Great Western Hospitals NHS Foundation Trust

TRUST BOARD

Thursday 12 March 2026, 9.30am to 1.00pm
MS Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Simon Wade, Andrew Hollowood, Judy Dyos	Verbal	LC	-	09:30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 15 January 2026 (draft)	7 – 14	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	15	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	16 – 18	LC	-	-
6.	**Staff Story – Site Team** Jill Kick, Head of Clinical Operations & Patient Flow	19 – 20	JK	Receive	09:40
7.	**Chair's Report** Liam Coleman, Chair	21 – 25	LC	Note	10:15
8.	**Chief Executive's Report** Cara Charles-Barks, Chief Executive Lisa Thomas, Managing Director	26 – 33	CCB/ LT	Note	10:25
BREAK (10 minutes) at 11.10 to 11.20am					
9.	**Integrated Performance Report** • Performance, Population & Place Committee Board Assurance Report (February 2026) – Bernie Morley, Non-Executive Director & Committee Chair • Quality & Safety Committee Board Assurance Report (January & February [verbal] 2026) – Claudia Paoloni, Non-Executive Director & Committee Chair	34 – 36 37 – 40	BM CP	Assurance Assurance	11:20

		PAGES	BY	ACTION	TIME
	• People & Culture Committee Board Assurance Report (March 2026) – Julian Duxfield, Non-Executive Director & Committee Chair	41 – 43	JD	Assurance	
	• Finance, Infrastructure & Digital Committee Board Assurance Report (January & February 2026) – Faried Chopdat, Non-Executive Director & Committee Chair	44 – 47	FC	Assurance	
	• Integrated Performance Report	48 – 102	All	Receive	
10.	**Audit, Risk & Assurance Committee Board Assurance Report (January & March 2026)** Helen Spice, Non-Executive Director and Committee Member	103 – 108	HS	Assurance	12:00
11.	**Charitable Funds Committee Board Assurance Report (March 2026)** Julian Duxfield, Non-Executive Director and Committee Member	109 – 110	JD	Assurance	12:10
12.	**Resident Doctor Peer Lead Board Report** Kathryn Bateman, Chief Medical Officer Lynsey Hewitson, Chief Registrar & Eleanor Tindall, Chief Registrar *(received at Medical Staff Support Group 4 February 2026)*	111 – 116	KB/LH	Approve	12:20
13.	**Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance** Benny Goodman, Chief Operating Officer *(received at Performance, Population & Place Committee 25 February 2026)*	117 – 121	BG	Assurance	12:40
	CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**				
14.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	None	CC	Approve	12:50
15.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-
16.	**Date and time of next meeting** Thursday 9th April 2026 at 9.30am	Verbal	LC	Note	-
17.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	13:00

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF TRUST BOARD HELD IN PUBLIC
15 JANUARY 2026 AT 9.30AM
INSTITUTE OF TECHNOLOGY, NORTH STAR CAMPUS, SWINDON / MS TEAMS (HYBRID)

Present:

Liam Coleman (LC)	Chair
Kathryn Bateman (KB)	Chief Medical Officer
Emily Beardshall (EB)*	Acting Chief Officer of Improvement & Partnerships
Cara Charles-Barks (CCB)	Chief Executive (part)
Faried Chopdat (FC)	Non-Executive Director/Deputy Chair
Julian Duxfield (JD)**	Non-Executive Director
Luisa Goddard (LG)	Chief Nurse
Benny Goodman (BG)	Chief Operating Officer
Sandra Gordon (SG)**	Non-Executive Director
Jude Gray (JG)*	Chief People Officer
Jonathan Hinchliffe (JH)*	Chief Digital & Transformation Officer
Andrew Hollowood (AH)*	Chief Clinical Transformation Officer
Bernie Morley (BM)	Non-Executive Director
Claudia Paoloni (CP)**	Non-Executive Director/Senior Independent Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Lisa Thomas (LT)	Managing Director
Simon Wade (SW)	Chief Financial Officer

In attendance:

Neil Clark (NC)	Associate Non-Executive Director
Caroline Coles (CC)	Company Secretary
Samaher Sweity (SS)	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Tania Currie (TC)	Head of Patient Experience & Engagement (agenda item 159/25)
Kat Simpson (KS)	Director of Midwifery & Neonatal Services (agenda item 163/25)
Laura Little (LL)	Project Co-ordinator for Maternity & Neonatal Services (agenda item 163/25)

Apologies:

Chris Burton (CB)	Non-Executive Director

* non-voting member
** indicates those members attending virtually by MS Teams

Number of members of the Public: There were 4 members of the public in attendance (Stephen Baldwin, Governor; Mary Day, Governor; Sarah Marshall, Governor: Russell Edwards, The Surgical Consortium; Archie Mahur, Netcompany)

Matters Open to the Public and Press

Minute	Description	Action
154/25	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
155/25	**Declarations of Interest** There were no declarations of interest.	

Minute	Description	Action

156/25 **Minutes of the previous meeting (public)**
The minutes of the Board meeting held in public on 11 December 2025 were adopted and agreed as a correct record.

157/25 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list. No updates or amendments were provided.

158/25 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

159/25 **Care Reflection – Duty of Candour Process**
Tania Currie, Head of Patient Experience & Engagement joined the meeting to present this item.

The Board received a care reflection film outlining Sandra's experience following a patient safety incident involving her mother. She highlighted the distress caused by delays in communication, despite her role as carer and advocate. The subsequent investigation report, later shared with the family, was appreciated for its honesty and demonstration of learning

It was noted that shortcomings had been identified in the early stages of the duty of candour process, particularly around timely communication. The Insights and Learning Team had subsequently reviewed Trust processes to ensure that more meaningful incident investigations took place with increased focus on patient and family engagement, and how learning should be shared in the future.

The Board Members discussed how learning from incidents and duty of candour compliance were monitored and embedded. It was confirmed that incidents were reviewed weekly through governance processes and only closed once there was evidence that learning had been implemented. It was also noted that incidents increased during periods of operational pressure, with additional governance support deployed to ensure timely reporting and investigation. Patient and family feedback highlighted variable experiences and the need to strengthen communication and openness.

A discussion took place regarding the processes for Power of Attorney registration and patient documentation, during which the Board noted the need for further clarification on Trust processes to ensure appropriate protection and empowerment of both staff and patients

The Chair thanked Tania Currie for the presentation, noting the experience of the duty of candour process along with the developments and improvements identified.

The Board **noted** the care reflection.

160/25 **Chair's Report**
The Board received and considered the Chair's Board Report which highlighted several key points:

- Confirmation that Vivien Coppen had been appointed as Deputy Lead Governor.
- It was noted that the Board safety visit referenced in the report had been cancelled due to operational pressures.

The Board **noted** the report.

161/25 **Chief Executive's Report**
The Board received and considered the Chief Executive's Report.

Minute	Description	Action

An update was provided by Cara Charles-Barks, Chief Executive on key areas of concern and organisational priorities. The report focused on the most significant current risks, particularly the ongoing financial recovery position and sustained operational pressures across the organisations. While financial recovery initiatives had been implemented and performance had been strong for much of the year, recent months had been more challenging due to increased front door demand, high ambulance conveyances, and extensive use of escalation areas and temporary staffing. Non Criteria To Reside (NCTR) occupancy remained high, with limited system-wide traction to reduce demand through alternative care pathways.

The Board received an updated on the severe operational pressures being experienced, including occupancy exceeding capacity, increased use of escalation spaces, and deterioration in some quality metrics. Actions were being taken to mitigate risk through additional staffing, enhanced clinical oversight, and close system coordination, though it was recognised that care was not being delivered in optimal environments. Cara Charles-Barks, Chief Executive formally thanked staff at the Great Western Hospital for their resilience and professionalism under sustained pressure.

It was noted that elective performance was reported as comparatively strong, with only a small number of long-wait patients remaining, largely due to complex cases requiring input from external partners. Wider system challenges were discussed, including rising ambulance conveyances and emergency attendances, highlighting fundamental demand and capacity constraints rather than short-term operational issues alone.

The Board reflected on the need to balance immediate tactical responses with longer-term strategic solutions. This included system-wide risk sharing, future capacity planning, service reconfiguration, and capital investment, alongside continued focus on recovery, transformation, and sustainable performance and financial improvement.

An update was provided on governance and group structure, including progress towards appointing a new Group Chair and the critical timeline for transition. In relation to the Group governance structure, it was confirmed that detailed work would be presented to the relevant governance committees, with plans for an engagement session for new and existing Non-Executive Directors.

The Board **noted** the report.

162/25 **Integrated Performance Report**

The Board received the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in November 2025 (October 2025 for Cancer).

Quarterly Pillar Metric deep dive

The quarterly deep dive of breakthrough objectives and pillar metrics were presented, with a particular focus to deliver rapid improvement over a 12 to 18 month period. It was reported that November performance data had showed significant improvement across several areas, with particular consideration given to performance in the context of ongoing operational pressures. The pillar metric deep dive had been undertaken to ensure the organisation remained on track to deliver its three-year strategy, with key metrics reviewed to identify any areas of concern or emerging risks, and would also inform whether priorities should be refined ahead of the next financial year.

Our Care

Luisa Goddard, Chief Nurse reported on progress against the breakthrough objective of reducing harm from inpatient falls, with metrics focused on total falls and falls with harm, noting that this breakthrough objective was now in its second year. A significant reduction

Minute	Description	Action

in both measures was reported, with the rate per 1,000 bed days now below the national average and comparator organisations. It was noted that there had been a recent increase in December 2025 and January 2026, which would continue to be monitored. Improvements were supported by strengthened rapid-learning processes and a continued focus on fall prevention, meaningful activity, and reducing patient deconditioning.

Overall harms continued to reduce, with year-on-year improvement in infection rates. A slight increase in *E. coli* bloodstream infections was noted, while other infections remained stable, and targeted workstreams were in place. Pressure ulcers had reduced overall and remained below the national average, reinforcing improvement in nursing-sensitive indicators, although recent performance remained an area of attention.

The Board also noted improvement in complaints performance following work to simplify processes, strengthen accountability, and improve engagement with complainants. Targets were met for the first time in December 2025, with recognition that further work was required to sustain progress. The Board acknowledged the positive impact of these improvements and commended staff for the progress achieved to date.

Our Performance

Benny Goodman, Chief Operating Officer reported on the Trust's non-elective length of stay breakthrough objective, noting that while overall progress remained limited, the focus on this metric was confirmed as an organisational priority. It was recognised that reducing admissions could increase the complexity and length of stay for remaining patients, and performance had been inconsistent, with some summer improvements not sustained into winter. Early January data suggested slight improvement compared to the previous year.

Positive developments included increased engagement with partner organisations on post-referral delays, supported by weekly data reporting, and the use of "go and see" ward rounds to build consistency and evidence for improved practice. Workforce constraints and variability in multidisciplinary input challenges remained, but these initiatives were expected to support better length of stay management in the year ahead.

In relation to the breakthrough objective on the proportion of outpatient first appointment pathways waiting <18 weeks, it was noted that this had remained at 66% and this position had been sustained since June 2025. Improvement had been achieved since November 2025 of the previous year despite cost-saving measures over the summer that reduced high-cost activity. The Board acknowledged that rising referral rates over the past four to five months had increased patient volumes across specialties, presenting ongoing challenges to maintaining timely access.

Our People

Jude Gray, Chief People Officer provided an overview of the breakthrough objective in relation to the Staff Survey results and associated People domain metrics, noting their strategic importance to patient care quality. High-level data indicated overall improvements in staff respect, experience of discrimination, and engagement, with most metrics stable and one metric declining. The Trust continued to perform well against national benchmarks despite operational pressures.

Analysis showed a modest increase in perceptions of respect and a reduction in disparity between white colleagues and ethnic minority groups, although overall experiences remained below desired levels, particularly among healthcare support workers. Reported experiences of discrimination had significantly improved, reflecting the impact of targeted interventions and leadership support.

Long-term sickness absence had decreased from 7.1% to 6.0%, mainly amongst unregistered nursing staff in surgical and elective areas, with anxiety, stress, and depression as key drivers. Initiatives including the long-term health commission, wellbeing

Minute	Description	Action

app, and enhanced face-to-face support contributed to improved staff management and 98.6% policy compliance. Overall, the Trust had maintained performance during a pressured period, though staff morale and workload remained areas for continued focus.

In response to a question asked by Sandra Gordon, Non-Executive Director about barriers to career progression for BAME staff, Jude Gray, Chief People Officer acknowledged that there were challenges around development and progression, despite measures like recruitment champions, and agreed to review the issues in more detail with the People Services team to provide a more comprehensive response, to also include a response to those concerns also raised by International staff.

Use of Resources

Simon Wade, Chief Financial Officer provided an overview of the Trust's sustainability and financial performance, noting that the breakthrough objectives had significantly contributed to the overall position. Non-pay expenditure had been a key focus, and a reduction of approximately £400K in average monthly non-pay spend had been observed over the last four months. While savings had not yet fully reached target levels, stabilisation and early reductions were acknowledged as positive developments. Factors influencing expenditure, including inflation, energy and supply costs, funding for elective activities, VAT rulings, and SLA-related software services, were discussed, highlighting elements outside direct control.

The Board noted the measures implemented to support savings, including discretionary spending limits, staff education on resource usage, and the establishment of task-and-finish groups targeting high-spend areas such as Cardiology. Efforts in standardisation and joint procurement were reported to be delivering benefits, particularly through Group procurement functions. Overspending was primarily linked to high-activity areas, including Pathology and Orthopaedics, but overall progress in controlling costs was recognised as significant given operational pressures.

The Board also discussed non-recurrent financial benefits, such as supplier rebates, and their contribution to overall performance. It was acknowledged that consistent progress against breakthrough objectives and further focus in some areas was required. Plans to align operational outputs with strategic planning for the following year were outlined, emphasising the need to maintain key priorities while evaluating opportunities for broader strategy adjustments.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (QSC) at its meeting on 18 December 2025 and the following was highlighted:

- Improvements were noted in pressure ulcer management and infection control as examples of successful interventions.
- Deep dive reviews were implemented for areas showing early signs of concern, providing better understanding of issues and enabling targeted actions.
- Patient concerns trends and themes reports continue to inform decisions and help address underlying issues effectively.
- Progress across initiatives was observed, though capacity pressures had influenced some metrics.

The Board **noted** the report.

163/25 **GWH Maternity Incentive Scheme (CNST) Year 7 Submission – Compliance Report**

Kat Simpson, Director of Midwifery & Neonatal Services and Laura Little, Project Co-ordinator for Maternity & Neonatal Services joined the meeting to present this item.

Minute	Description	Action

The Board received a paper which outlined the Trust position on Year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

It was noted that the Trust was declaring compliance with all ten Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Safety Actions in Year 7 of the scheme and that this submission had been signed off by the Chief Nurse, Non-Executive Director Maternity & Neonatal Safety Champion, and ICS Accountable Officer and gone through a robust governance process, including the Quality & Safety Committee.

Kat Simpson provided further assurance that a comprehensive and robust evidence base was in place to demonstrate compliance which centred around quality and delivery of maternity and neonatal care, drawing on clinical guidance, audits, performance data, patient experience, and system-level oversight. The Board noted the rigorous scrutiny applied to this compliance, providing confidence that improvements were evidenced and sustained.

The Board also received an overview of the Maternity Outcomes Signal System (MOSS), a newly introduced tool designed to enhance maternity care by rapidly analysing routinely recorded ward-level data to identify emerging safety concerns and improve outcomes for mothers and babies.

The Board thanked the team for the significant work undertaken continuously throughout the year to reach compliance.

RESOLUTION:
The Board approves the final CNST compliance position for GWH in preparation for the NHSR Declaration Form to be submitted on 3 March 2026.

164/25 **Safe Staffing 6-month review for Nursing, Midwifery & AHP**

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

The report outlined recommendations for maintaining a safe sustainable nursing, midwifery and allied health professional (AHP) workforce through the triangulation of professional judgement and professional evidenced based acuity tools.

It was noted that acute nursing was broadly in a positive position, with funding supporting a 1:8 nurse-to-patient ratio and strong retention, although staffing required daily adjustments to cover shortfalls. The Board discussed ongoing work to mitigate risks associated with higher patient-to-nurse ratios and to ensure care hours per patient day were accurately captured across all wards and escalation areas.

The report highlighted improvements in maternity staffing, including compliance with supernumerary coordinator status, 1:1 care throughout established labour, and enhanced neonatal skill mix. Despite current midwifery vacancies, recruitment had reduced gaps and training programmes were progressing.

Allied Health Professional (AHP) staffing had significantly improved, with better retention and reduced therapy delays during winter, supported by clear workforce planning. Challenges around Occupational Therapy vacancies and Physiotherapy recruitment were acknowledged, alongside the positive impact of induction and retention initiatives.

Board members discussed the limitations of averaged metrics such as care hours per patient day, emphasising the importance of monitoring real-time nurse-to-patient ratios and red-flag events to proactively identify staffing risks. The importance of triangulating staffing data with patient outcomes, sickness, and turnover rates was reinforced. Discussions also addressed the balance between safe staffing and budgetary constraints, noting the need to

Minute	Description	Action

consider additional establishment cover to account for leave while maintaining financial sustainability.

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

The Board **noted** the report.

165/25 **Cyber Security Framework – Board Assurance Report**

The Board received and considered a report which outlined the current national picture on cyber security and the national recommendation on key areas of focus. It was noted that the approach for national assurance of local organisations was through the Data Security and Protection Toolkit (DSPT), which had been migrated to the Cyber Assurance Framework content and approach for 2024/25 onward, and aligned with the national cyber strategy for healthcare.

Jonathan Hinchliffe, Chief Transformation & Innovation Officer reported on the organisation's cyber security framework and assurance arrangements, which had been previously considered by the Finance, Infrastructure & Digital Committee (FIDC) at its meeting in November 2025. The report provided assurance on the safety and security of systems and highlighted a significantly matured cyber security posture, sustained improvement, and strong compliance with national requirements, whilst recognising that cyber risk remained inherently high and required continuous investment and testing.

The report also outlined the increased national threat landscape, including intensified ransomware activity, supply chain vulnerabilities, and state-sponsored threats, alongside new regulatory requirements and higher evidential standards. In relation to controls at this organisation, progress was noted in technical controls, audit outcomes, penetration testing, and business continuity planning, with further improvement required in incident rehearsal, staff awareness, and supply chain resilience.

The Board sought clarification and assurance regarding business continuity arrangements and any related agreements, including whether decisions had been taken, the rationale for them, and their regulatory basis. It was agreed that a brief offline update to be provided and formal assurance to return to the Board at an appropriate time once the approach and timing had been agreed.
Action: Chief Digital & Transformation Officer

The Board **noted** the report, the ongoing risks and continued oversight through existing governance arrangements.

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.

166/25 **Ratification of Decisions made via Board Circular**
None.

167/25 **Urgent Public Business (if any)**
None.

Minute	Description	Action
168/25	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 12 March 2026 at 9.30am at Wichelstowe & Oakhurst Meeting Room, Pierre Simonet Building (Vygon), Gateway North, Latham Road, Swindon, SN25 4DL.	
169/25	**Exclusion of the Public and Press** The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.	

The meeting finished at 12.50hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – March 2026				
ARAC – Audit, Risk and Assurance Committee, CFC – Charitable Funds Committee, FIDC – Finance, Infrastructure & Digital Committee, PPPC – Performance, Population and Place Committee, PCC – People & Culture Committee, QSC – Quality & Safety Committee, RemCom – Remuneration Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
15 January 2026	165/25	**Cyber Security Framework – Board Assurance Report** Brief offline update to be provided to clarify and provide clarification and assurance regarding business continuity arrangements and related agreements, including whether decisions had been taken, the rationale for them, and their regulatory basis. Formal assurance to be provided at an appropriate time once the approach and timing had been agreed.	Chief Digital & Transformation Officer	

Future Actions				
None				

Report Title	**Question for the Board**				
Meeting	**Trust Board**				
Date	**12/03/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices					

Purpose

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

Assurance Level

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

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

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

Assurance in respect of the process of obtaining and gaining response to questions to the Board.

Report

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

This paper reports the question and response asked of the Deputy Chief Nurse on 26 January 2026

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

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

Risk + Oversight		Risk Score
Key risks – risk number & description (Link to BAF / Risk Register)	n/a	

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Deputy Chief Nurse
Next Steps	Present at Council of Governors meeting

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

Explanation of above analysis:

Recommendation / Action Required

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	Caroline Coles, Company Secretary
Date	**05/03/2026**

Questions to the Board				
Topic	**Questioner**	**Question**	**Responder**	**Response**
Nursing and Midwifery Council (NMC) judgement	Chris Callow, Lead Governor	Media coverage on a NMC judgement which involved a former employee of the Trust the question was around how can the Trust be assured that this will not happen again.	Ana Gardet, Deputy Chief Nurse	Once the Trust were aware of the allegations, the former employee was immediately suspended from duty and did not work for the Trust again. An internal investigation was undertaken, during which both the police and the Local Authority Designated Officer (LADO) were involved. Following their review, no charges were brought While it is not possible to eliminate all risk, a number of actions have been implemented to reduce the likelihood of recurrence. These include strengthening our Persons in Position of Trust (PiPoT) processes, embedding safeguarding considerations within the four-step model, and implementing a competency framework for triage practice. The Division of Medicine also developed and implemented an action plan to address the identified learning.

