social Care Council, Tech UK. Global Director and UKI Director of Provider Transformation for Dedalus Group	ongoing				X				X	
328	**Non-Voting Board Members**															
330	22-Jun-22	Naginder	Dhanoa	Chief Digital Officer (joint role with Salisbury NHS FT)	N											