Report Title	**Staff Board Story – Site Team**				
Meeting	**Trust Board**				
Date	**12/03/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Jude Gray, Group Chief People Officer Benny Goodman, Chief Operating Officer				
Report Author	Claire Warner, Site HR Director				
Appendices					

Purpose

Approve ☐	Receive ✓	Note ☐	Assurance ☐
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Assurance Level

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

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

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

Report

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

This month's Board story presents the experience of the Site Team during a sustained period of critical incident, primarily driven by significant pressures in bed capacity and overall capacity.

During this time, GWH operated at consistently high occupancy levels with minimal flexibility in the system. The Site Team was required to manage continuous escalation, complex flow challenges, and frequent risk-based decisions to maintain patient safety. Bed shortages and delayed patient flow created ongoing operational strain across the site. From a frontline

perspective, this has been a period of increased workload, the need to balance quality of care with system constraints.

The purpose of sharing this story is to ensure that the Board hears directly the lived experience behind performance metrics and escalation reports. The Board is asked to actively listen, reflect on the implications for workforce wellbeing and capacity planning, and consider how strategic decisions can better support sustainable flow and resilience across the organisation

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

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

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

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

Explanation of above analysis:

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is asked to actively listen to the staff experience, reflect on its implications for workforce wellbeing and operational capacity and support action that strength flow and resilience.

Accountable Lead Signature	Jude Gray, Group Chief People Officer
Date	**27/02/2026**

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**12/03/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

Purpose

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

Assurance Level

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

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

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

Due process followed.

Report

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

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

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

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

Risk + Oversight | **Risk Score**

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to note the updates.

Accountable Lead Signature	Liam Coleman, Chair
Date	**04/03/2026**

Chair's Board Report

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

1. Council of Governors

1.1 Due to relocating to another area Deputy Lead Governor Vivian Coppen has had to step down as governor. Stephen Baldwin will be taking on the role of Deputy Lead Governor.

1.2 We welcome a new governor, Tim Poole as Swindon Governor representative following Vivian's departure.

1.3 The following table outlines the key meetings, training and events during January and February 2026 that governors participated in:-

January to February 2026 – Council of Governors		
Date	**Event**	**Purpose**
6 January 2026	Meeting with Chair, Company Secretary and Lead Governor	Governor induction
14 January 2026	Business & Planning Working Group	To identify key issues in relation to Trust finance

26 January 2026	Informal Governor meeting with NEDs	Relationship building with Non-Executive Directors - Will Smart, Non-Executive Director and Neil Clarke, Associate Non-Executive Director attended this meeting
28 January 2026	Public Health Talk, Carers in GWH	Tania Currie presented to members and governors
29 January 2026	Extraordinary BSW Joint Nomination & Remuneration Committee	Following the withdrawal of one of the shortlisted Group Chair candidates, leaving a single remaining candidate, the extraordinary Joint Council of Governors Nominations & Remuneration Committee meeting agreed to pause the substantive Group Chair recruitment process. The panel concluded that proceeding with only one candidate would not provide an appropriate level of competition for such a significant appointment.
3 February 2026	Councils of Governors briefing session on Group developments.	BSW Hospitals Group Development and Governance Discussions which included Group NED model, Group Operating Blueprint, Group Chair recruitment, transforming models of care, planning and Group narratives and benefits realisation
3 February 2026	Extraordinary Council of Governors meeting	To approve moving to an Interim Group Chair position for 18 months.
13 February 2026	BSW Joint Nomination & Remuneration Committee	Consider and approve recruitment process for BSW Hospitals Interim Group Chair
18 February 2026	BSW Joint Nomination Committee	To agree BSW Hospitals Interim Group Chair shortlisted candidates for interview.

18 February 2026	Engagement & Membership Working Group	To advise and support the Trust in increasing Trust membership and improving membership engagement
23 February 2026	Board Safety visit – Falcon Ward	Attended by governors
3 March 2026	Governwell Webinar – What the 10 year health plan means for your governors	To update governors on the 10 year health plan
5 March 2026	Council of Governors meeting	Regular meeting to update and discuss Trust issues. Additional to the standard agenda items there were reports on Quality Accounts and the priorities for 2026/27, governor development 2025/26.

2. Non-Executive Directors

2.1 *Safety Visits*
There was 4 Board safety visit during the period covered by this report as follows:-

Date	Area	Board Member
19 January 2026	Mortuary	Luisa Goddard, Chief Nurse Bernie Morley, NED Helen Spice, NED
26 January 2026	Aldbourne Ward	Kathryn Bateman, Chief Medical Officer Claudia Paoloni, NED
23 February 2026	Falcon Ward	Luisa Goddard, Chief Nurse Helen Spice, NED Sandra Gordon, NED
25 February 2026	Mercury Ward	Kathryn Bateman, Chief Medical Officer Will Smart, NED

3. Trust Chair Key Meetings during January & February 2026

Meeting
BSW Hospitals Group Joint Committee
BSW Hospitals Group Remuneration Committee in Common
BSW Hospitals Group Collective Narrative Discussion
BSW Hospitals Group Council of Governors Development Session
BSW Hospital Group Chairs Meeting
BSW All Trusts Board Workshop
BSW Recovery Assurance Meeting
GWH Board of Directors Meeting

Meeting
GWH Extraordinary Joint FIDC & PPPC Meeting
GWH Board of Directors Development Session – Freedom to Speak Up
GWH Governors/Company Secretary
Introductory meeting with GWH newly elected governors
RUH Board of Directors Meeting
RUH Extraordinary Board of Directors Meeting in Private
RUH NEDs Meeting
RUH Lead Governors Meeting
RUH Council of Governors
RUH Staff Governor & NED Monthly Feedback Meeting
RUH Nomination & Remuneration Committee
RUH Meeting with MPs
RUH Paid Breaks Grievance Appeal Hearing
1:1 with ICB Chair
1:1 with South West Regional Director
1:1s with Vice Chairs
1:1s with Managing Directors
1:1s with Chief Executive
Group Chairs' Forum

Report Title	**CEO report**				
Meeting	**Trust Board**				
Date	**12/03/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Cara Charles-Barks, Chief Executive				
Appendices					

Purpose

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

Assurance Level

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

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

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

Report

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

The Chief Executive's report covers:

- Risks
- National update
- Group development
- Operational update
- Quality
- Workforce, wellbeing and recognition

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

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

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

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

Explanation of above analysis:

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	**05/03/2026**

1. Risks

1.1 Financial position and recovery

The financial position for month 10 showed a deficit of £6.8m, with a year-to-date adverse variance of £35.2m.

At an individual Care Organisation level, performance has remained challenged across all sites due to the financial impact of continued operational pressures and the difficulties of delivering efficiencies in these circumstances. The year-to-date deficit positions for Care Organisation are Royal United Hospitals Bath (£18.3m), Great Western Hospitals (£8.5m) and Salisbury (£8.4m). These are in line with the revised recovery plan submitted in February 2026 which assumes a year end deficit of £42m.

All Care Organisations have a number of measures in place to mitigate the deficit position, which includes additional controls, closure of escalation capacity, and increased delivery of elective income.

1.2 Urgent and emergency care update

UEC remains challenged across all three care organisations. This is due to a number of factors including demand, acuity of patients, and flow through our hospitals. The number of patients waiting to leave acute trust beds remains a challenge – with sustained high numbers of NCTR across all three organisations.

Additional surge beds in community hospitals and additional pathway capacity has been put in place in response to the demand, but the position remains challenging. UEC improvement plans are in place and focus on improving internal processes, discharges, and ensuring decisions regarding care are taken in a timely way.

A further challenge across all three acutes is an increase in the number of cases of winter flu and norovirus in January and February.

Ongoing key risks – Delivery of four-hour performance and 12-hour delays in Emergency Departments continues to be challenging. The non elective demand into acute trusts remains at a higher level than planned. NCTR continues above plan and the acute focus is on ensuring daily discharges are aligned to meet the demand and internal flow through the beds. There are several internal and system actions underway to mitigate these key risks and the focus continues to be on quality and safety across the trusts.

All three organisations will have an increased and refreshed focus regarding the reduction of care of people within corridors. We recognise that this is not the experience we would want anyone to have and will be working hard to resolve this.

1.3 Elective

A number of risks to delivery are currently being managed across BSW Hospitals Group on elective care. These include ongoing operation pressures on UEC as outlined above, a focus to maintain activity as appropriate, in line with national guidance, as a result of the national shortage of Heraeus cement. In addition:

- Sprint delivery. A national RTT sprint has been launched for Q4 across BSW. The sprint requires a focus on additional new appointments in Q4 and an improvement to delivery of 18 weeks at year end.
- Advice and Refer. A requirement of the national NHSE planning guidance is to adopt Advice and Refer for all elective referrals to Trusts. This aims to reduce the need for new appointments by providing more advice electronically. Work is underway to design and implement the shift from a referral support services to Advice and Refer across the Group and a series of shared tools have been developed to support modelling and implementation across the three care organisations.

2. National update

2.1 Resident Doctors industrial action

The British Medical Association (BMA) announced that Resident Doctors in England have voted to continue industrial action for another six months (until August 2026) in their February 2026 ballot, with 93% voting yes on a 53% turnout. This follows a rejection of the Government's offer and previous strikes, the last of which was in December 2025.

2.2 National Cancer Plan for England

A new National Cancer Plan was published in early February 2026 which sets out a long term approach to improving cancer outcomes, experience and equity over the next decade so that by 2035, 3 in 4 people diagnosed with cancer will be cancer-free, or living well with cancer, after 5 years – as well as improved quality of life for people living with the disease.

Further information on the National Cancer Plan can be found at https://www.gov.uk/government/collections/national-cancer-plan-for-england

3. Group development

3.1 Joint Committee

Our latest BSW Hospitals Group Joint Committee meeting was held on 18 February 2026 with a focus on Financial Sustainability & Recovery, Risks in Care Organisations and across Group, Integrated Performance Report Development, our Group Non-Executive Director Model, the Roadmap for transition to Group Board, Group Assurance Manual and Terms of Reference for the Group Board, and Risk & Assurance Committee. A report from the February Group Joint Committee has been included with March Trust Board papers.

3.2 Leadership Team

Since the last report, we have seen the appointment of Mark Ellis as our Chief Risk Officer. The Remuneration Committees in Common also approved the appointment of Judy Dyos, Chief Nursing Officer at SFT, as interim part-time Chief Strategy Officer. With these appointments, the Executive leadership team is fully established albeit with two interim positions still in place.

The recruitment of an interim Group Chair continues with interviews scheduled for early March.

3.3 Group Governance and Assurance Arrangements and Transition Roadmap

The governance development work to support safe mobilisation to our new Operating Model is continuing led by our Governance Working Group. Supporting this work, the Non-Executive Governance Reference Group met on 2nd February, to consider the Governance Roadmap and transition timeline.

3.4 Group Priorities and Prioritisation Approach

Our five areas of prioritised focus for the Group and Care Organisations remain as follows:

1. Recovery (Performance & Finance)
2. EPR implementation
3. Clinical transformation
4. Corporate Services Review
5. 2026/27 planning including Group Mobilisation

The Group Leadership team meets weekly to monitor progress in these priority areas.

3.5 EPR Deployment Options Appraisal

The EPR programme, has been working on delivery planning. Final costs and draft delivery plan will be presented to the BSW Group Executive, Care Organisations, and BSW Hospitals Group Joint Committee in March 2026, with a final delivery plan to be confirmed in April.

3.6 Clinical Transformation Programme

Clinical Transformation Groups (CTGs) will be established to support clinical service transformation with an ambition to mobilise at least six CTGs in 2026. A steering group comprising clinical, operational and transformation leads from the three Care Organisations has been established and will work to ensure the programme is resourced to enable successful delivery.

3.7 Corporate Services Programme

Our Corporate Services Programme is making progress with the design stage for services underway and governance arrangements well established. The Steering Group and Design Authority meet regularly, and designs have been approved for seven corporate services with consultation planning well underway. The financial impact of the programme is being tracked for each service, with clear targets set for 2026-27 and 2027-28.

3.8 Group Board-to-Board Development Days

The 2026/27 Group Board dates are being scheduled. A Board-to-Board development day is planned to take place in early May 2026 and will focus on Group Strategy and preparations for transition to our new Group Operating Model.

3.9 Councils of Governors Workshop

On 3 February the three Councils of Governors had a development session.. There was briefing and discussion on the Group Chair appointment process, the Group Operating Blueprint, including Non-Executive Director Model development, and the role of Governors in a Group model.

Great Western Hospitals NHS Foundation Trust update

4. Operational update

4.1 Latest operational position

An internal critical incident was declared and remained in place for a significant part of February due to very high demand and difficulties with maintaining patient flow through the hospital.

Outbreaks of flu, Covid-19, and norovirus resulted in wards being shut, making our position more challenging.

This resulted in long waits for patients and put extra pressure on staff caring for higher than usual numbers of sick patients.

In January this year we saw just over 1,500 more attendances to our urgent and emergency care services than in January 2025, bringing the total number of visits to the Urgent Treatment Centre or Emergency Department to 11,633 in the first month of this year – an average of 375 adults and children every day.

We continue to ask the public to consider whether there are alternative places they could seek advice or treatment rather than coming to hospital, such as 111 and pharmacies.

4.2 Modular ward

We have secured capital funding for a new modular facility, which will see a temporary ward containing 22 additional beds installed.

Work has begun to prepare the space for the modular ward, which will provide us with additional bed capacity.

This will help us to reduce the number of patients being cared for in escalation areas.

4.3 Mask-wearing

Having taken into account current levels of respiratory infections within the community and presentations across our organisation, we have stood down mandatory mask-wearing in front door and unscheduled care areas of the hospital. Standard infection prevention and control precautions remain in place and we will continue to monitor rates of infection in the community.

5. Quality

5.1 Care Quality Inspection of maternity services

In January the Care Quality Commission carried out an unannounced two-day inspection of our maternity services.

The CQC were positive about the department's calm, friendly environment, and recognised the personalised approach in place.

They noted good working relationships and visible leadership which supports staff to speak up and be listened to.

The team is already working to address areas of focus highlighted by the CQC, including infection prevention and control measures and decluttering.

Thanks to all staff who were involved in the visit, welcoming inspectors and answering their questions and providing information at short notice.

The final report by the CQC will be published in due course.

6. Workforce, wellbeing and recognition

6.1 Agenda for Change pay award

The Government announced last month that NHS staff on Agenda for Change contracts would receive a 3.3 per cent pay increase in 2026-27. Staff will receive their new rate of pay from April 2026. The announcement does not apply to medical staff.

6.2 Flu vaccination campaign

So far this year, we have vaccinated more than 4,200 staff, students, volunteers and Serco staff as part of our flu campaign.

This year we have vaccinated 62 per cent of frontline staff, compared to 58 per cent at the same point last year.

6.3 STAR of the Month

John Boyle, Clinical IT Applications Trainer and Receptionist on the Medical Assessment Unit, has won our latest Star of the Month Award.

He has been recognised for his kindness, patience and for being a great team player, supporting the team on MAU with their IT support and ensuring they have the resources they need to succeed at work.

6.4 Neonatal award

Our Neonatal Unit team have received the BLISS Bronze Award. This accreditation demonstrates the team's commitment to family integrated care, and their work to initiate real change which is improving the involvement parents have in their baby's care as well as tackling health inequalities in neonatal care.

6.5 Award for supporting resident doctors

Charlotte Goode, Senior Undergraduate Administrator, has been awarded the Medical Undergraduate Administrator of the Year 2025 by King's College London. Charlotte was recognised for her work to support resident doctors on placement at GWH from King's College.

6.6 Hospital radio

Our Hospital Radio volunteer team have been shortlisted in two categories at the National Hospital Radio Awards – the Best Station Promotion and Best Special Event of the Year, which follows their 12-hour request show to commemorate the station's 60th anniversary last year.

6.7 National Apprenticeship Week

During National Apprenticeship Week, we held an awards ceremony celebrating 38 colleagues who have successfully completed their apprenticeships in the last year. We are now supporting 209 apprenticeships across the Trust – the highest number we have ever achieved.

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	25th February 2026	
Committee Chair	Bernie Morley Non-Executive Director	
Link to Strategic Objective	Pillar 3: Better Together	
Link to Board Assurance Framework	BAF 3: SR 4 – Performance and SR5 - Partnerships	
Improving Together Pillar Metrics	Waiting List – over 52 week waiters	Cancer waiting times
	Emergency Care – demand in area / time in ED	Elective waits – reducing inequality
Improving Together Breakthrough Objective	Non-elective average length of stay	Wait to First outpatient appointment

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Operational Highlight Report (see below)		
2. IPR - DM01	Substantial	No
3. IPR – RTT	Partial	No
4. IPR – Cancer Services	Partial	No
5. IPR – ED / 4 hours	Limited	No
6. IPR – Ambulance Handover	Good	No
Quarterly 15+ Risk Report	Good	No
EPRR Update	Noted	
Partnership Report	Noted	
Health Inequalities Report	Noted	

POINTS OF ESCALATION	RTT and cancer have both moved into Tier 2 for performance.
KEY AREAS TO NOTE	**ED 4 hours:** Combined 4 hour performance was 66.5% in Jan down from 69.9% and 7.9% off plan. UTC had sustained performance at 149 mins. ED and CEU at 472 mins. **Ambulance handovers:** Following 3 months of handover time under 33 minutes, handover times increased to 45 minutes on average for January, noting a continued material year on year increase in conveyance rates. **Cancer:** 28 day FDS at 71.6% up from 61.6% in Oct but remains 10% off plan, with skin colorectal and breast being main contributors. The 62 day standard is at 71%, up from 65.8% and 2% off plan. SFT support on plastics is currently under discussion.

	31 day is up to 91.4% up from 83.6%. **RTT** 58% of patients waiting under 18 Weeks (1.4% off plan), 740 over 52 weeks (an increase from 559). 5 patients over 65 weeks, a reduction from 28 in November, and all have plans to be treated before April. 2 patients now waiting over 78 weeks (down from 3 in November). Waiting list highest in General Surgery, Trauma and Orthopaedics and Gastro. 3 streams being looked at to address RTT position: • Demand Management to look at areas with increased growth • A review of waiting list validation • Looking to increase treatment capacity **EPRR** Substantially compliant, 60 of 62 standards fully compliant, 2 partially compliant. Business Impact Assessments and Business Continuity Plans are in progress but as of yet incomplete. EPRR team dealt with 8 Business Continuity incidents, 4 Critical Incidents, and 3 UEC performance declarations – most of which were issues around patient flow. **Partnerships** There are still areas with HCRG around the contract and SLAs that are being worked through. Discussion with HCRG is ongoing. We are supportive of the movement towards Neighbourhood Health and playing an active part in plans across Swindon. Commissioning and policy drivers differ between partners. In particular the boundary of integrated neighbourhood teams proposed by HCRG vary from the geography of PCNs in Swindon and Swindon Borough Council is moving forward with family hubs. National guidance and contracts for Primary Care are due to be published. **Health Inequalities Report** TMC reviewed the Newham framework for GWH with a score of “fundamental” (4 point scale) across 6 domains, with scores in between “not meeting fundamental” and “fundamental” in collecting the right data, and interventions to address health inequalities. We are building our Health Inequalities plan with an increased focus on interventions. The committee received a copy of the BSW Health inequalities draft strategy.
BOARD ASSURANCE FRAMEWORK & RISKS	In the last quarter: One new risk at 16 has been introduced around surgical patient flow. One escalated risk (from 12 to 16): due to wait 45 offload implementation, the risk to patients in the ambulatory area has increased as a result of increasing overall demand. No risks closed or de-escalated, but there has been a decrease in overdue risks and overdue actions.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**DM01**: DM01 has reached 91.1%, a small drop from 92.9%. The additional endoscopy through the CDC is now fully functional. Increases noted specifically in Cystoscopy and Audiology, with additional space for NOUS also created. **Non-elective LOS** NEL LOS at 6.1 days in January which is 0.6 days better than last year. A number of projects are in play to facilitate this improvement including the implementation of the Swindon DVT pathway.
REFERRALS TO OTHER BOARD COMMITTEES	None

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

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

Board Committee Assurance Report

Committee	**Quality & Safety Committee**	
Meeting Date	22.1.26	
Committee Chair	Claudia Paoloni, Non-Executive Director	
Link to Strategic Objective	Pillar 1 : Outstanding Care	
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality	
Improving Together Pillar Metrics	Reducing Harms	Patient Experience
Improving Together Breakthrough Objective	Falls Harm Prevention	

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Falls (IPR breakthrough objective). Falls	Partial	
2. IP&C (IPR breakthrough objective)	Good	
3. Complaint Response Rate (Breakthrough Objective)	Partial	
4. Deep Dive: Gram negative Infections	Good	
5. Deep Dive: Controlled drug assurance	Good	
6. IPR Maternity	Good	
7. Maternity safety Report	Good	
8. Q3 PRMT	Good	
9. Q2 Saving Babies Lives-compliance position report	Good	
10. Introduction of the NHS England Maternity Care Bundle	Note	
11. Maternity Survey 2025	Note	
12. Safer Staffing-monthly update	Note	
13. Corridor Care	Partial	
14. 15+ Risk report	Note	
15. EDS update	Note	
16. Prevention Future Deaths, regulation 28-Drug Overdose	Note	

POINTS OF ESCALATION	**IPR: Reduction Total Harms:**
	• Deterioration across several metrics this month, improvement workstreams in place for all areas affected.
	
	IPR: Infection Control:
	• Actions from recent catheter care audit are being implemented and monitored.
	• Klebsiella rates static.
	• Increase in C Difficile rates (11 from 7) but still in line with our trajectory.
	• MSSA cases increased from 1 to 5.
	• Trust remains, however, above trajectory for Klebsiella and E.Coli.
	• Increased educational and early recognition measures have been initiated.
	• Results from urinary catheter audit have now been shared at ward level in January 2026.
	
	IPR: Breakthrough Objective: Falls
	• Some increase in numbers of falls this month to 91 from 76.
	• 4 patients experienced moderate harm.
	• 10 patients have fallen more than once
	  ○ deconditioning remains a contributory factor – a deconditioning initiative is being introduced between January and March 2026
	  ○ likely increase in capacity issues also contributory.
	• Still within target trajectory.

	Pressure Ulcers: • Hospital acquired pressure harms increased in December, reflecting the increased operational pressures. • Still remains below Trust trajectory. • Disappointingly, there was an increase in category 3 harms, but no category 4. • There were 16 harms over 14 patients with 6 being device related. • Targeted education, training and enhanced guidance being implemented.
	Complaints and Concerns Response Rate: • The complaint response rate has achieved 82%. First time met KPI in a year. • Achieved through increased divisional oversight and weekly progress meetings. **DEEP DIVE REVIEW: Gram negative infections** • Rates for several key infections have improved: Klebsiella and Pseudomonas. • Trust is under trajectory for *C.Difficile* and Pseudomonas. • MRSA remains below regional average. • GWH has lower rate than SW average for half of the monitored infections. • Continued strengthening of the fundamentals of good infection control practice – enhanced ward presence, targeted audits, education initiatives by IPC team. • Some infections remain above trajectory improvement plan, but mitigating measures put in place. • *E.Coli* remain above trajectory and above SW Region; predominant cause urinary tract infection often associated with urinary catheter use. • External audit of urinary catheter care completed October 26, IPC team now supporting targeted improvement activity based on learnings. • MRSA is above internal trajectory target but below regional average. Trust is prioritising improvements in catheter care, hand hygiene, decontamination of equipment. Increased ward presence of IPC team. “Back to basics” education programme. Quality improvement initiatives on catheter care. **DEEP DIVE: Controlled Drug Assurance** Received comprehensive report on risk management, audit, education, reporting concerns, improvement actions and development. Recent improvement initiatives: • Introduction new medicines in theatres policy. • Installation of CCTV in pharmacy and CD movement in and out of pharmacy. • Review of end-of-life medications to improve access and reduce delays. • Rationalising use epidural diamorphine in response to national shortage. Good assurance around CD related incidents and concerns. GWH works within regulatory and governance frameworks for controlled drugs. Robust audit. Embedded incident management processes. Good education and training plan. High standards maintained throughout.
	Maternity Integrated Performance Report • Sustained performance in staffing metrics, reflecting the effectiveness of the escalation policy in ensuring safe care,1:1 care had been maintained in all cases. • High capacity in neonatal unit due to exceptional high numbers pre-term babies, causing some staff capacity stresses, but safety maintained through staff flexibility. • 0 notifiable deaths in December. • 4 safety incidents graded moderate or above, all being reviewed. • Learnings from Regulation 28 national reporting-disseminated and incorporated into local governance.

	• December saw a significant number of open Datix cases being closed. • An increase in reportable incidences have been noted around hypoglycaemia pathway, but on investigation this has been shown to be related to incorrect identification of correct pathway choice-resulting in targeted education to address knowledge gaps. • CNST 7 was released in April 2025. The committee received a paper and assurance that the Trust position was full compliance. • Safeguarding child protection level 3 remains below required threshold. Enforced measures are being introduced. • CTG hourly review and peer compliance is below required threshold, with training interrupted due to acuity and capacity of service. A robust plan is in place to address.
	Maternity and neonatal Quality and Safety Report Q2: • Robust report received. • Good assurance around incident reporting and investigating. • MOSS (Maternity Outcomes Signal System) system for real time maternity monitoring of intrapartum period now working and complementing existing systems to ensure rapid response to signals of concern. • Perinatal Mortality Review tool fully utilised, within correct timeframes, no themes identified. • Good assurance around regulatory compliance. • Full oversight of staffing, current establishment. Meets BR+ recommendations. • Good assurance around measures to manage acuity and capacity pressures. • GWH no longer outlier in region for post-partum haemorrhage >1.5L. • Badgernet has shown mismatch with Datix data which is being investigated. • CQC has visited for inspection-report to follow. • Elective caesarean section lists are overrunning, affecting patient experience and flow. Programme of review underway. • Caesarian section rate continues to increase which has an impact on length of stay. • Triage area environment inadequate for purposes, bid for improvement work submitted.
	Perinatal Mortality Review Tool report Q3 • All standards met in Q3.
	Saving Babies Lives Q2 • Continued compliance. • 5 out of 6 elements fully compliant. • Last element being reviewed to ensure still compliant with latest version.
	Introduction of the NHS England Maternity Care Bundle • Received introduction into the new Maternity care bundle which will have key areas of focus: • Venous thromboembolism. • Pre-hospital and acute care. • Epilepsy in pregnancy. • Maternal mental health. • Obstetric haemorrhage. The team are planning to ensure early engagement to ensure timely alignment with national expectations.
	National Maternity Survey • Part of the mandatory CQC survey, part of the National Patient experience Survey. 300 patients invited. 41% response rate which is lower than 2023 and 2024. • Overall results remain stable, with majority of results staying the same.

	• Areas of achievement, partners able to stay on ward, being given help when needed, offered time to discuss pregnancy, awareness of medical history and not considering making a complaint. • Areas for improvement include choice of where to have baby, being left alone when worried, help with feeding at home, and delays with discharge from ward. • Direct correlation with 2024 survey not possible as due to changes in questions and methodology. **Principles for Providing patient care in Corridors** • Against national backdrop that corridor care is unacceptable, must not be normalised and should only occur in extremis and for the shortest period, GWH has reviewed current practice. • Foundational controls are in place, but gaps in governance, documentation, risk assessment, patient experience, de-escalation, fire and Infection control assurance have been noted. • Over next 30-180 days strong action plan being implemented with a task and finish group overseeing delivery at pace. Committee has partial assurance around impact at this stage as GWH continues to operate at very high occupancy rates >99% with associated high need for corridor care use.
KEY AREAS TO NOTE	
BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	Performance, Population & Place Committee – looking for assurance around delayed access to diagnostics and procedure date and impact on disease progression with risk of inoperability or poorer /more limited outcomes.

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

SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
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Board Committee Assurance Report

Committee	**People & Culture Committee**	
Meeting Date	3rd March 2026	
Committee Chair	Julian Duxfield, Non-Executive Director	
Link to Strategic Objective	Pillar 2: Valued Teams	
Link to Board Assurance Framework	BAF: SR 2 (Culture), SR 3 (Workforce Planning)	
Improving Together Pillar Metrics	Sickness rates	Staff survey – recommend place to work
	Staff survey – addressing discrimination disparity	
Improving Together Breakthrough Objective	Staff Survey – respect from colleagues	

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. **Annual Leadership Report**	Good	x
2. **Health and Wellbeing Highlight Report & KPIs**	Good	x
3. **Q3 Corporate Services Workforce Recovery Update**	Partial	x
4. **Q3 Medicine Workforce Recovery Update**	Partial	x
5. **Q3 SPC Workforce Recovery Update**	Good	x
6. **Q3 FaSS Workforce Recovery Update**	Partial	**x**
7. **Group Immigration and Visa Update**	N/A	**x**
8. **Update on Sexual Safety Charter Implementation at GWH**	N/A	**x**
9. **Corporate Services Design Update**	N/A	**x**
10. **Annual Job Planning Report**	Good	**x**
11. **Integrated Performance Report**	N/A	**x**
12. **Risk Register Report**	N/A	**x**
13. **Board Assurance Framework**	Substantial	**x**

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	Over the last 12 months good progress has been made in identifying the key areas required for developing improved leadership capability across the Trust and in delivering a range of interventions. A set of behaviours, which align with the well embedded SATR values were co-created in 25/26 with over 5000 contributions. The roll-out of this 'Our Behaviours' framework underpins much of the work being done in this area. It was encouraging to see the continued progress made within the Leadership and Organisational Development (OD) portfolio, with an increase in leadership development opportunities for staff, including the successful 90% rollout of the Line Management Expectations framework. Participation in leadership training programmes has doubled, demonstrating strong engagement and organisational commitment to capability building. In addition, the TED tool has been further embedded as both a diagnostic and supportive OD instrument, strengthening its role in identifying development needs and enabling targeted interventions. However, it should be noted that adoption is not consistent across all areas and further consideration should be given to how the Group model should impact this activity. It was also noted that further work is required to strengthen and embed medical leadership.

	The review of the Trust's Occupational Health and Wellbeing Service uses the NHS Health and Wellbeing Framework, which covers personal health and wellbeing, fulfilment and environment, to assess our provision. Across many areas good progress has been made in the last 12 months, and there is a wide range of interventions across GWH which staff are well engaged with. GWH is sharing data with the other two Trusts on this issue. The Committee had a dialogue with each division to assure progress against the workforce recovery targets. The assurance ratings above reflect a balance of the management focus on this issue which has progressed well over the last year but also the under-delivery on workforce reduction in three of the four divisions. It was noted that the tension between the workforce numbers and operational pressures and safety & quality is a difficult issue. The update the Committee received on work visas outlined the ongoing changes to the UK visa system and the work that the three Care Organisations have jointly undertaken on their approach to visa issuance and duration to ensure continued compliance while supporting the recruitment, retention and stability of our international workforce. NHSE launched a 'Sexual Safety Charter' in 2023 and in December 2024, GWH adopted the National Sexual Misconduct Policy, adding local amendments. In January 2025, the Trust launched an eLearning module on "Understanding Sexual Misconduct in the Workplace." However, to date only 5% of the Trust employees have completed this learning and there are plans to make this training mandatory. Specialist investigation training is also planned. A Chaperone policy has introduced for patients, and we will need to train staff, most likely via the level 2 safeguarding training. The Committee received an update on the corporate services organisational change programme. Consultation is currently underway in relation to HR at Level 3, with Estates, Digital and Strategy progressing through their respective staff-side committees as part of the formal consultation process. Communications and Governance design work is also in progress. It was noted that the programme continues to be delivered by the existing team, predominantly within GWH. Approval has been secured for a Band 7 Change Manager role, with interviews scheduled to strengthen programme capacity. The Committee acknowledged the scale and complexity of the programme, which impacts approximately 3,000 staff across a £154m operational footprint and is aligned to a £16.8m savings target. The annual report of medical job planning and revalidation demonstrated good progress, after three annual cycles, with the using the SARD (Secure Appraisal and Revalidation Database) system. Revalidation, appraisal, and job planning are now fully implemented and embedded as business as usual across the organisation. It was noted that for next year's assurance the committee should focus on how the system is enabling productivity improvement and supporting operational change. The committee noted that the 2025 staff survey results are currently embargoed and so a meaningful review of many elements of the IPR was not possible.
BOARD ASSURANCE FRAMEWORK & RISKS	The risks remained unchanged and the committee noted the transition from the existing '5x5' risk model to the '5+5+5' model. The committee reviewed and approved the BAF.

CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

Key to committee assurance ratings
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Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**	
Meeting Date	26 January 2026	
Committee Chair	Faried Chopdat, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	**Level of Assurance**	**Board Action Required? Yes ✓ or No x**
1. BSW Financial & Recovery Workstreams Update	Limited	x
2. Month 9 Finance Position	Partial	x
3. Improvement & Efficiency Program	Partial	x
4. Seasonal Plan Verbal Update	Note	x
5. 2026/27 Planning Update	Partial	x
6. National Cost Collection Results	Good	x
7. Estates & Facilities Risk Report	Good	x
8. PFI Quarterly Report	Good	x
9. PFI Facilities Management Services Review	Good	x
10. ERIC Submission Update	Good	x
11. Dorset & Wiltshire Fire & Rescue Service Audit update	Partial	x
12. Digital Risk Report	Good	x
13. Data Protection, IT Resilience & Cyber Security	Good	x
14. Digital Strategic Plan	Good	x
15. Procurement Recommendation Reports: Temporary Staffing Partner & Supply of Modular Buildings	Approve	x

POINTS OF ESCALATION	**BSW Financial Update:** The BSW Hospitals Group had made progress stabilising its finances earlier in 2025/26, but the past two months have brought significant operational challenges, with key recovery plan measures falling short. After a thorough review, forecasts now show the Group will miss its stretch outturn target of £14.5m by around £24m. For Month 9, the financial position is £28.5m off plan at the group level, with a notable shortfall at GWH. Despite receiving deficit support funding and additional funding for recent industrial action, recovery targets were not achieved.
POINTS TO NOTE	**Month 9 Financial Position**: As of Month, 9 2025/26, the Trust has a year-to-date deficit of £5.8m, entirely due to missed recovery and efficiency targets, high staffing and operational costs, and reliance on deficit support funding. While income is above plan, increased pay and non-pay expenses—especially agency staffing and costs related to industrial action—have offset these gains. The Trust's financial position remains challenging, with ongoing financial risks from unachieved savings and heavy dependence on external support.
	Improvement and Efficiency Plan: The Trust began 2025/26 with a £32.4m efficiency savings target, including £2.8m carried forward. By Month 9, £17.81m (74% of the year-to-date target) had been delivered, leaving a shortfall of £6.17m. Corporate and Medicine divisions contributed most, with strong workforce, procurement, and medicines management savings. However, only 47% of savings are recurrent and 25% of schemes remain high-risk. Work is ongoing to develop major transformation themes for 2026/27.
	Dorset & Wiltshire Fire & Rescue Services Audit: Following a September 2025 Dorset & Wiltshire Fire & Rescue Service (DWFRS) audit, the Trust, THC, and Serco have worked collaboratively to address identified fire safety concerns. Significant progress has been made on remedial actions, with regular updates and requests for deadline extensions provided to DWFRS. However, some improvements—particularly those requiring Building Safety Regulator approval—are delayed due to ongoing challenges in appointing a suitable principal contractor. The Trust is also addressing a backlog of Primary and Secondary Fire Risk Assessments (FRAs), investing in additional resources and external consultancy to complete these by March 2026. Despite delays, there is strong engagement from all parties, and fire safety improvements remain a top priority for the Trust.

	2026/27 Planning Update: The Trust's planning processes have advanced, but both the Trust and the wider BSW system face significant financial challenges, making it unlikely they will meet their recovery plan—resulting in only Partial assurance and possible increased scrutiny. In January, a comprehensive 3-Year Operational Plan and 5-Year Integrated Delivery Plan were finalised with system partners, combining clinical, corporate, and system priorities. An Extraordinary PPPC/FIDC was held to review these plans, focusing on finance, efficiency, activity, workforce, risk, and board assurance statements.
REFERRALS TO OTHER BOARD COMMITTEES	N/A

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

Committee	**Finance, Infrastructure & Digital Committee**	
Meeting Date	23 February 2026	
Committee Chair	Faried Chopdat, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Financial & Recovery Workstreams Update	Limited	x
2. Month 10 Finance Position	Partial	x
3. Improvement & Efficiency Program	Partial	x
4. Way Forward Program Risk Register	Good	x
5. Planning Update	Note	x
6. Costing Engagement & Service Line Reporting	Good	x
7. Site Utility & Resilience – 6 monthly updates	Good	x
8. Electrical Incident Closure Report	Good	x
9. Health & Safety Quarterly Report	Good	x
10. BAF Strategic Risks – Q3	Substantial	x

POINTS OF ESCALATION	**BSW Financial Update:** The financial position of both the Trust and the wider BSW system is significantly challenged in the 2025/26 financial year. Currently, there needs to be greater confidence in the deliverability of efficiency and workforce plans across all BSW organisations before the assurance rating can be improved. Whilst the BSW Group has made tangible progress in stabilising its financial position, the last two months have been challenging from an operational perspective, with key operational enablers of the recovery plan not meeting required standards. Current projections indicate the stretch-out position of £14.5m will be missed, and a revised, more likely, outturn of £42.0m will be achieved.
POINTS TO NOTE	**Month 10 Financial Position**: The Trust has a year-to-date deficit of £8.5m for M10 2025/26, which is £8.5m worse than planned. Operational pressures in January, including increased emergency attendances and additional escalation beds, have raised costs and reduced income. While income is above plan, both pay and non-pay costs are significantly over budget, with efficiency savings falling short. Despite regular committee oversight, there is increasing concern about meeting the breakeven target by year-end.
	Improvement and Efficiency Plan: The Trust started 2025/26 with a £27m efficiency savings target, including £2.8m carried over from the previous year. As of Month 10, £20.41m in savings have been delivered, which is £6.37m below the year-to-date target (76% achievement). Monthly delivery remains strong, especially from Corporate and Medicine divisions, but only 46% of savings are recurrent and 25% of schemes are high risk. Ongoing work is focused on delivering further transformation plans for 2026/27. If delivery does not improve, an extra £10.1m deficit will be carried forward, with £0.6m still unaccounted for. The assurance level is rated as Partial, emphasizing the need for continued focus on achieving the targets.
	Way Forward Risk Report: The Committee noted that the risk management process and reporting are adequate and effective and is assured that risks are identified, appropriately rated, and mitigation actions are in place. All risks rated 15+ were presented with appropriate mitigation actions.
REFERRALS TO OTHER BOARD COMMITTEES	N/A

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

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GOOD	

	Good Assurance. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
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Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**12/03/2026**	Part 1 - Public	☐	Part 2 - Private	☐
Accountable Lead	Benny Goodman, Chief Operating Officer Luisa Goddard, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Rob Presland – Deputy Chief Operating Officer Ana Gardete – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer Johanna Bogle – Deputy Chief Financial Officer				
Appendices	Use of Resources: • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

Purpose

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

Assurance Level

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

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

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

Report

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

Our Performance

During this period it should be noted that GWH declared two separate critical incidents due to flow and operational pressures. These were from 4th January to 16th January and 25th January to 29th January. Current as at the time of writing, the Trust has been in a further critical incident since 1st February 2026 with a peak of 20 empty and closed beds further affecting flow and discharge throughout the hospital. Hot debriefs have been completed to inform the incident responses and a more detailed "cold" debrief will be completed with during February. The impact of winter pressures is evident in both elective and urgent and emergency care performance during this period, which has also affected the Month 10 financial position.

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

STRATEGIC Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

RTT performance is off plan in January with 58% of patients on the wait list under 18 weeks (1.4% below plan), 740 patients over 52 weeks (272 patients or 58% worse than plan) and with 1.7% of the total wait list over 52 weeks (0.4% worse than plan). At the end of January there were only 5 patients waiting longer than 65 weeks, with three in Plastics and two in ENT, all of which have plans before the end of the financial year.

Waiting list pressures are most prominent in the specialties of General Surgery, Trauma and Orthopaedics and Gastroenterology. There are three streams of work currently underway to improve the position. First, demand management counter-measures targeting the areas with highest growth in clock starts to understand the root causes including a review of coding and classification, consultant to consultant referral practices and potential data quality issues such as duplicate referrals. The second is a review of waiting list validation practices with targeted work to improve waiting list validation towards 90%, specialty level validation resource to ensure all patients are validated down to 12 weeks wait, and extended data quality improvement effort to reduce unoutcomed appointments which hold up the next steps in a patient's pathway. The final workstream is treatment capacity and all Clinical Divisions continue to explore productivity opportunities and insourcing and outsourcing arrangements to increase the rate of clock stops before the end of the financial year.

January's position is also highly likely to have been affected by the flow pressures in January with the elective orthopaedic ward running at less than 50% capacity for electives over two weeks due to increasing non-elective demand putting pressure on the bed base.

Weekly specialty reviews led by the COO continue to take place with Operations Directors and operating plans have been established to recover towards 67% within 18 weeks during 2026/27.

- Cancer waiting times

Cancer performance for the 28-day faster diagnosis standard recovered by 10 percentage points from November with December and is at 71.6%. However, this remains at 10% below operating plan target and the Trust is not meeting the national standard of 80%.

Cancer Faster Diagnosis is heavily impacted by the capacity issues seen in the Skin, Colorectal and Breast pathways and counter-measures are in place including additional waiting list initiatives to recover performance which have improved performance in December. Additional funding from the cancer alliance is expected to further support the position towards the end of the financial year, but there remain backlogs to work through which means that overall breach reduction is not expected until March.

62-day performance for urgent suspected cancer referral to treatment recovered to 71% and is currently 2% below operating plan. Tumour site trajectories are most challenged within Urology, Breast and Plastics. Cancer pathways for Plastic patients remain under review with mutual aid being discussed with Salisbury NHS Foundation Trust.

Cancer 31-day performance was at 91.4% and with outpatient capacity in Plastics and Breast being the top contributors to breaches.

The cancer recovery plan remains in place and GWH has been successful in securing £0.25m from the Cancer alliance to increase capacity by almost 1,000 patients in the final quarter of this financial year, with investment also in reporting capacity for radiology and pathology to support more timely diagnoses in tumour sites that have backlogs.

- Time in Emergency Department

Combined 4-hour performance was 66.5% in January and 7.9% worse than operating plan. Recovery plan counter-measures initiated in November have been sustained for Type 3 UTC but the high level of bed occupancy and use of escalation spaces during this period has impacted upon Type 1 admitted flow.

However, it should also be noted that there has been exceptional growth in Type 1 attendances which were 15% higher than plan in January for the last two months and are currently 6% above plan for the year to date. Most of this additional activity has been seen in the second half of the year and special cause variation can be seen in the mean length of wait in ED as a result during January.

Ambulance handover performance in January was 45 minutes and above the 33 minute trajectory for the first time in four months. However, this remains a significant improvement on 12 months ago and conveyances continue to average at 75 per day (15-20 more than were typically conveyed before July when Wait 45 was embedded).

GWH has therefore performed well in the context of such unprecedented demand, with risk in the community being managed as well as possible and recovery shown in our 4 hour UTC performance. However, our admitted pathway 4 hour performance has deteriorated and this is shown by the increased prevalence of corridor care and use of temporary escalation spaces across front door areas and the wards.

Tactical and operational plans continue to focus on reducing length of stay in assessment areas to maximise same day emergency care opportunity and pull from ED and a business case for a modular unit has now been approved with delivery timescales for this Spring.

OPERATIONAL BREAKTHROUGH OBJECTIVES

- Non-Elective Length of Stay

Data shows that non-elective length of stay was 6.1 days in January, which is 0.6 days better than 12 months ago. There has been a 0.7 day reduction since the start of the financial year in April. The priority areas of focus are currently as follows:

  - Implementation of the Clinical Operational Standards monitoring tool following a successful launch event with clinical leads on 3rd February
  - Design of the discharge planning workstream to inform best practice for Board rounds and complex discharge team support
  - Implementation of the Pathway 1 streamlined referral process pilot for Swindon patients
  - Implementation of no criteria to reside to "referral sent" time stamp reporting to inform counter-measures in the referral work up stage of the process
  - A deep dive into SAU pathway and length of stay improvement commissioned for review at the March programme board
  - Ongoing delivery of projects within the existing programme including evaluation of the Swindon DVT pathway and progression of Frailty pathway improvements

- Proportion of Outpatient First Appointment Pathways Waiting <18 Weeks

The number of non-admitted (Outpatient) pathways waiting for a first appointment under 18 weeks was 64% in January, unchanged from December. Current performance reflects the increase in new additions to the non-admitted wait list that have been observed since the summer, and the impact of reduced activity following industrial action disruption in November and critical incidents in December and January.

Service developments in areas such as paediatrics have been completed and productivity in relation to outpatients per consultant WTE are being reviewed as part of the outpatient clinic template redesign work across clinical divisions.

Clinic template re-design remains a key priority for improving waiting times and productivity, with a minimum 2% improvement required in 26/27 across all areas.

ALERTING WATCH METRICS

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

Diagnostics – January DM01 performance was 91.1%. MRI, CT and Dexa scans are all achieving the national constitutional standard and the Trust is currently achieving the end of year target earlier than planned. Additional Endoscopy capacity from the Community Diagnostics Centre went live on 18th November and focused recovery efforts on Cystoscopy and Audiology are expected to sustain the good performance and mitigate forthcoming risks from seasonal pressures and demand on non-DM01 diagnostic work. Additional space has also been created to increase non obstetric ultrasound capacity and wait list recovery.

Temporary Escalation Spaces (TES) and No Criteria to reside patients – The use of TES increased in January with an average of 54 spaces in use across front door and ward areas.

Overall no criteria to reside was 21.4% of the bed base and this relates to higher than planned number of days delayed waiting for pathway 2 (inpatient rehabilitation) capacity in Swindon. The number of pathway 1 (home with new package of care) patients also increased in January with a surge in patients following Christmas and New Year requiring additional temporary capacity in the Discharge Support Team. A streamlined referral process was also implemented for Swindon to reduce delays in accessing community capacity for Pathway 1. Multi-agency discharge planning events have continued throughout this period with support for community hospital and acute hospital beds to maintain flow. Daily discharge planning meetings with Matrons and Ward managers have also taken place as part of the Trust incident response to support earlier pathway navigation decisions and early intervention for complex discharge planning. This has helped with a 70% reduction in patients with pathways not set.

Our Care

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

Strategic Pillar Targets

1. To achieve zero avoidable harm within 5-10 years.
2. To maintain a consistent Trust wide complaint response rate of 80% and upwards.

The number of harms is relatively unchanged in month at 130.
Complaint response rate was 76%. While this is a small decrease from December's rate of 82%, it represents a notable improvement compared with January 2025, when the rate was 69%.

Breakthrough Objectives

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

Aim for 2025/26

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

The numbers of patients who experienced falls that resulted in moderate harm or above was zero in month. The number of patients with two or more falls has decreased to 7 in month compared to 10 in December.

Alerting Watch Metrics

The overall Friends and Family Test positive response rate for January is 86.2%, a slight decrease from 88.2% in December. Day Case feedback remains strong at 95.7%, staying consistent with the previous month and above the internal target. In contrast, the Emergency Department and Urgent Treatment Centre positive response rate has fallen to 76%, down from 82.7% in July and just below the internal target of 78.5%.

Concerns received in January increased to 522, up from 342 in December. The number of patient falls decreased slightly to 89 compared with 91 in the previous month. Klebsiella cases also reduced, falling to 2 in January from 4 in December.

Non-alerting Watch Metrics
The number of complaints received in month has decreased to 81, compared to 94 received in December.

The number of E. coli cases has remained stable at 10 this month, and the Trust continues to sit above the threshold. C. difficile cases have increased to 7, compared with 3 in December, bringing the Trust back to threshold following one month below. Methicillin-Sensitive Staphylococcus aureus (MSSA) cases have fallen to 2 this month from 5 in December, although the Trust remains above threshold. One Methicillin-Resistant Staphylococcus aureus (MRSA) case has also been reported this month.

The number of hospital-acquired pressure ulcers has remained the same in month at 16.

Further points to note relating to non-alerting watch metrics include:
- Safer staffing fill rates remain above the National target of 85%.
- No Patient Safety Incident Investigations have been declared in December.

Our People

This section of the report outlines workforce performance in alignment with the pillars of the Trust's *People Strategy*: Workforce Planning, Opportunity, Employee Experience, Development, and Leadership. Each pillar is evaluated through a combination of Key Performance Indicator (KPI) achievement scores and self-assessment ratings based on monthly progress.

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

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

- **Staff Survey – Recommend as a Place to Work**
  Target: 63%
  2024 Staff Survey score: **59.6%** (no change from the previous year)
  Q2 Pulse Survey: **50.6%** (decline compared to Q1 54.7%)

- **Staff Sickness Absence**
  Target: 3.5%
  December 2025 figure: **4.5%**, (deterioration from previous month 4.2%)

- **Equality, Diversity & Inclusion (EDI) – Disparity in Experience**
  Target: 9.4%
  2024 Staff Survey: **11.9%** (improvement from previous year 12.7% last year)
  Q2 pulse survey: **15.6%**, (decline of 10.6% compared to Q1)

Breakthrough Objectives
The Pulse Survey results for *"I receive respect"* have remained stable in Q1 and Q2. In contrast, the pillar metric *"Recommend as a place to work"* has shown a decline.

The 2025 Annual Staff Survey has now closed, and analysis is underway both locally and at Group level to understand performance, identify key themes, and inform priorities and actions for the coming year. Initial results have been shared under embargo with a limited audience

to support early sense-checking and alignment. Full Trust-level results and management reports are expected to be formally published in March, following completion of Group-level analysis and validation. This analysis will inform the Trust's ongoing focus on improving staff experience and engagement, including refinement of local actions aligned to the breakthrough objectives and Pillar Metric: 'Recommending as a place to work'.

The Q1 Pulse Survey closed at the end of January, and results are expected mid-February to provide an updated measure of staff engagement, including performance against the Trust's breakthrough question.

Sickness Absence
The Trust's ambition remains to create a healthy, supportive, and inclusive work environment. Trust sickness absence increased to 4.5% in December, up from 4.2% in November, and remains above the Trust target of 3.5%. The increase was driven by long-term absence, which now represents the majority of absence in month (2.3% long-term; 2.2% short-term).

Long-term absence management continues to focus on supporting individuals with their condition or disability, assessing return to work within a 12-month period through Occupational Health, Health and Wellbeing case conferences and external assessments. The Absence Management Working Group remains focused on preventing short-term cases converting to long-term absence, with the 'Managing Long-Term Conditions' policy supporting the 85 colleagues currently on long-term absence.

The Sickness Absence Working Group continues to drive improvement through targeted operational support and audit. In January, 31 hours of face-to-face People Operations support were delivered to hotspot teams. A three-monthly audit in the Children's Unit showed compliance improving to 90%, and a first audit in Cellular Pathology achieved 65% compliance, establishing a baseline for improvement. Development of a new interactive manager resource is underway to strengthen early intervention and reduce avoidable absence.

Vacancy Rate
The Trust vacancy rate remained static in January at 70 WTE / 1.4%. Our over-established position for all nursing continues at -71 WTE, with Registered Nursing over-recruited by 66 WTE and Unregistered Nursing over-recruited by 10 WTE.

Further Medical & Dental recruitment has improved the vacancy for this staff group, reported at -4 WTE (over-established) in January.

Allied Health Professionals and Healthcare Scientists vacancy levels have deteriorated marginally in January, increasing from 22 WTE to 24 WTE (3.0%).

In line with current controls, Admin & Clerical vacancy remains high at 127 WTE / 11%.

Temporary Staffing
Bank usage increased significantly in January to 334 WTE, over plan by 158 WTE. Usage is largely due to current operational pressures, with additional resource across Nursing and Medical teams being used to support flow during critical incident. Bank spend is at £21.9M YTD, £4M above plan.

Agency usage increased in January from 24 WTE to 31 WTE, although remaining below plan. Agency spend is at £4.5M YTD, £2.9M above plan. In-month, the increase is wholly attributable to increased mental health nursing cover, particularly within Paediatrics. Whilst

above plan, agency spend in-month was 1.2% of our workforce costs. This remains below our KPI of 4.5%.

Workforce Recovery
In January, we used 5,350 WTE to deliver our services. This represents an adverse variance of +300 WTE against our planned 5,050 WTE. Usage increased by 55 WTE compared to December and is our highest year-to-date position.

Substantive workforce remained broadly stable in January but continues to sit above plan at +144 WTE. This variance is wholly driven by clinical recruitment above the scenario 2a plan. Administrative & Clerical staffing remains significantly below plan where posts are being held, however this underspend is fully offset by clinical growth outside of the scenario 2a assumptions.

Temporary staffing increased further in January, rising by 53 WTE compared to December. Agency usage grew by 7 WTE, driven by increased mental health nursing within Paediatrics. Bank usage increased by 46 WTE, largely reflecting additional staffing required to support patient flow during the critical incident, alongside pressures from enhanced care requirements and a higher sickness absence rate.

Reviewing current performance against plan at staff group level:

- All Nursing: +218 WTE
- AHP/STT: +31 WTE
- Medical & Dental: +71 WTE
- Admin & Clerical: -17 WTE

Use of Resources

For M10 2025/26 the Trust has an adjusted deficit position of £8.5m YTD, which represents an £8.5m adverse variance to plan. In M10 the Trust had a £2.6m forecast deficit as part of a 'most likely' position, but finished with a £2.7m deficit. The £0.1m adverse position is due to costs relating to ongoing critical incidents, with over 50 escalation beds open, resulting in additional staffing and lost elective income. The Trust has been operationally challenged in January, with NCTR at 20% of the bed base, type 1 ED attendances 15% over plan and ambulances averaging 75 per day (compared to 60 last year).

On a year-to-date basis, income is £7.6m ahead of plan. ERF income is £0.3m below plan, following underperformance of £1.1m in M10 due to the impact of critical incidents. The Trust is £0.9m below the ICB affordability cap. Other patient income is £3.7m over plan. This includes £1.3m of industrial action funding (net of lost income associated with strikes) and other income streams such as RTA, depreciation and vaccination income, some of which offsets with cost. It also includes a £0.6m underperformance on private patient income. High cost drugs income is £0.6m ahead of plan, which also offsets with cost. Other operating income is £3.6m ahead of plan; programmes such as EPR and CDC will have corresponding pay and non-pay costs.

The pay position is £10.6m adverse to plan, with undelivered cash releasing efficiency savings accounting for £5.9m. This includes a Trustwide target of £2.8m with no associated plans, with service transformation / benchmarking schemes within Divisions accounting for the remainder. The position includes run rate savings of £1.2m driven by prior year gains, the closure of escalation areas earlier in the year and agency framework savings. There is also a £2.7m underspend against Corporate admin lines due to unfilled posts. The remainder of

the variance is due to industrial action costs of £1.3m and £7.3m of agency and locum overspends, the majority against medical and dental staff covering 97 WTE of clinical vacancies, sickness and escalation costs. It should be noted that the Trust has been running with over 50 additional beds and escalation areas when in critical incident.

Non-pay is £5.5m adverse to plan. Undelivered cash-releasing efficiency savings accounts for £2.9m with a Trustwide target of £1.4m with no associated plans. There are also efficiency plan underperformances against Procurement and Specialty Review schemes within the clinical divisions. Clinical supply and outsourcing costs across the Trust are overspent by £3.5m, while the position also includes a £0.3m provision for car parking VAT costs and a PFI technical adjustment of £0.2m. A £0.5m net drug cost adverse variance offsets with income, Additional run rate savings from prior year benefits total £0.9m with a further £1.0m benefit from education and finance-related costs.

At M10 total recurrent efficiency delivery is expected to be £11.5m against a plan to deliver 2/3rds of the target (£21.6m) recurrently. If we cannot improve this delivery, we are carrying an additional £10.1m deficit into our underlying position. The plan only includes £9.5m of carry forward, so the remaining £0.6m is a risk.

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

As at M10 the Trust is £8.5m overspent against budget. A key driver of this is an underperformance of £10.0m against the cash releasing efficiency savings programme, delivering £15.8m year-to-date against a target of £25.8m. Of the £15.8m delivered, 61% was recurrent. It should be noted that the Trust has also delivered £4.5m of cost avoidance/run rate reductions due to prior year benefits taken in year and exiting escalation areas. While not removing budget, they are crucial in helping to reduce the overspent position. Our underlying position remains challenging and the objective for all divisions and specialties is to find recurrent saving schemes.

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

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

Task & finish groups including Finance, Procurement and Specialty leads are continuing for Theatres (SPC) and Cardiology (Medicine) and one is now in place for Pathology (FaSS).

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

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

Risk + Oversight	Risk Score

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

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

Explanation of above analysis:

The IPR report identifies issues where minoritized protected groups experience is less favourable than other groups. This is specifically around the staff survey question 16B and experience of discrimination from colleague or manager. The staff survey provides this data by ethnicity, and it is likely that other groups both protected and non-protected have reported discrimination. The report identifies a number of countermeasures and actions are underway and planned to reduce discrimination for all staff and specifically those in protected groups.

The report references workforce indicators such as sickness, retention and vacancy rate which are likely to be affected by the disparities between the working life experience of majority group staff and minoritized staff. National analysis of the NHS (National Health Service) staff survey studies, results indicate that exclusionary behavior correlates with staff intention to leave the NHS and other research indicates the link between discrimination and physiological, psychological, and behavioral consequences. By addressing the disparity, we will be:

- *Helping to reduce the Trust Disparity Ratio (probability white staff being promoted from lower to upper bands compared to BAME (Black, Asian, and Minority Ethnic) staff) over time*
- *Helping to reduce the impact of conscious and unconscious bias, thereby increasing opportunities for marginalised candidates to join the Trust – this will positively impact the shortlisting-to-appointment ratio (WRES (Workforce Race Equality Standard) and WDES)*
- *Supporting retention and engagement by improving perceptions and experience of equal opportunities*
- *Improve our employee value proposition*

Sharing good practice so that they can continue to apply good practice beyond the boundaries of the programme

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	Benny Goodman, Chief Operating Officer
Date	**05/03/2026**

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

February 2026

January 2026 & December 2025 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

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

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Target/Thres.	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Percentage of RTT patients treated within 18 weeks		56.9%	58.0%	57.8%	59.6%	60.8%	61.2%	60.5%	60.7%	60.6%	59.8%	59.0%	58.0%
Percentage of RTT patients waiting over one year		3.1%	2.5%	2.2%	2.0%	1.8%	1.8%	1.6%	1.4%	1.3%	1.4%	1.5%	1.7%
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	75% (Nat)	86.2%	83.5%	80.4%	76.8%	79.2%	74.5%	65.6%	61.4%	63.9%	61.6%	71.6%	Reported one month
Percentage of patients treated for cancer within 62 days of referral	85% (Nat)	72.7%	82.1%	70.8%	69.7%	78.2%	69.3%	65.6%	65.8%	66.7%	65.6%	71.0%	Reported one month
Percentage of Emergency Attendances within Four Hours	95% (Nat)	72.3%	69.9%	69.5%	70.1%	69.1%	69.1%	67.8%	68.1%	69.9%	71.0%	71.3%	66.5%
Percentage of Emergency Attendances over Twelve Hours	2% (Nat)	8.9%	8.3%	9.0%	8.5%	5.6%	5.6%	5.8%	7.4%	7.4%	7.5%	7.2%	10.7%
Planned surplus/deficit		74	690	-2149	-3476	-1173	-801	-1411	-1105	-480	-1484	-929	-2734
Rate of productivity		-13.0%	-14.0%	-11.0%	-13.0%	-13.0%	-8.1%	-10.0%	-14.0%	-12.0%	-15.0%	-13.0%	Reported one month
Readmission rate		14.6%	15.4%	15.3%	16.0%	15.3%	17.0%	17.4%	15.5%	15.1%	16.3%	15.2%	14.8%
Summary Hospital Level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
Average number of days between planned and actual discharge date		2.7	2.7	2.6	2.4	2.2	2.3	2.7	2.7	2.9	2.9	2.7	2.8
Percentage of inpatients referred to stop smoking services		10.0%	11.1%	11.5%	11.9%	12.0%	12.1%	11.3%	11.4%	11.3%	11.2%	11.5%	10.5%
Percentage of people waiting over six weeks for a diagnostic procedure or test	99% (Nat)	88%	91%	85%	85%	84%	86%	89%	90%	93%	92%	90%	Reported one month
Rates of MRSA		0.0	5.5	0.0	0.0	0.0	5.8	0.0	0.0	0.0	0.0	0.0	One month behind
Rates of C-Difficile		24.6	27.7	28.1	48.9	33.7	23.0	11.9	11.9	23.0	6.1	17.7	One month behind
Rates of E-Coli		43.0	33.3	56.1	43.4	39.3	51.8	50.7	41.7	63.4	42.6	58.9	One month behind
Percentage of NHS Trust staff to leave in the last 12 months	14.8% (Int)	10.4%	10.9%	10.3%	11.7%	11.6%	11.9%	13.1%	12.8%	11.4%	11.2%	11.1%	One month behind
Sickness absence rate	3.5% (Int)	4.9%	4.5%	4.1%	4.1%	4.2%	4.4%	4.3%	4.1%	4.3%	4.2%	4.5%	One month behind
Rate of annual growth in under 18s elective activity		30.9%	27.7%	16.4%	11.8%	9.6%	4.9%	4.2%	4.5%	4.1%	0.0%	0.0%	0.0%

Key Indicators

Great Western Hospitals NHS Foundation Trust

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

Metrics	2023	2024
CQC inpatient survey satisfaction rate	8.0	7.9
CQC National maternity survey score	8.6	8.2

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

Metrics	2020
CQC safe inspection score	Requires improvement

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

- Pressure harms
- Falls
- Hospital acquired infections
- Medication incidents
- Never Events

The Breakthrough Objective for 2025/26 continues to focus on improvement work to reduce harm from inpatient falls.

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

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

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

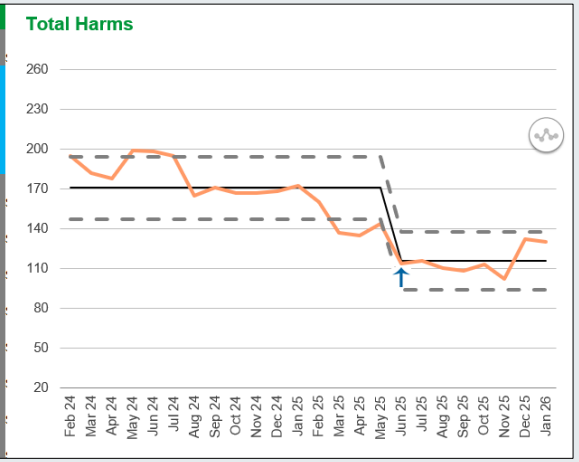
This metric reflects the Trust's commitment to learning from patient feedback and ensuring timely, high-quality responses to concerns raised.

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

Complaints response rate is tracked each month against timescale.

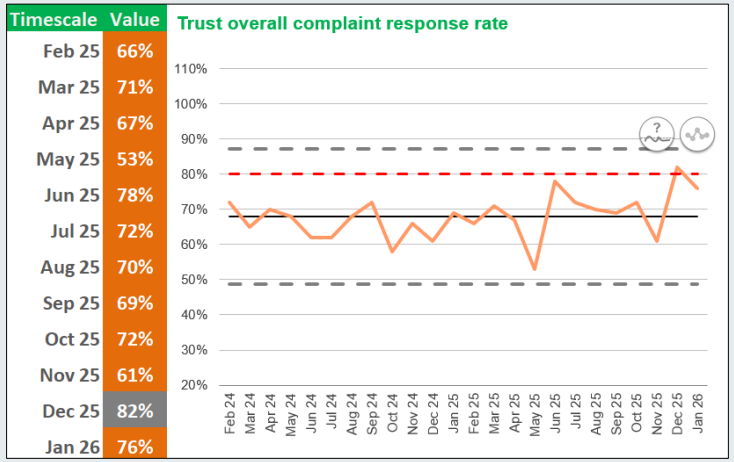
Total Harms
To achieve and sustain zero avoidable harm.

Timescale	Value
Feb 25	160
Mar 25	137
Apr 25	135
May 25	144
Jun 25	114
Jul 25	116
Aug 25	110
Sep 25	108
Oct 25	113
Nov 25	102
Dec 25	132
Jan 26	130



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

Timescale	Value
Feb 25	66%
Mar 25	71%
Apr 25	67%
May 25	53%
Jun 25	78%
Jul 25	72%
Aug 25	70%
Sep 25	69%
Oct 25	72%
Nov 25	61%
Dec 25	82%
Jan 26	76%



Counter Measures

The total number of harms in January was 130, representing a slight decrease from December (132). This is a marked improvement compared with January last year, when 170 harms were reported.

Falls decreased slightly to 89 compared to 91 in December, with no moderate harm or above falls.

Methicillin-Sensitive Staphylococcus Aureus (MSSA) cases reduced to 2 from 5 in December, while E. Coli blood stream infections remained constant with 10 cases reported in January.

There were 7 C. diff cases, up from 3, which remains in line with the Trust's annual trajectory. Hospital-acquired pressure ulcers have remained unchanged in month at 16.

In January, complaint response rate was 76%. While this is a small decrease from December's rate of 82%, it represents a notable improvement compared with January 2025, when the rate was 69%.

During January, efforts were focused on preparing for the February launch of the revised complaint processes and policy to provide stronger and more sustainable improvements in response times.

Trust-wide A3 improvement work is ongoing, with a strong emphasis on understanding and addressing the key factors that contribute to concerns and complaints. This includes enhancing early clinical involvement and supporting more effective communication.

Executive Summary

NHS Great Western Hospitals NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance

In December, 55 pathways breached the standard with 43.0 being allocated to GWH resulting in performance of 71.0%. Of these, 29% are attributed to the Urology pathways & 21% to Colorectal. Skin pathways made up 20% of pathway breaches. These pathways are seeing issues with capacity for appointments and diagnostics. A number of pathways are also impacted by the need for multiple and repeat diagnostics.

RTT: Number of patients waiting over 52 weeks (February Submission, January Data)

RTT performance decreased by 0.98%, to 57.98%, when compared to last month's position. This is due to decreasing <18 week waiting list size and the increasing waiting list size in >18-week patient cohort. The total number of patients waiting over 52 weeks in January increased by 56 to 740, compared to the previous month.

There were 5 patients reported at 65 weeks at the end of January, a decrease of 5 from previous month. 3 plastics, 1 x general surgery and 1 x gastroenterology.

There were 2 x 78-week breaches reported in January, both from the plastics service.

A level of risk remains for February across a few key specialties; including General Surgery, Urology and Trauma and Orthopaedics. This is due to trust critical incidents impacting elective lists. However, for the remaining months of Q4 Plastics stands out as our biggest capacity risk and mitigating actions continue with an aspiration to clear all breaches by March.

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

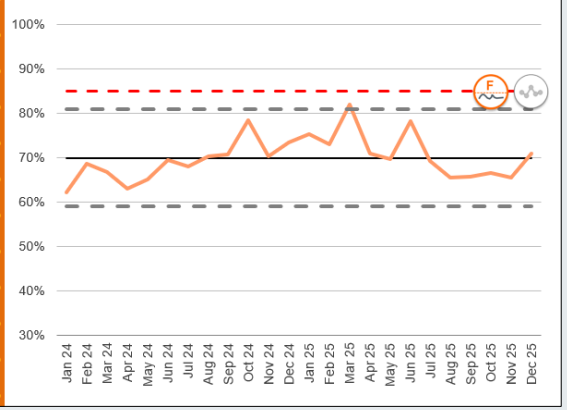
Our position and trajectory plans for clearance have been shared with regional colleagues.

Benny Goodman | Chief Operating Officer

Cancer 62 Day

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

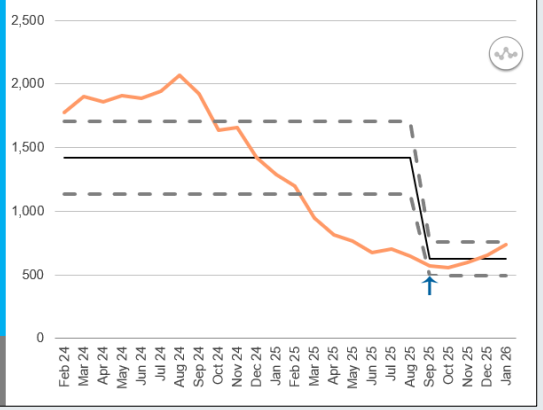
Timescale	Value
Jan 25	75.3%
Feb 25	73.1%
Mar 25	82.1%
Apr 25	70.9%
May 25	69.7%
Jun 25	78.2%
Jul 25	69.3%
Aug 25	65.6%
Sep 25	65.8%
Oct 25	66.7%
Nov 25	65.6%
Dec 25	71.0%



RTT: Number of patients waiting over 52 weeks

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

Timescale	Value
Feb 25	1,195
Mar 25	950
Apr 25	816
May 25	764
Jun 25	679
Jul 25	707
Aug 25	646
Sep 25	573
Oct 25	559
Nov 25	602
Dec 25	658
Jan 26	740



Counter Measures

Risk: Urology Pathways are impacted by scan reporting delays in Radiology (capacity & vacancies)
Mitigation: Recruitment of radiology clinical team concluding since summer 25 will improve reporting turn-around times

Risk: Capacity issues for **Colorectal** first and follow up appointments
Mitigation: Additional WLI activity has been requested from the cancer alliance and south west region.

Risk: Capacity in Dermatology for first appointment and treatments
Mitigation: Additional activity being provided by external provider to help meet demand. Referral triage model changed to manage number of consultant appointments needed.

Risk: Insufficient capacity to eliminate waits over 65 weeks in Plastics
Mitigation:

- Mutual aid fully utilised as it becomes available
- Unfit patients/patient choice being managed in line with Trust Access Policy.
- Improved clinical review processes introduced with emphasis placed on the use of PIFU if a patient cannot be discharged.
- Validation of waiting lists
- Access team led intensive validation to work through cohort and increase clock stop run rate.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

ED Attendance as a Percentage of Population by Deprivation Quintile

We want to understand whether our population's level of deprivation effects the use of emergency services. The metric shows that there is a difference in the percentage of the population who utilise ED/UTC that correlates with deprivation quintile. The populations in the most deprived quintile nationally (group 1) access ED/UTC slightly more frequently than less deprived populations (groups 2-5) although this gap has narrowed over time.

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

In January, there was an increase compared to December, representing a deterioration following several months of improvement. Countermeasures that have been introduced and continue to be implemented:

- Wiltshire In reach results continues to develop with the team in reaching to ED and assessment wards proactively identifying NCTR at Day 0 (which could be seem as a positive or negative as increase in numbers) in addition to a reduction in the referral submitted. This is providing rich data to evidence the benefit of social care reviews across assessment wards.
- Early escalation of barriers in CTR now on Nerve Centre for monitoring and utilised – DST utilising and collating.
- Targeted approach to Pw0's on site calls and outcomes (internal delays reduction being monitored) - linking with silvers to action – a focus for Jan MEGA MADE alongside
- Introduction of 48 hours.48 hours ,7 days – target dates for partners continues
- 21 day LoS panel to commenced on the 12/11/25 for CTR & NCTR – there is a reduction week on week as it stands for December lowest of 25 patients
- Winter plans internally being implemented – and adapted via tactical command
- Mega MADE commencing 15th Dec – system in reach – continuing into Jan 2026

Discharge Ready to Discharge average days:

Overall: PW0 – 0.7 days (increase on Nov), PW1 – 4.9 days(increase Nov), PW2 – 5.7 days (decrease), PW3 –13.9 days(decrease)

Swindon LA – PW1 **(Home first)** – 4.3 days (decrease), PW2 – 14.6 days (decrease), PW3 – 24.6 days (decrease)– **December saw the highest on record for Home first discharges 134**

Swindon BSW – PW1 – 3 days (Same), PW2 – 2.2 days (decrease) , PW3 – 8 days (Increase)

Wilts LA- PW1 – 2.6 days - 5 days, PW2 – 3 da ys - 6 days, PW3 – 9.7 days -

Wilts BSW – PW1 – 5.2 days - 2.6, PW2 – 4.4 days - 4.3 , PW3 – 0 days - 9

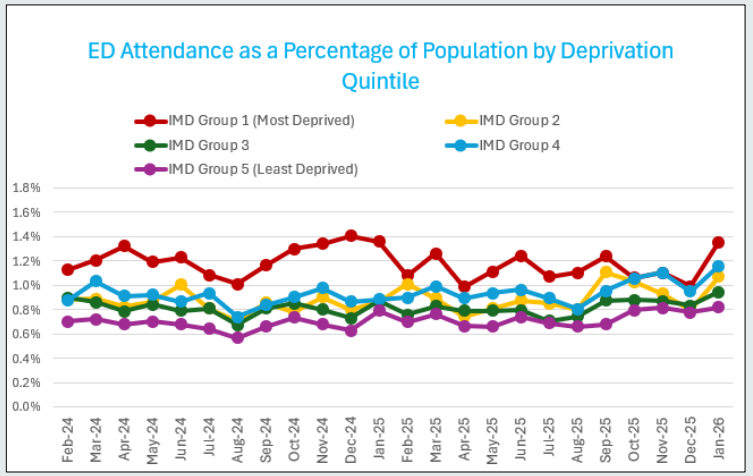
Self funders – PW1 – 6 days - 5.9 days, PW2 – 6 days - 6 days, PW3 – 2 days 9 days

Areas of focus for improvement – self funders and not set pathways which will feature in Jan MADE

Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

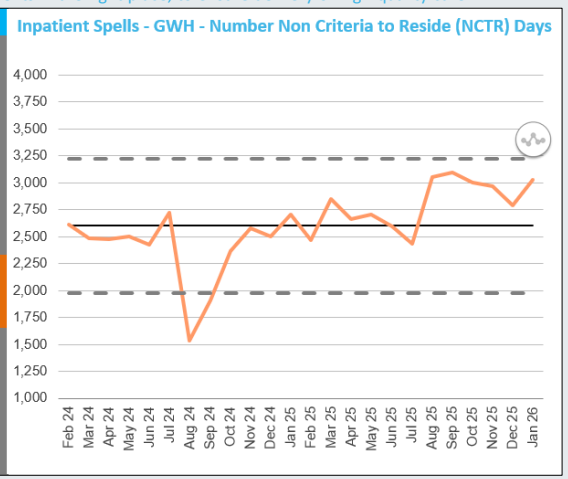
ED Attendance as a Percentage of Population by Deprivation Quintile



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

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

Timescale	Value
Feb 25	2,468
Mar 25	2,851
Apr 25	2,663
May 25	2,710
Jun 25	2,594
Jul 25	2,439
Aug 25	3,054
Sep 25	3,095
Oct 25	3,007
Nov 25	2,973
Dec 25	2,793
Jan 26	3,027



Counter Measures

We are seeking to understand the impact deprivation may have on our population's access to emergency services in order that we can work with people to provide alternative and earlier access to care where appropriate. The difference in access between people from the most deprived quintile and the rest of the population has widened again in January with an upward trend in the proportion of the population attending ED (biggest increases in IMD group 4 and group 5).

An executive Go & See to high intensity user team MDT has informed forward plans; we need to consider how we gain population insights for the changing use and attendance rate to ED over time. We are reviewing our approach to young people who access ED frequently to review whether similar support would support alternative pathways and earlier intervention. We are progressing work with the voluntary sector in this space particularly for mental health presentations where GWH benchmarks high.

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

Opportunities:

- 48 hours, 48 hours and 7 days introduced for PW1 - PW3 continuing
- To review the approach to criteria led discharge for patients and maximise opportunities for earlier in the day discharge including to discharge lounge. - continuing with positive outcomes Project being undertaken by Chief Registrars in medicine - linked to weekend flow and SOPs being designed
- Power BI report with themes for delays up and running – shared at Transfer of Care A3 working group.
- 21 day LoS Panel commencing the 11/11/25 ToR shared and KPIs to be shared weekly - This is implemented and working

Reflections:

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

Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime (ED & CEU) in January 2026 was 472minutes (comparable to November 2025) against the national standard of 240 minutes, and the highest time since Feb 2025. Mean length of stay has been affected by continued flow across the organisation, leading to ED outward flow and capacity to manage incoming patients.

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

Emergency Care – Urgent Treatment Centre - Mean Stay

The total attendance mean time wait for a patient in January 2026 was 149 minutes against the national standard of 240 minutes, best performance since February 2025. Staffing and acuity have continued to be challenging leading to periods with longer length of stay, sometimes with 4hrs wait to be seen although discharge has then been prompt.

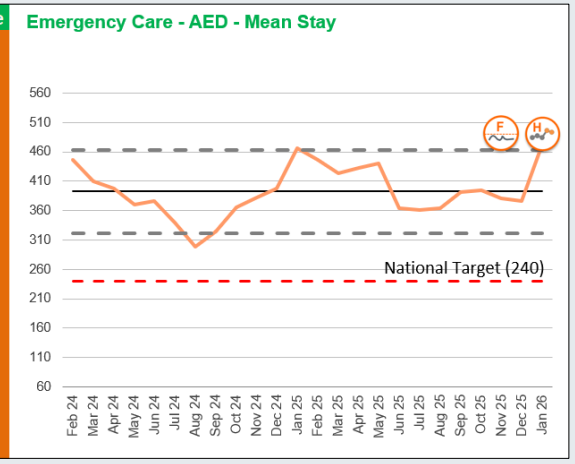
Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

Emergency Care – Emergency Department - Mean Stay

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

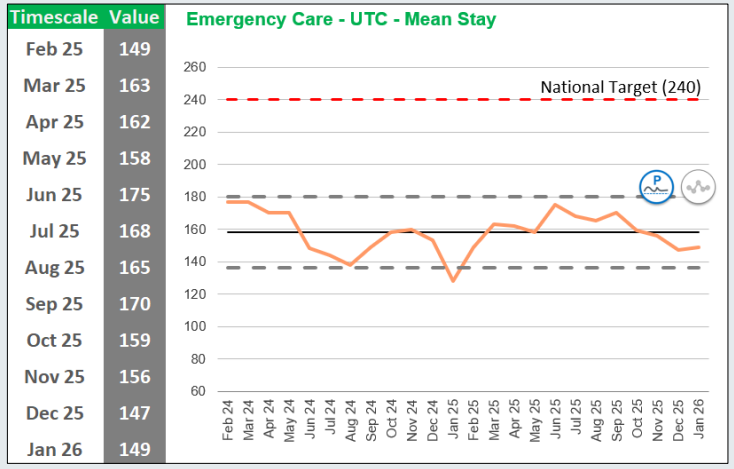
Timescale	Value
Feb 25	447
Mar 25	423
Apr 25	433
May 25	440
Jun 25	364
Jul 25	361
Aug 25	364
Sep 25	392
Oct 25	394
Nov 25	381
Dec 25	377
Jan 26	472



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Feb 25	149
Mar 25	163
Apr 25	162
May 25	158
Jun 25	175
Jul 25	168
Aug 25	165
Sep 25	170
Oct 25	159
Nov 25	156
Dec 25	147
Jan 26	149



Counter Measures

- Recruitment of substantive Registrars in ED – will give increased 'Senior Decision Maker' cover
- Joint approach to IFD 'management' and daily operational oversight – IFD Silver & huddles.
- Rapid Assessment Area process revision – minimise delays and onward movement.
- Process change for patient management in 'Chairs' - identify quick discharges and re-reviews of patients with results -
  - Maximize early discharge for non-admitted cohort
- Review 'Internal Professional Standards' - Early transfer to Specialty Wards
- Recruitment of AMU consultant into ED, to support inter departmental working and continue development of pathways eg. SDEC
- Review/increase alternate capacity

- Review of UTC shift supportive Senior Lead role
- Recruiting into newly budgeted Medical & Practitioner roles, process ongoing near completion – will provide substantive clinical leadership 7/7
- New Clinical Lead appointed
- ICB support to reduce attendances to UTC - increased community clinic places - Pharmacy 1st, Paediatric Acute Respiratory Hubs.
- Full utilisation of MAU/SDEC pathways

Executive Summary

Great Western Hospitals NHS Foundation Trust

Sickness Absence (rate)

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

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

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

Our target for sickness absence is 3.5%, and performance in December 2025 was 4.5%, an increase compared to the previous month.

Staff Recommendation as a Place to Work

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

In 2023 and 2024 the Trust achieved 60% performance.

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

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

The number of staff who would recommend the organisation as a place to work increased from 53.3% in 2022 to 59.6% in the 2023 Annual Staff Survey.

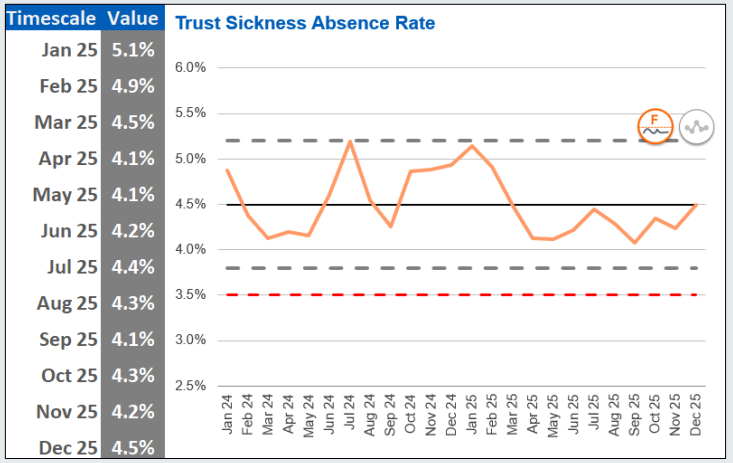
Whilst a small decline was seen in this metric throughout the year, the 2024 Annual Staff Survey results show a sustained result at 59.6%.

Jude Gray
Director of Human Resources (HR)

Trust sickness absence rate

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

Timescale	Value
Jan 25	5.1%
Feb 25	4.9%
Mar 25	4.5%
Apr 25	4.1%
May 25	4.1%
Jun 25	4.2%
Jul 25	4.4%
Aug 25	4.3%
Sep 25	4.1%
Oct 25	4.3%
Nov 25	4.2%
Dec 25	4.5%



Staff % recommend the organisation as a place to work

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

Counter Measures

- Sickness absence increased in December from 4.2% to 4.5%, with the increase coming from long-term absence. The mix between short and long term absence has changed, with long-term sickness now making up the majority of absence in month (2.3% long term and 2.2% short term).
- Long term absence management focusses on supporting the individual with their condition/disability to assess the likelihood of their return to work within a 12-month period. The emphasis of support is through Occupational Health, Health and Wellbeing case conferences, and GP/external assessment with a view to providing compassionate management and resolution that works for all parties.
- The Trust Absence Management Working Group will continue to focus on short-term cases, preventing their conversion into long-term absence. To support the current case-mix, the 'managing long-term conditions' policy will be applied to support the 85 individuals on long-term absence.

- In January, 65 staff attended the compassion training, aiming to deepen understanding of compassion and provide support in becoming more compassionate towards themselves and colleagues.
- The Health & Wellbeing service provided additional support to front-door services during the critical incident period including tea trolley visits, some food deliveries, and drop-in wellbeing support.
- 3 departments were supported through the Trauma Risk Management pathway (TRiM).
- The annual flu campaign launched on 1st October, and as of 10th February 63% of our staff have been vaccinated.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

Discrimination has been a longstanding issue in the NHS, the GWH NHS Staff Survey results 2024 highlights highlight that 18.6% of Ethnic and Minoritized staff have experience discrimination compared to 6.7% of white staff. Staff can also experience discrimination based on other grounds including disability, sex, sexual orientation, age, religion and other protected and non-protected characteristics

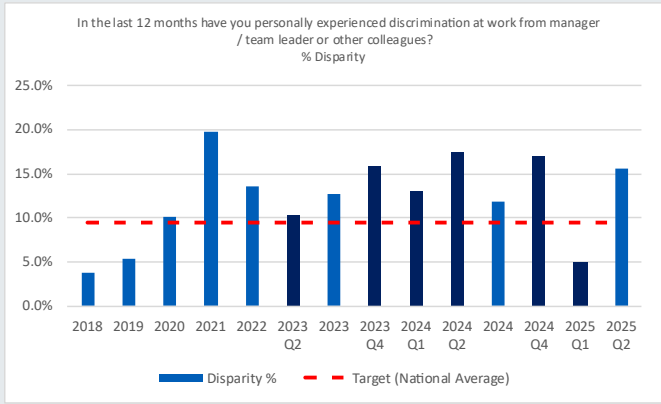
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

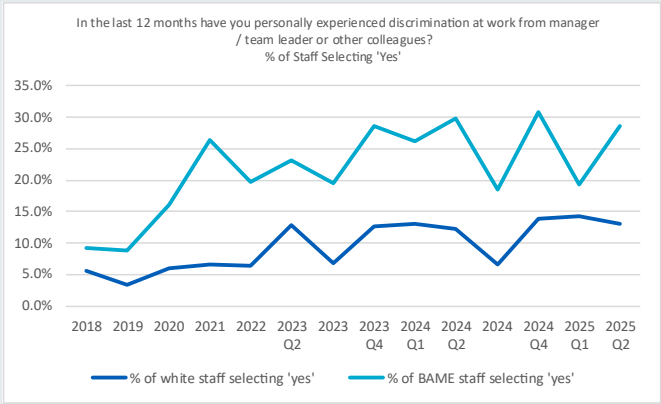
The Trust ambition in 2023 was to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

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

Jude Gray
Director of Human Resources (HR)

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





Counter Measures

- Introduction to Cultural Intelligence (CQ) is now live, the 30-minute workshop defines CQ, introduces the CQ and Behavioural Preference assessments and highlights the benefits of improving CQ. The assessments can be commissioned for a team event or used to by individuals or small groups who want to improve inclusion or address intercultural conflict. A CQ workshop can also be delivered without the assessment. Five members of the EDI/OD team are now certified to administer the assessments.
- The Trust will mark Race Equality Week (2-6 February) by inviting staff to take part in 5-minute challenges across the week. This initiative raises awareness, encourages staff to take action and promotes the Race Equality Network.
- The EDI Champions year 2 evaluation is under way and will conclude mid-February. EDI champions were first introduced to the Trust early 2024, as a result of winning the EDI Improvement Award. The 2025-26 evaluation will highlight the impact they are making and their support needs. 38% of those who have responded to date have stated their presence has had a positive impact in their 'team/department', 17% feel their impact has been systemic (e.g. division, cultural change).

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

For M10 2025/26 the Trust has an adjusted deficit position of £8.5m YTD, which represents an £8.5m adverse variance to plan. In M10 the Trust had a £2.6m forecast deficit as part of a 'most likely' position, but finished with a £2.7m deficit. The £0.1m adverse position is due to costs relating to ongoing critical incidents, with over 50 escalation beds open, resulting in additional staffing and lost elective income. The Trust has been operationally challenged in January, with NCTR at 20% of the bed base, type 1 ED attendances 15% over plan and ambulances averaging 75 per day (compared to 60 last year).

On a year-to-date basis, income is £7.6m ahead of plan. ERF income is £0.3m below plan, following underperformance of £1.1m in M10 due to the impact of critical incidents. The Trust is £0.9m below the ICB affordability cap. Other patient income is £3.7m over plan. This includes £1.3m of industrial action funding (net of lost income associated with strikes) and other income streams such as RTA, depreciation and vaccination income, some of which offsets with cost. It also includes a £0.6m underperformance on private patient income. High cost drugs income is £0.6m ahead of plan, which also offsets with cost. Other operating income is £3.6m ahead of plan; programmes such as EPR and CDC will have corresponding pay and non-pay costs.

The pay position is £10.6m adverse to plan, with undelivered cash releasing efficiency savings accounting for £5.9m. This includes a Trustwide target of £2.8m with no associated plans, with service transformation / benchmarking schemes within Divisions accounting for the remainder. The position includes run rate savings of £1.2m driven by prior year gains, the closure of escalation areas earlier in the year and agency framework savings. There is also a £2.7m underspend against Corporate admin lines due to unfilled posts. The remainder of the variance is due to industrial action costs of £1.3m and £7.3m of agency and locum overspends, the majority against medical and dental staff covering 97 WTE of clinical vacancies, sickness and escalation costs. It should be noted that the Trust has been running with over 50 additional beds and escalation areas when in critical incident.

Non-pay is £5.5m adverse to plan. Undelivered cash-releasing efficiency savings accounts for £2.9m with a Trustwide target of £1.4m with no associated plans. There are also efficiency plan underperformances against Procurement and Specialty Review schemes within the clinical divisions. Clinical supply and outsourcing costs across the Trust are overspent by £3.5m, while the position also includes a £0.3m provision for car parking VAT costs and a PFI technical adjustment of £0.2m. A £0.5m net drug cost adverse variance offsets with income, Additional run rate savings from prior year benefits total £0.9m with a further £1.0m benefit from education and finance-related costs.

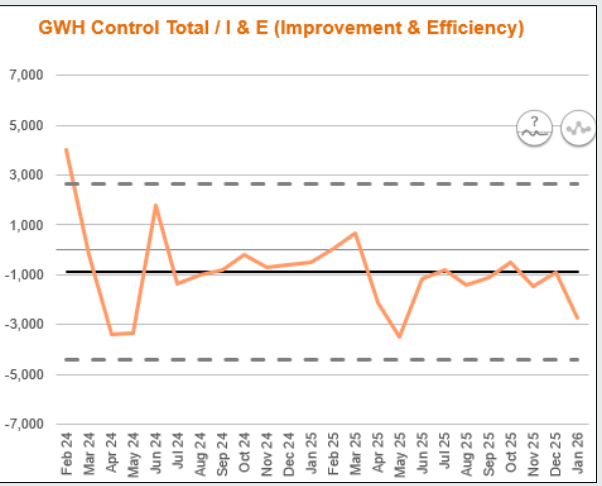
At M10 total recurrent efficiency delivery is expected to be £11.5m against a plan to deliver 2/3rds of the target (£21.6m) recurrently. If we cannot improve this delivery, we are carrying an additional £10.1m deficit into our underlying position. The plan only includes £9.5m of carry forward, so the remaining £0.6m is a risk.

Simon Wade | Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
Feb 25	74
Mar 25	690
Apr 25	-2149
May 25	-3476
Jun 25	-1173
Jul 25	-801
Aug 25	-1411
Sep 25	-1105
Oct 25	-480
Nov 25	-1484
Dec 25	-929
Jan 26	-2734



Counter Measures

Cash releasing efficiency savings were £0.9m below target in month. Actual savings delivered were £1.7m against a plan of £2.6m. Pay was £0.5m under plan and non-pay £0.3m under plan, with income a further £0.1m under plan. Recurrent delivery was 61% in month and is 59% year-to-date, in line with M09. Note that the Trust has also made cost avoidance/run rate savings of £4.5m at M10 relating to prior year benefits transacted in-year and the closure of escalation areas. Divisions and services are included in financial recovery workstreams such as substantive workforce, temporary staffing and better buying to focus on delivery recurrent cash out savings.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Carbon Footprint / Sustainability

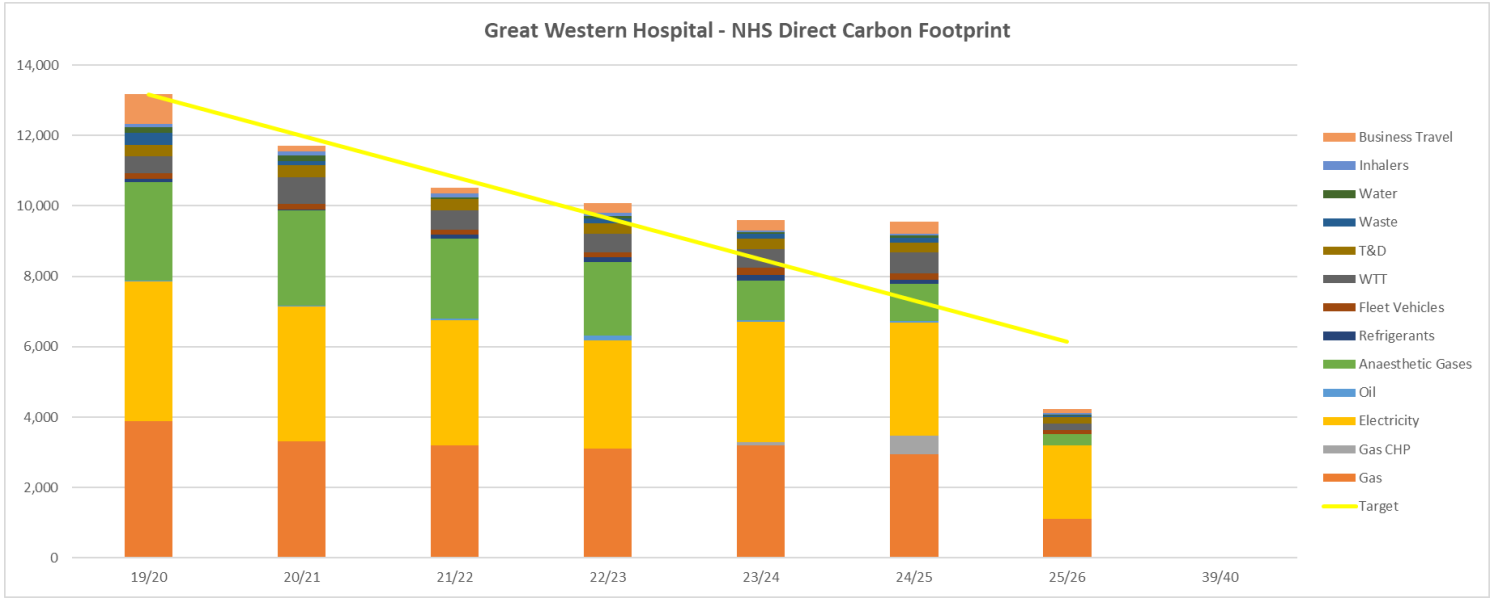
Sustainability is fundamental to maintaining high quality care; to help us meet the needs of today without compromising the needs for future generations.

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

Great Western Hospital's 2025-2026 Carbon Footprint (draft):

The graph to the right of the screen shows the draft carbon footprint for the first 6 months of 2025-2026 (April- September 2025).

Note:
2024-2025 saw a decrease in GWH Carbon Footprint by –0.57%. The reason for a lower reduction compared to years previously was due to an increase in Gas CHP usage which was up by 2,431,005 kwh. The Trust also saw an increase in business travel driven by air travel where an additional 48,467km were flown in 2024-2025 compared to 202-2023



Counter Measures

Great Western Hospitals NHS Foundation Trust's Green Plan for 2025-2028 has been approved. The plan outlines the actions and initiatives we aim to deliver to meet our sustainability targets and for the Trust to be Net Zero Carbon for direct emissions by 2040 and for indirect emissions by 2045.

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

Several sustainability working groups and sustainability champions are in place around the trust to tackle department/ ward-based schemes.

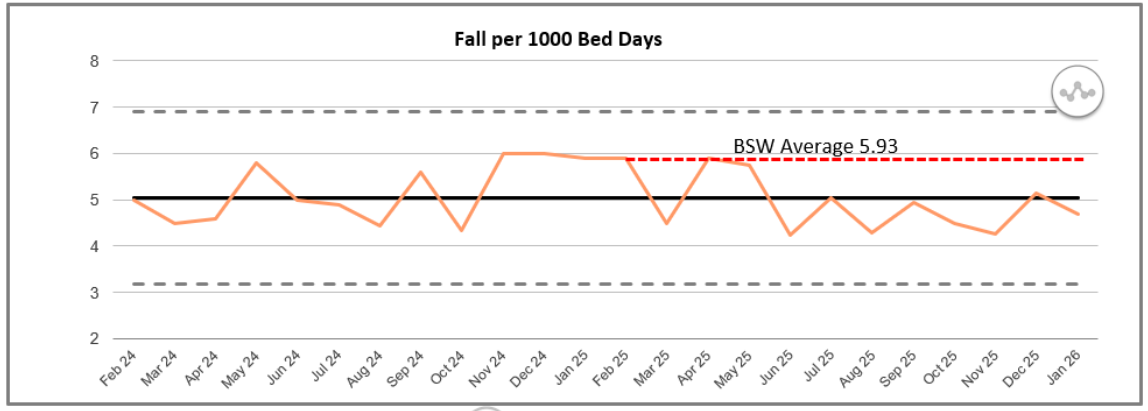
Simon Wade
Chief Financial Officer

2025/26 Breakthrough Objectives

Reducing Falls & Falls With Harm

Great Western Hospitals NHS Foundation Trust

Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
5.90	4.50	5.91	5.75	4.23	5.03	4.30	4.95	4.50	4.27	5.15	4.69



Common cause - no significant change

Understanding the Data

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

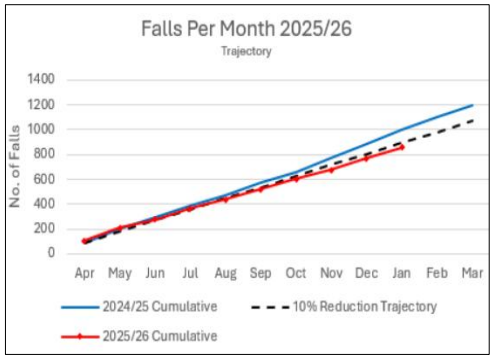
Aim for 2025/26

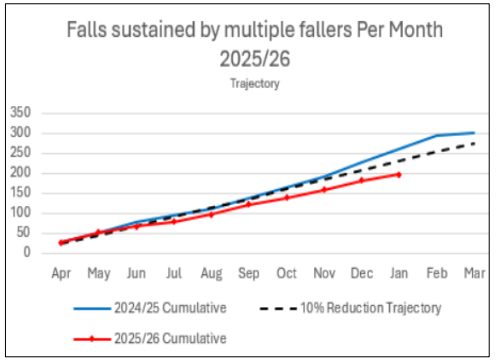
Reduction in the number of Total Falls by 30% over 3 years.
Reduction in the number of patients experiencing moderate harm or above by 10% each year
Reduction in the number of patients that fall more than once by 20%.

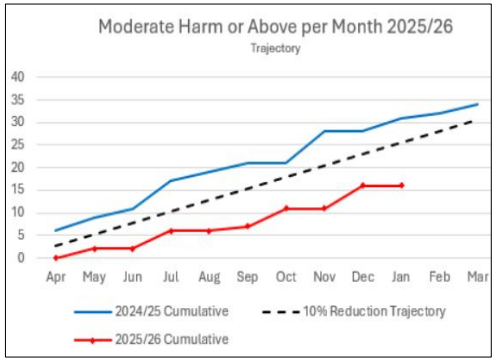
We are driving this measure because…

Analysis shows that inpatient falls are a top cause of moderate and above harm in the Trust. Between April 24- March 2025, 1192 Falls were reported, 22 resulted in moderate harm, 11 resulted in severe harm, and one resulted in death. Even when a fall has resulted in no apparent harm, falls can cause psychological distress, prolonged hospital stay and delayed functional recovery.

Reducing inpatient falls will help the Trust to reduce harm, improve experience and reduce the financial burden of increased length of stay, costs of additional surgery/ treatment.







Performance

In January 89 falls were reported, a decreased from 91 in December. There were no falls resulting in moderate or severe harm in month.

Each incident is being reviewed through a weekly panel, where learning is identified and shared across teams to prevent recurrence and improve patient safety.

Improvement Actions considered:

Monthly ward-based audit has been introduced for patients assessed as requiring enhanced care. The purpose of this audit is to review each patient's needs throughout the month, ensure the level of enhanced care provided remains appropriate.

A thematic review of 12 falls reported in Surgical Assessment Unit (SAU) between September and November 2025 has been undertaken. Improvement actions have been identified which will inform divisional falls plans.

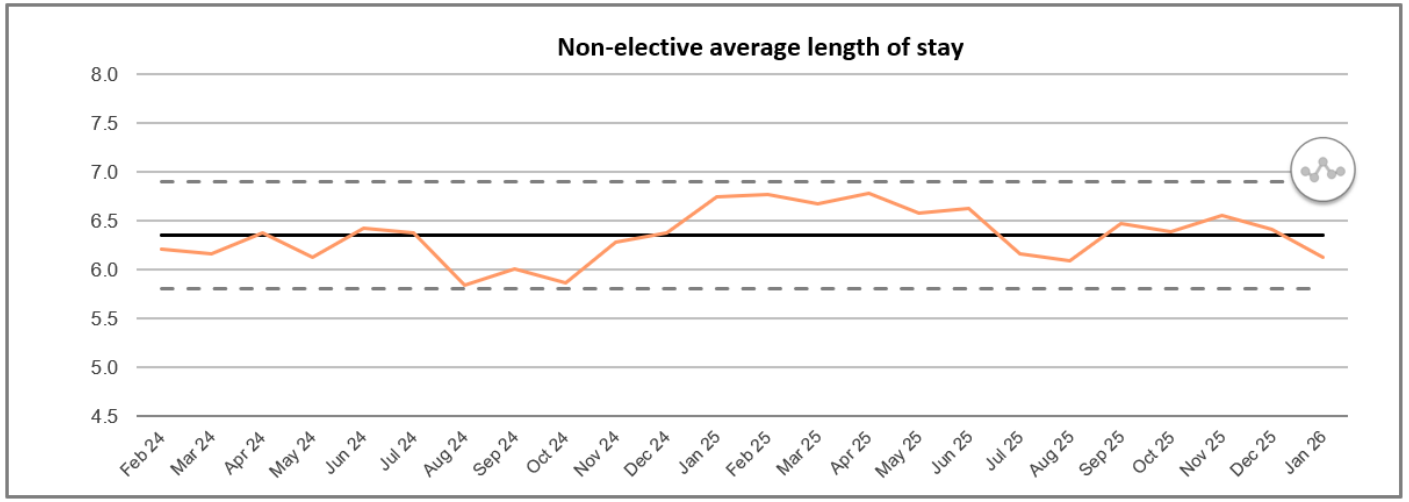
A quarterly report on falls training is now shared with divisional leadership teams to support oversight, promote consistent practice, and help identify areas where further improvement or additional training may be required.

2025/26 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Non-elective average length of stay

Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
6.8	6.7	6.8	6.6	6.6	6.2	6.1	6.5	6.4	6.6	6.4	6.1



Common cause - no significant change

Understanding the Data

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

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

We are driving this measure because…

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

Performance

Data shows that non-elective length of stay was 6.1 days in January, which is 0.6 days better than 12 months ago. There has been a 0.7 day reduction since the start of the financial year in April. The priority areas of focus are currently as follows:

- Implementation of the NHS England and Getting it Right First Time (GIRFT) Clinical Operational Standards monitoring tool following a successful launch event with clinical leads on 3rd February
- Review of discharge planning processes to inform best practice for Board rounds and complex discharge team support
- Implementation of the Pathway 1 streamlined referral process pilot for Swindon patients and ongoing counter-measures to reduce the number of days lost when patients no longer meet the clinical criteria to reside
- Ongoing delivery of projects within the existing transformation programme including evaluation of the new Swindon Deep Vein Thrombosis pathway and progression of Frailty pathway improvements to increase same day emergency care capability
- Ongoing improvements to the medical model with support from the GIRFT national team

The Trust wide Urgent and Emergency care transformation programme continues to focus on sustaining the improvements made in non-elective length of stay and embedding further progress into 2026/27.

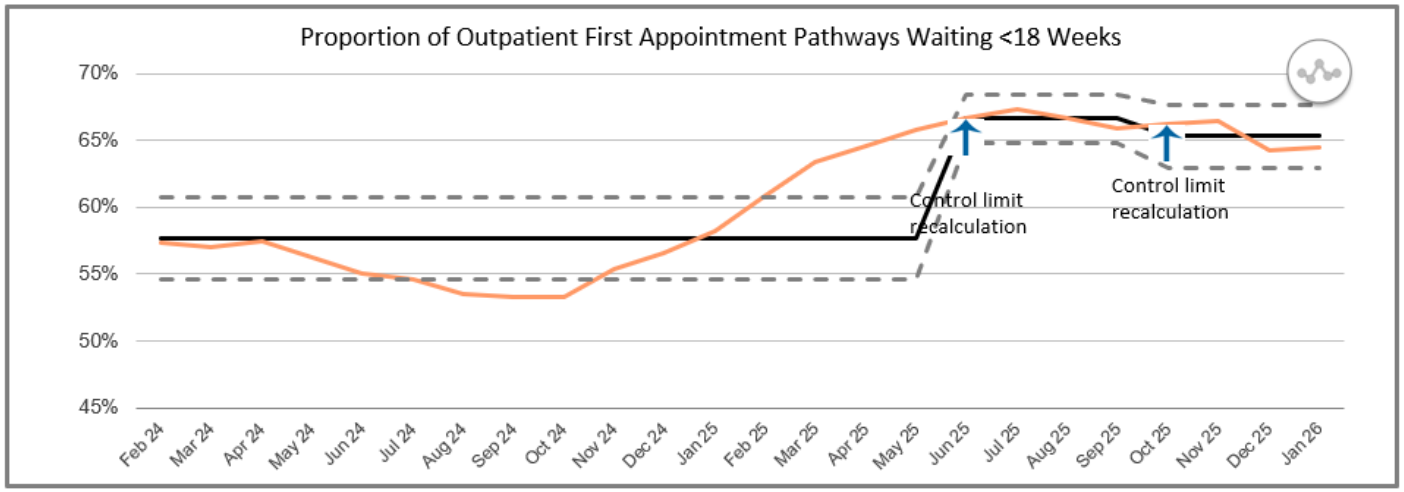
Risks

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

2025/26 Breakthrough Objectives

Proportion of Outpatient First Appointment Pathways Waiting <18 Weeks

Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
61%	63%	65%	66%	67%	67%	67%	66%	66%	66%	64%	64%



Common cause - no significant change

Understanding the Data

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

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

We are driving this measure because...

Timely access to care is essential for better outcomes. By improving performance on this measure, we aim to reduce delays, improve patient experience, and meet the 72% target by March 2026.

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

Performance

Performance for January closed at **64%**, same as December. This dip is attributable to several factors:

- Industrial Action: The resident doctor strike during December impacted outpatient activity, reducing available clinical capacity and delaying first appointments.
- Seasonal Annual Leave: December traditionally experiences a reduction in overall activity, including new outpatient bookings, due to staff annual leave and reduced clinic schedules over the holiday period.

Despite these challenges, work continued to progress on initiatives aimed at improving this KPI. Notably, significant progress has been made on redesigning the Paediatric service. The current model operates as a single Referral Assessment Service (RAS) with one service pathway. During December, the Standard Operating Procedure (SOP) and the design of the services that sit behind the RAS were finalised.

From January, pathways will be reconfigured so that referrals are triaged into the correct service at the outset. This change ensures patients are booked into the right clinic with the right clinician first time, reducing time to first appointment. Approximately 1,500 new referrals will be re-triaged into these new services before being seen by the appropriate clinician, which is expected to deliver a measurable improvement in waiting time compliance and improvement to the Time to First overall by the end of the year.

Risks

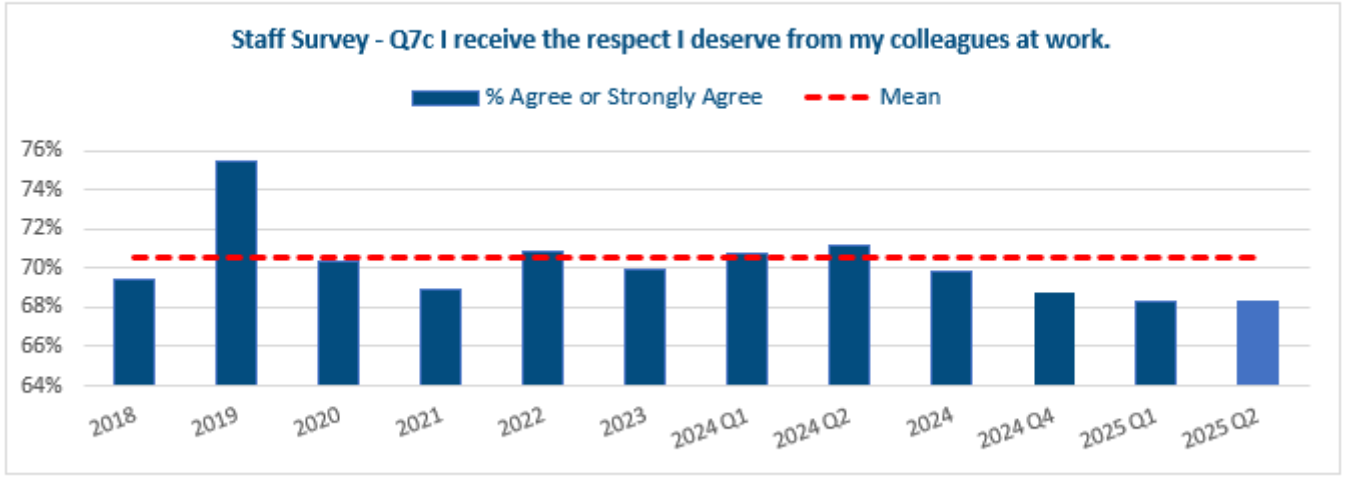
- Administrative capacity to build and support new pathways may result in delays to implementation or pausing of this sub workstream.
- Capacity Constraints: If there is insufficient capacity to handle the increased demand for early appointments, it could delay the overall process and hinder the achievement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

2025/26 Breakthrough Objectives

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

Great Western Hospitals NHS Foundation Trust

2018	2019	2020	2021	2022	2023	2024 Q1	2024 Q2	2024	2024 Q4	2025 Q1	2025 Q2
69.40%	75.44%	70.37%	68.85%	70.80%	69.96%	70.70%	71.10%	69.80%	68.70%	68.30%	68.30%



Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

The 2025 Staff Survey results remain under embargo until March 2026, however data highlights have been shared with Divisional Senior Leaders outlining top and worst performing questions, and areas of positive/negative movement compared to the previous year on recommending the organisation as a place to work and receiving respect from colleagues at work.

This information will be used by Divisional teams to plan their breakthrough objectives for the next 12 months. At Trust level, a focus on embedding our behaviours and improving the underlying culture is being proposed to drive performance against our pillar metric. It is anticipated that Divisional teams will ensure alignment to this approach when setting breakthrough objectives for the coming year.

The roll out of 'our behaviours' continues, with a Trust-wide communication delivered in January celebrating our behaviours. Promotional visuals are planned for February across the Trust bringing our behaviours to our teams, and the annual EDI conference date has been shared with a plan to embed our behavioural framework throughout.

Risks

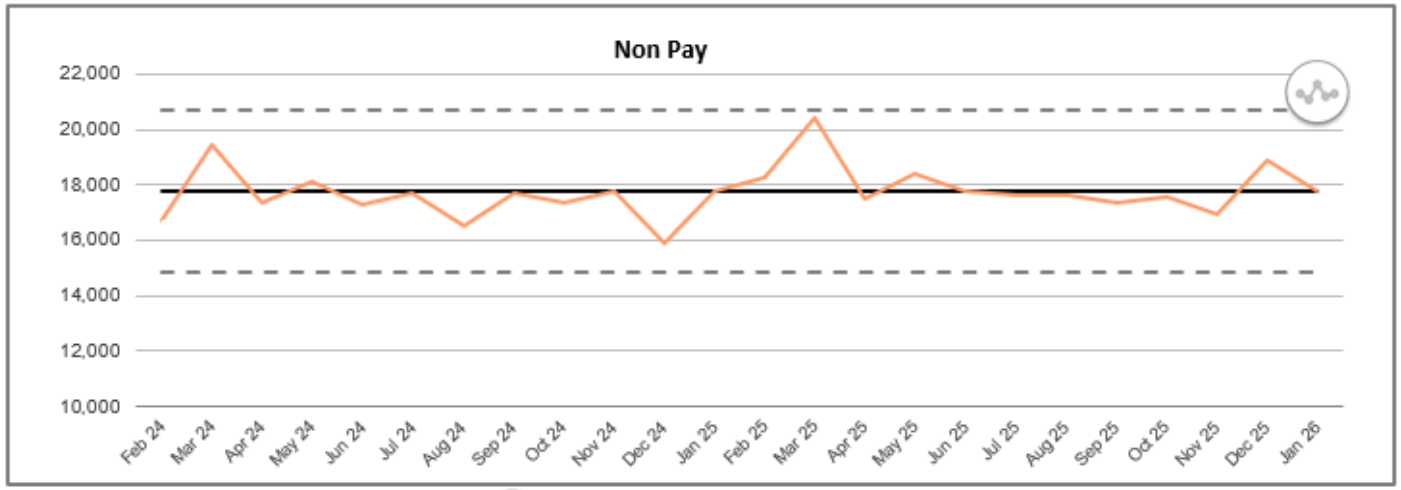
- Significant risk to staff morale and engagement due to current financial challenges, requirement to reduce our workforce, and organisational change. The majority of workforce controls are impacting our non-clinical workforce, however initial results suggest no material impact to our scores in this question. There is further risk that as the Corporate Services Redesign programme progresses we will see a decline against our breakthrough objective, this risk is being managed through the programme team.

2025/26 Breakthrough Objectives

Non-Pay run rate stabilisation and reduction

Great Western Hospitals NHS Foundation Trust

Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
18289	20422	17485	18390	17782	17611	17661	17385	17596	16912	18918	17777



Common cause - no significant change

Understanding the Data

The graph shows that non-pay spend has been on an upward trajectory over the previous 2 years. The sharp increase in Mar-25 reflected increase in stocks and accruals pertaining to 24/25. Costs reduced by £1.1m in Jan-26 due to additional bad debt, depreciation and higher outsourcing costs in M09.. While some increase in costs will be driven by inflationary uplifts in supplier contracts and additional activity, the focus of the breakthrough objective will be on highlighting increases within influenceable areas such as clinical supplies, and looking for potential mitigations to current spend.

We are driving this measure because...

The Trust has a £32.4m efficiency savings target for 25/26, which is £2.7m per month. As at M10 the Trust has delivered £15.8m of actual cash releasing savings, leading to an under delivery of £10.0m. Finding recurrent cash releasing savings is crucial if the Trust is to deliver on its savings programme and achieve a breakeven budget.

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

Performance

M10 non-pay costs were £1.1m lower than M09 driven by £0.6m of bad debt provision, £0.6m of additional depreciation and £0.4m of CDC outsourcing costs offset by income all incurred in M09.

The focus of the breakthrough objective will be highlighting the drivers of the non-pay increase at account and specialty level. Task & Finish groups organised between clinical/operational leads within key specialties, Procurement and Finance are already in place for Cardiology (Medicine) and Theatres (Surgery and Planned Care) following analysis in 24/25. T&O, Day Surgery and Pathology have flagged as increasing run rate and/or overspending against budget in 25/26 with further work being undertaken to understand the drivers and potential mitigations.

Other schemes to mitigate non-pay spend and embed a cost control culture will also be undertaken. Posters have been positioned in ward/clinical stock areas showing top 10 items purchased. More information will be added over the coming weeks and months to heighten awareness. The Trust has removed authorisation for staff who can approve items for <£10k and freezing or adding additional approval for accounts considered to be discretionary (eg. Stationery, books and subscriptions etc).

Risks

The risks to achievement include:

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

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26	Trend
Concerns and Complaints	No. of concerns received	SPC	H	457	435	342	522	
IP&C	Klebsiella	2.17 (Int)	?	2	4	4	2	
FFT	Overall response rate (%)	28.8% (Int)	?	22.0%	21.2%	22.8%	24.0%	
	Positive response (%)	90.0% (Int)	?	84.3%	84.0%	88.2%	86.2%	
	ED & UTC Positive Responses	78.5% (Int)	?	76.7%	78.8%	82.7%	76.0%	
	Inpatients Response Rate	28.6% (Int)	?	28.7%	26.1%	26.0%	24.9%	
	Maternity Response Rate	45% (Int)	?	14.8%	18.4%	25.7%	30.2%	

Performance & Counter Measure

The PALS service received 522 concerns in January, an increase from 342 in December. Communication continues to be a key theme, including delays in phone calls being answered. Senior nurses are taking a proactive approach to address issues early and to support patients during periods of high escalation.

There were 2 Klebsiella bloodstream infection cases in January. A detailed review is underway to understand any contributing factors and to strengthen our infection-prevention measures. Following the catheter-care audit completed in October, the catheter supplier has attended several quality-improvement meetings to support additional staff training and to review best practice for positioning catheter bags, helping to reduce the risk of future infections.

Family and Friends Test (FFT) response rates increased in January, rising from 22.8% to 24%, with the improvement largely driven by maternity services. The overall Trust positive response rate decreased slightly to 86.2%,-with reduced positive responses in the Emergency Department and Urgent Treatment Centre contributing most to this change. Positive response rates increased across all other areas.

Risks

The risks around FFT procurement remain on the register with supplier provision of services and contractual changes. Procurement is now progressing - with a projection of commencing in April.

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

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26
Harm	Patient safety incident investigation	SPC		0	3	1	0
	No. of Falls in month	SPC		86	76	91	89
	No. falls with moderate harm or above	SPC		4	0	6	0
	Medication incidents with moderate harm	SPC		1	1	2	1
	Pressure Ulcer (Hospital Acquired)	SPC		11	10	16	16
Concerns and Complaints	No. of complaints received	SPC		72	106	94	81
	Number of reopened complaints	SPC		5	3	4	3
IP&C	C.Diff	4.50 (Int)		4	1	3	7
	MRSA	0 (Int)		0	0	0	1
	MSSA	1.92 (Int)		0	1	5	2
	E.coli	7.50 (Int)		11	7	10	10
	Pseudomonas	1.75 (Int)		2	0	0	2

Performance & Counter Measure

In January there were no Patient Safety Incident Investigation (PSII) declared. Currently, 12 investigations are in progress, with 7 overdue against set timelines. To strengthen oversight and accelerate completion, the Learning to Improve group continue to review overdue cases at each meeting, ensuring focused support where progress has been challenging.

The number of falls reported in month is 89, a decrease from 91 reported in December. There has been no falls with moderate or above harm in month.

The number of Hospital-acquired pressure ulcers reflected the same position this month at 16. The overall cumulative rate remains below the Trust's planned reduction trajectory with a rate of 0.84 per 1000 bed days for total pressure ulcer harms.

The level of harm remains higher than previous months with three category 3 pressure harms, a slight decrease of 1 in month 16 harms were recorded across 14 patients, with 2 device-related. Targeted education, training, and enhanced rounding guidance are being implemented to reduce these incidents.

There was 1 medication incident recorded as moderate harm or above. The immediate learning has been identified including training and stock drug reviews.

In January, the Trust received 81 new complaints, a reduction from 94 in December. All feedback is reviewed to identify learning and support ongoing improvements to patient experience, with a particular focus on strengthening communication, especially for patients on waiting lists.

The Trust remains above trajectory for E. coli and Klebsiella bloodstream infections and below target for Pseudomonas bloodstream infections. A significant proportion of Gram-negative cases continue to be associated with urinary tract infections (UTIs). An external audit of catheter practice, completed in October, has been shared at divisional level this month to support targeted improvement work.

There have been two cases of Methicillin-Sensitive Staphylococcus Aureus (MSSA) and one case of Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection. To strengthen prevention measures, the division has commenced a project to update the Visual Infusion Phlebitis (VIP) score, supporting improved monitoring and management of peripheral lines.

Risks

There remains a risk due to the lack of accessible information, which does not fully meet the requirements of the Accessible Information Standard and the Equality Act. Patients are currently directed from our website to contact the PALS team with any additional needs or challenges as an interim measure. This risk is being monitored by the Patient Quality sub-Committee, with an action plan shared and discussed this month.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26
Safer Staffing	Safer Staffing – average fill rate RN (%)	85.0% (Nat)	P	89.4%	92.9%	90.7%	93.6%
	Safer Staffing – average fill rate HCA (%)	85.0% (Nat)	P	111.2%	116.3%	119.4%	118.8%
FFT	ED & UTC Response Rate	19.6% (Int)	?	19.8%	18.4%	19.3%	19.6%
	Inpatients Positive Responses	90.4% (Int)	?	90.6%	89.7%	90.6%	91.6%
	Daycases Response Rate	29.8% (Int)	?	31.2%	28.9%	28.4%	28.7%
	Daycases Positive Responses	95% (Int)	?	95.8%	94.8%	95.5%	95.7%
	Outpatients Positive Responses	94% (Int)	?	90.0%	78.8%	100.0%	100.0%
	Maternity Positive Responses	92.5% (Int)	?	91.6%	86.7%	94.4%	95.3%

Performance & Counter Measures

During January, additional escalation areas were opened to support increased demand. Despite these pressures, staffing fill rates remained above the national target and within the safe parameters required for safer staffing.

Trust's new FFT supplier will enable improved thematic reviews of the data. The new system will also support patients to give feedback in written form as well through a digital system.

Staff are giving proactive verbal reminders to day case patients about the Friends and Family Test, explaining how important their feedback is and encouraging them to respond when they receive the text message.

Improvement work for patient experience includes the set-up of a new patient family and carer information hub that can provide support services, signposting and advice particularly related to unpaid carers and discharge planning.

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

Our Performance

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26	Trend
RTT	No. of >=18 weeks waiters		H	16401	16827	17583	18469	
	No. of >=52 weeks waiters		L	559	602	658	740	
DM01	No. of patients on DM01 waitlist		L	7755	6949	6670	One month behind	
	DM01 performance %	99% (Nat)	F	92.9%	92.0%	90.1%	One month behind	
	DM01 6 week wait breaches		L	554	553	660	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	F	66.7%	65.6%	71.0%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	91.1%	89.4%	91.4%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	54.3%	47.6%	62.4%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	F	63.9%	61.6%	71.6%	One month behind	

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

Performance & Counter Measure

DM01

January's validated DM01 performance improved from 90.1% in December to 91.1%. This improvement has been driven by a reduction in patients waiting over six weeks (down from 660 to 593). The total diagnostic waiting list reduced slightly from 6,670 to 6,638. While overall performance has improved, endoscopy remains the principal pressure, with colonoscopy at 75.1%, flexi-sigmoidoscopy at 80.0%, and cystoscopy at 69.2%. These pathways continue to impact overall DM01 compliance. Imaging modalities remain strong, with MRI and DEXA delivering 100% and CT at 99.8%, providing stability across the diagnostic portfolio. Total activity in January was 12,568 tests and procedures, demonstrating sustained high throughput following the Christmas period.

Countermeasures

Ultrasound remains the largest waiting list at 2,465 patients, with 179 waiting over six weeks (performance 92.7%). Additional clinics continue to run, supported by expanded capacity at Cherwell, to prevent further ageing of this pathway.

Audiology remains below the 95% standard at 84.3% (102 breaches) and continues to present a year-end delivery risk.

Endoscopy performance is expected to remain variable in the short term as the team transitions from in-house WLI delivery to embedding services within the new CDC endoscopy unit in West Swindon, which opened on 25 October and continues to stabilise following initial start-up challenges.

Cancer

62 Day performance remains heavily impacted by pathway issues in Urology, where diagnostic reporting delays and all options nature of prostate patients means a large number of breaches continue. 29% of the 43.0 breaches allocated to GWH were on a Urology pathway

31D performance fell short in December due to capacity issues in outpatients. Of the 15 pathways that breaches, 13 were in Skin.

Cancer waiting times for first appointment remain below standard. Breast is the largest contributors with 41% of all breaches, with Skin next with 21%. Capacity was the main reason for breaches, being responsible for 81% of breaches. Capacity for Other Appointments accounted for 58% of the capacity breaches

Cancer Faster Diagnosis is heavily impacted by the capacity issues seen in the Breast& Colorectal pathways. Breast accounted for 36% of all breaches, where 99% related to outpatient capacity.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	69.9%	71.0%	71.5%	66.5%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	7.4%	7.5%	7.2%	10.7%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	49.0%	52.0%	51.9%	44.0%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	14.4%	14.1%	13.3%	19.6%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	91.8%	92.4%	94.4%	93.6%	
	Total ED Type 1 Attendances (all arrival methods)	SPC	H	6185	6142	6312	6337	
	Emergency Care - AED - Median Stay	240 (Int)	F	281	240	240	326	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4-hour performance (type 1 and 3) dropped to 66.5% (down 5%). This is below the 25/26 national target. The decrease in overall performance relates to type 3 performance decreasing under 95% over last few months (previously sustained at 95% or above) and Type 1 continuing with an average of around 45% to 52% in January.

Total % over 12 hours (Type 1) in January 19.6% increased by 6.3% from last month at 13.3%. Any prolonged length of stay in ED leads to overcrowding and subsequent delays in ambulance offload.

Management of 'Timely Handover Process' with ambulance patients off-loaded as per 'WAIT 45' into ED temporary escalation spaces, predominantly maintained as nine trolley spaces: THP continues to be used consistently to support THP protocols with the ambulance services . Counter measures remain in place within the Breakthrough objective slides and are now being refreshed as part of the Trust UEC and Flow programme reset around reducing non-elective length of stay.

Risks

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26
RTT	No. of >=78 weeks waiters	SPC		3	5	5	2
Cancer	No. of referrals received	SPC		2055	1972	1859	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.1%	0.0%	0.0%	0.0%
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC		88.3%	88.3%	86.8%	86.9%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		58.2%	60.8%	62.3%	57.8%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		51.6%	51.0%	61.4%	60.7%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	199	196	188	200
	Emergency Care - UTC - Median Stay	240 (Int)	P	153	149	137	141

Performance & Counter Measure

ED, CEU & UTC

ED – 5,028 CEU – 1,065, UTC – 5,546

Triage performance for ED for 15-minute decreased 4.5% from 62.3% to 57.8%

For Type 3 (UTC only) triage performance within 15 minutes decreased 0.7% from 61.4% to 60.7%

Risks

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

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

Our Performance

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26
ED	Total Number of Ambulance Handovers	SPC		2285	2296	2474	2107
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		690.90	547.41	562.70	1063.15
	Number of Ambulance Handover Over 15 Minute Waits	SPC		1655	1681	1809	1682
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC		72.4%	73.2%	73.1%	79.8%
	Number of Ambulance Handover 30 Minute Waits	SPC		916	730	929	904
	Percentage of Ambulance Handover Over 30 Minutes	SPC		40.1%	31.8%	37.6%	42.9%
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		217	728	924	772
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		9%	32%	37%	37%
	Average hours lost to ambulance handover delays per day	SPC		22	18	18	38

Performance & Counter Measure

ED, CEU & UTC

Number of ambulance conveyances decreased in December to 2107, an decrease of 367 on December. Average daily hours lost increased to 38, an increase of 20 from December.

Ambulance arrivals averaging 75 per day in January 2026 compared to 80 in December 2025

W45 Ambulance Offload protocol went live 6th October 2025 (offload in under 45 minutes) and has been extremely challenging throughout November, December and January with an organisational response required.

Risks

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		585	578	558	708
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		290	277	276	343
	Elective Patients Average Length of Stay (Days)	SPC		3.6	3.0	2.7	3.2
	Non-Elective Patients Average Length of Stay (Days)	SPC		6.4	6.6	6.4	6.1
	GWH Discharges by Noon (%)	SPC		14.8%	16.6%	15.7%	18.5%
	Number of Stranded Patients (over 14 days)	SPC		141	132	119	141
	Number of Super Stranded Patients (over 21 days)	SPC		86	78	64	76
	Adult general and acute type 1 bed occupancy	SPC		99.3%	99.3%	98.0%	98.5%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	H	21.2%	21.7%	20.9%	21.4%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.76%	95.88%	95.29%	95.29%
	The Number of Patients in Temporary Escalation Spaces within ED	SPC		28	29	27	35
	Total adult general and acute Temporary Escalation Space beds occupied	SPC		9	12	10	19
	Total paediatric general and acute Temporary Escalation Space beds occupied	SPC		0	0	0	0
	Total Temporary Escalation Space beds occupied	SPC		9	12	10	19

Performance & Counter Measure

Patient Flow

- ED 4 hour performance remedial action plan across Type 1 admitted, Type 1 non-admitted and Type 3 UTC.
- Trust wide UEC Flow and Transformation programme phase 2 is now in progress to support reduction in bed occupancy.
- Rapid Ambulance Handover Standard Operating procedure enacted – Trust actions to progress towards a 33minute average handover delay underway. Offloading onto hospital trolleys and one directional flow approach started in July.
- Review of Better Care Fund commitments to support reduction in discharge ready delays. Swindon and Wiltshire local authority support for improvement in P1 length of stay and P2.

Risks

There is a risk of ongoing ambulance handover delays if overall bed occupancy and no criteria to reside does not reduce further, system calls are in place to monitor trajectory. Trust focus remains on improvements that can be made to earlier discharge in the day and escalating the completion of next steps for discharge which will reduce length of stay and positivity impact on NCTR reduction.

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

Use of Resources

Great Western Hospitals NHS Foundation Trust

Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26
Use of Resources	Capital Expenditure (£'000)	SPC	L	-1723	1693	1878	1835
	Pay (£'000)	SPC	L	27286	28109	28203	27668
	Non Pay (£'000)	SPC		17596	16912	18918	17777

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

Performance & Counter Measure

Capital spend at M10 is £9.3m against a plan of £17.2m, giving an underspend against plan of £7.9m. The £9.3m includes a £2.6m disposal of community property. Other key underspend drivers are EPR (£1.7m), estate schemes (£0.7m) and medicine / equipment replacement (£1.8m) with the remainder due to divisional related CDEL scheme underspends. The Trust was advised to slow its capital schemes due to its revenue position in M02, which has now been reversed , but contributed to the profile of spend being behind plan.

M10 pay costs are £0.5m lower than M09 due to industrial action costs incurred in prior month.

Non-Pay costs are £1.1m lower than M09 driven by £0.6m of bad debt provision, £0.6m of additional depreciation and £0.4m of CDC outsourcing costs offset by income all incurred in prior month.

Risks

The £10.0m shortfall on the Trust's cash releasing efficiency savings programme at M10 is a key driver behind the £8.5m adverse variance to budget. Delivering on the overall efficiency savings target of £32.4m through recurrent cash out schemes, particularly on pay with associated WTE reduction, is vital if the Trust if to achieve its breakeven plan in 25/26.

Our People

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Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Oct-25	Nov-25	Dec-25	Jan-26
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	11.4%	11.2%	11.1%	One month behind

Plan Area	Metric	Target /SPC Target Icon	2017	2018	2019	2020	2021	2022	2023	2024
Workforce	Staff Survey response rates	44% (Nat)	46.5%	43.6%	40.0%	53.4%	39.5%	58.7%	69.0%	71.0%
	My immediate manager takes a positive interest in my health and well-being	67.4% (Nat)	68.8%	67.5%	74.8%	69.2%	64.4%	67.6%	70.4%	70.9%
	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	57.5% (Avg)	59.6%	54.1%	60.4%	57.1%	56.1%	56.4%	56.5%	Waiting for data

Performance & Counter Measure

- Improvement for the third consecutive month to leavers within their first year of employment, decreasing to 11.1% and remaining below target.
- The 2025 Staff Survey closed on 28th November with a final response rate of 66%

Risks

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

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

Our People

Workforce Scorecard

NHS
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Pillar	Type	Metric	Unit/Measure	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Trend Vs	
																		Last Month	Jan-25
		Vacancy																	
	W	Vacancy Rate	%	7.00%	3.34%	3.06%	2.98%	4.28%	4.26%	4.18%	4.25%	3.67%	3.04%	2.40%	1.82%	1.39%	1.40%	↑	↓
	W	Vacancy Rate	WTE	-	182.32	167.40	162.89	215.93	215.09	210.64	214.60	185.13	153.23	120.97	91.70	70.16	70.46		
	W	All Nursing Vacancy	%	7.00%	1.8%	1.2%	1.0%	0.1%	0.1%	0.1%	0.0%	-0.7%	-1.4%	-1.8%	-2.7%	-3.0%	-3.2%	↓	↓
	W	All Nursing Vacancy (Reg & Unreg)	WTE	-	47.73	33.37	27.15	3.52	1.47	1.23	-1.17	-16.13	-33.00	-43.91	-65.00	-71.04	-75.82		
	W	All Registered Nursing Vacancy	WTE	-	-24.01	-10.00	-8.16	-10.86	-7.52	-9.24	-10.35	-17.41	-37.44	-52.63	-61.21	-64.62	-65.86		
	W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	-41.32	-37.51	-33.85	-41.18	-38.96	-38.48	-40.30	-44.56	-61.01	-71.45	-74.96	-78.25	-68.28		
	W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	71.74	43.37	35.31	14.38	8.99	10.47	9.18	1.28	4.44	8.72	-3.79	-6.42	-9.96		
	W	Medical Vacancy	%	7.00%	8.01%	8.92%	8.25%	8.31%	8.05%	8.10%	8.00%	4.60%	2.55%	0.09%	0.08%	0.10%	-0.56%	↓	↓
	W	Medical Vacancy	WTE	-	60.01	66.79	61.77	61.95	59.95	60.35	59.64	34.29	18.97	0.70	0.57	0.76	-4.15		
	W	STT/AHP Vacancy	%	7.00%	2.2%	1.7%	1.9%	8.3%	7.7%	7.1%	7.4%	7.5%	6.4%	5.5%	4.6%	2.7%	3.0%	↑	↑
	W	STT/AHP Vacancy	WTE	-	19.03	14.42	16.50	66.18	61.87	56.78	59.15	59.90	51.32	44.34	37.17	21.65	23.85		
	W	SMA Vacancy	%	7.00%	4.7%	4.5%	4.9%	7.5%	8.2%	8.3%	8.7%	9.6%	10.4%	10.7%	10.7%	10.6%	11.3%	↑	↑
	W	SMA Vacancy	WTE	-	55.55	52.82	57.47	84.28	91.80	92.28	96.98	107.07	115.94	119.84	118.96	118.79	126.58		
	W	Recruitment Time to Hire - AFC	Days	46.00	42.19	44.30	33.60	34.80	36.40	39.70	37.70	41.30	40.30	39.10	36.20	37.80	38.90	↑	↓
	W	Recruitment Time to Hire - Bank	Days	46.00	42.90	42.70	38.30	40.00	18.00	40.20	61.10	51.70	28.50	26.50	18.80	21.80	30.60	↑	↓
	W	Recruitment Time to Hire - Medical	Days	46.00	45.02	41.00	36.50	38.00	37.40	40.20	49.00	40.10	39.50	35.50	39.10	39.20	42.40	↑	↓

Our People

Workforce Scorecard

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NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Trend Vs Last Month	Trend Vs Jan-25
		Workforce Utilisation																	
	W	Substantive WTE	WTE	-	5,276.50	5,303.02	5,307.53	4,827.81	4,828.65	4,833.10	4,829.14	4,858.61	4,890.51	4,922.77	4,952.04	4,973.58	4,974.68		
	W	Additional Substantive WTE	WTE	-	12.96	13.66	16.45	11.97	11.84	9.79	9.54	10.88	11.32	11.83	11.15	10.34	10.54		
	W	Bank WTE	WTE	-	325.49	305.77	413.99	311.69	306.31	270.91	287.37	304.15	241.73	274.78	298.19	287.23	333.51		
	W	Agency WTE	WTE	-	39.05	31.77	64.42	48.54	54.27	45.68	44.12	29.32	27.72	26.43	26.99	24.18	31.36		
	W	Total WTE Utilised	WTE	-	**5,654.00**	**5,654.22**	**5,802.39**	**5,200.01**	**5,201.07**	**5,159.48**	**5,170.17**	**5,202.96**	**5,171.28**	**5,235.82**	**5,288.37**	**5,295.33**	**5,350.09**		
	W	Planned Establishment WTE	WTE	-	5,458.82	5,470.42	5,470.42	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,045.14		
	W	Variance to planned est	WTE	-	195.18	183.80	331.97	156.27	157.33	115.74	126.43	159.22	127.54	192.08	244.63	251.59	304.95		
	W	GL Funded Establishment WTE	WTE	-	5,458.82	5,470.42	5,470.42	5,043.74	5,043.74	5,043.74	5,043.74	5,215.77	5,204.43	5,202.37	5,200.96	5,210.18	5,215.34		
	W	Variance to GL funded	WTE	-	195.18	183.80	331.97	156.27	157.33	115.74	126.43	-12.8	-33.1	33.4	87.4	85.1	134.75		
	W	Planned Est, vs GL Funded	WTE	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-172.0	-160.7	-158.6	-157.2	-166.4	-170.20		
	W	Actual Worked vs Planned Establishment	%	-	103.58%	103.36%	106.07%	103.10%	103.12%	102.29%	102.51%	103.16%	102.53%	103.81%	104.85%	104.99%	106.04%		
	W	Total Workforce Cost £	£	-	£27.24M	£27.93M	£28.58M	£26.55M	£26.60M	£26.34M	£25.70M	£30.78M	£27.60M	£27.27M	£27.86M	£28.11M	£27.86M		
	W	Agency Spend as % of Total Spend	%	4.50%	2.52%	1.97%	2.14%	2.26%	2.40%	2.75%	1.82%	1.70%	1.78%	0.97%	1.05%	0.59%	1.17%	↑	↓
	W	Agency Spend £	£	-	£0.69M	£0.55M	£0.61M	£0.60M	£0.64M	£0.72M	£0.47M	£0.52M	£0.49M	£0.26M	£0.29M	£0.17M	£0.33M		
	W	Agency Target £	£		£0.39M	£0.37M	£0.36M	£0.20M	£0.19M	£0.18M	£0.17M	£0.16M	£0.16M	£0.15M	£0.14M	£0.13M	£0.12M		
	W	Agency Spend vs Target £	£ Diff	£0.00M	£0.30M	£0.18M	£0.25M	£0.40M	£0.45M	£0.55M	£0.30M	£0.36M	£0.33M	£0.12M	£0.15M	£0.04M	£0.20M	↑	↓
	W	Bank Spend £	£	-	£1.71M	£2.66M	£2.70M	£2.21M	£2.18M	£2.05M	£1.92M	£2.36M	£1.97M	£1.94M	£2.50M	£2.67M	£2.11M		
	W	Bank Target £	£		£1.50M	£1.42M	£1.34M	£2.90M	£2.56M	£2.22M	£1.88M	£1.53M	£1.19M	£1.31M	£1.38M	£1.45M	£1.47M		
	W	Bank Spend vs Target £	£ Diff	£0.00M	£0.22M	£1.24M	£1.36M	-£0.69M	-£0.38M	-£0.17M	£0.05M	£0.83M	£0.78M	£0.63M	£1.13M	£1.22M	£0.64M	↓	↑
		Retention																	
	W	All Turnover %	%	13.00%	11.08%	11.01%	11.26%	11.31%	11.16%	10.85%	10.74%	10.38%	10.20%	9.94%	9.65%	9.62%	-	↓	↓
	W	Voluntary Turnover %	%	11.00%	8.62%	8.48%	8.55%	8.41%	8.29%	8.13%	7.94%	7.68%	7.49%	7.19%	7.00%	6.90%	-	↓	↓
	W	Number of Leavers	Headcount	-	35	30	70	38	32	43	41	43	50	43	30	41	-		
	W	Number of RN Leavers	Headcount	-	9	8	12	8	8	11	9	9	13	11	6	13	-		
	W	Registered Nursing Vol Turnover	%	-	7.25%	7.28%	6.96%	6.51%	6.16%	6.01%	5.80%	5.46%	5.69%	5.50%	5.44%	5.33%	-		
	W	Number of Unreg Nursing Leavers	Headcount	-	1	5	9	6	10	9	8	8	8	8	9	10	-		
	W	Unregistered Nursing Vol Turnover	%	-	10.27%	9.77%	10.06%	9.45%	9.81%	9.21%	9.38%	9.49%	9.13%	8.94%	8.97%	8.79%	-		
	W	Leavers within 1st Year - Rolling 12 Month	%	-	9.02%	10.37%	10.94%	10.30%	11.68%	11.62%	11.93%	13.09%	12.84%	11.35%	11.24%	11.09%	-		
	W	Number of starters	Headcount	-	55	49	48	35	20	47	38	46	91	57	65	34	-		

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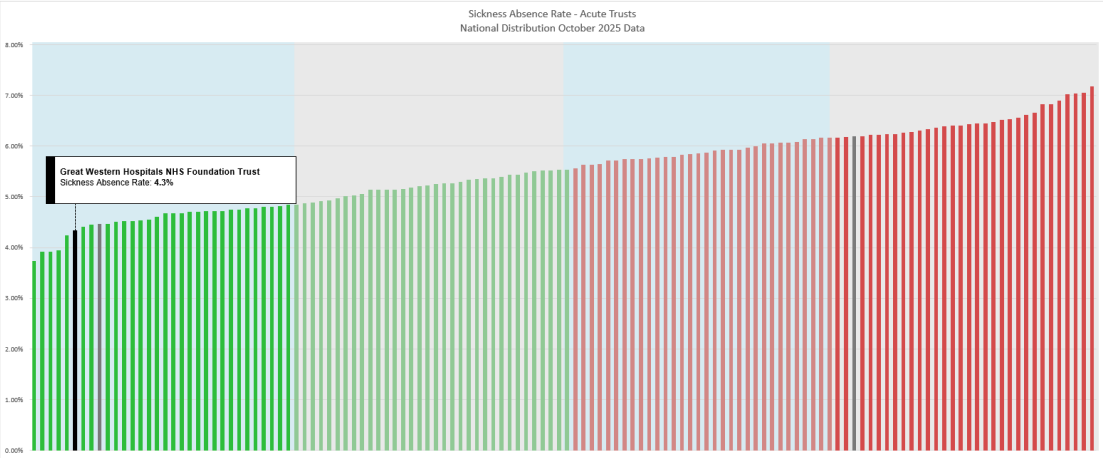
Pillar	Type	Metric	Unit/Measure	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Trend Vs Last Month	Trend Vs Jan-25
		Absence																	
	D	Sickness Absence % Rolling 12 Month	%	3.50%	4.61%	4.65%	4.68%	4.68%	4.68%	4.65%	4.59%	4.57%	4.55%	4.51%	4.46%	4.42%	-		
	D	Sickness Absence %	%	3.50%	5.14%	4.92%	4.49%	4.13%	4.11%	4.22%	4.44%	4.29%	4.08%	4.35%	4.24%	4.50%	-		
	W	Long Term Sickness %	%	2.00%	2.12%	2.49%	2.22%	2.12%	2.09%	2.24%	2.30%	2.40%	2.05%	2.02%	2.01%	2.28%	-		
	W	Short Term Sickness %	%	1.50%	3.02%	2.42%	2.26%	2.01%	2.02%	1.98%	2.14%	1.88%	2.03%	2.33%	2.23%	2.22%	-		
	W	Sickness Absence Cost £	£	-	£897.5k	£773.1k	£815.5k	£681.0k	£702.2k	£685.5k	£769.3k	£760.1k	£742.3k	£791.4k	£748.6k	£806.7k	-		
	W	WTE Days Lost	WTE	-	8,414.0	7,299.3	7,397.7	5,979.0	6,159.6	6,117.3	6,674.6	6,456.8	5,979.9	6,638.5	6,303.8	6,943.7	-		
		Learning & Development																	
	W	Mandatory Training Compliance %	%	85.00%	90.27%	90.03%	90.03%	90.46%	90.94%	91.66%	91.60%	91.10%	91.38%	91.23%	91.55%	91.47%	91.31%		
	W	Role Essential MT %	%	85.00%	89.79%	89.70%	89.86%	90.57%	90.95%	91.77%	91.95%	91.33%	91.70%	91.68%	92.05%	91.98%	91.95%		
	W	CQC Safe MT %	%	85.00%	90.89%	90.45%	90.24%	90.33%	90.92%	91.52%	91.15%	90.79%	90.99%	90.67%	90.91%	90.83%	90.49%		
	W	Bank-Only Mandatory Training Compliance %	%	85.00%	83.96%	81.72%	80.81%	65.69%	64.67%	64.11%	73.77%	79.71%	77.67%	76.14%	78.59%	78.32%	78.63%		
	W	Appraisal Compliance %	%	85.00%	84.51%	84.35%	84.40%	83.88%	81.56%	80.36%	80.08%	80.91%	80.81%	79.02%	78.86%	78.39%	76.91%		
	W	Non Medical Appraisal Compliance %	%	85.00%	84.63%	84.44%	84.24%	84.15%	82.14%	81.04%	80.45%	80.90%	80.30%	78.65%	78.80%	78.51%	77.75%		
	W	Medical Appraisal Compliance %	%	85.00%	83.68%	83.68%	85.48%	82.08%	77.82%	76.02%	77.75%	80.99%	83.98%	81.21%	79.20%	77.67%	72.12%		
		Demographics																	
	W	Staff in Leadership Roles % (B8a+)	%	-	4.29%	4.25%	4.27%	4.30%	4.36%	4.30%	4.20%	4.15%	4.14%	4.20%	4.27%	4.30%	4.31%		
	W	Staff in Leadership Roles WTE (B8a+)	WTE	-	278.00	276.00	277.00	255.00	259.00	256.00	252.00	248.00	249.00	254.00	260.00	263.00	264.00		
	W	% of Leadership Roles who are Female (B8a+)	%	-	70.50%	69.93%	69.68%	68.24%	68.34%	67.58%	67.86%	68.15%	68.67%	69.29%	69.23%	68.82%	68.94%		
	W	% of Leadership Roles who from BME (B8a+)	%	-	6.47%	6.52%	6.50%	5.88%	6.18%	5.47%	5.56%	5.65%	6.02%	6.30%	6.15%	6.84%	6.82%		
	W	Staff in Leadership Roles % (B8c+)	%	-	0.94%	0.94%	0.92%	1.01%	1.03%	1.01%	1.00%	1.00%	1.00%	1.01%	0.98%	0.98%	1.03%		
	W	Staff in Leadership Roles WTE (B8c+)	WTE	-	61.00	61.00	60.00	60.00	61.00	60.00	60.00	60.00	60.00	61.00	60.00	60.00	63.00		
	W	% of Leadership Roles who are Female (B8c+)	%	-	55.74%	54.10%	53.33%	53.33%	52.46%	51.67%	53.33%	53.33%	55.00%	57.38%	56.67%	56.67%	58.73%		
	W	% of Leadership Roles who from BME (B8c+)	%	-	4.92%	4.92%	6.67%	5.00%	4.92%	5.00%	5.00%	5.00%	5.00%	6.56%	5.00%	5.00%	6.35%		
	W	% of Leadership Roles who are disabled (B8c+)	%	-	3.28%	3.28%	3.33%	3.33%	3.28%	3.33%	3.33%	3.33%	3.33%	3.28%	3.33%	3.33%	4.76%		
	W	Male % of Workforce	%	-	18.58%	18.61%	18.67%	19.33%	19.44%	19.51%	19.67%	19.87%	20.00%	19.98%	20.06%	20.08%	20.05%		
	W	Female % of Workforce	%	-	81.42%	81.39%	81.33%	80.67%	80.56%	80.49%	80.33%	80.13%	80.00%	80.02%	79.94%	79.92%	79.95%		
	W	BME % of Workforce	%	-	28.67%	29.29%	29.43%	30.08%	30.30%	30.65%	30.66%	30.71%	31.50%	31.63%	31.75%	32.19%	32.11%		
	W	White % of Workforce	%	-	63.94%	63.48%	63.22%	62.05%	61.76%	61.35%	61.27%	60.43%	59.79%	60.38%	60.20%	59.90%	60.05%		
	W	ER Cases Closed	Number	-	54	33	41	56	47	50	48	49	56	66	61	55	49		

Our People



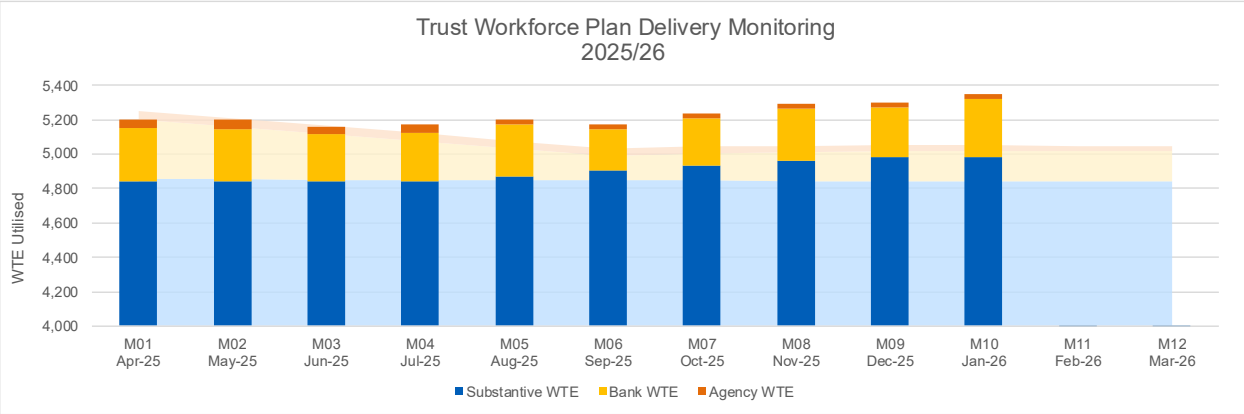
Performance & Counter Measure

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

- Targeted operational actions continued in January, with 31 hours of face-to-face People Operations support delivered to identified sickness hotspots, focusing on management confidence, policy adherence and consistent absence practice.
- Two absence audits were completed:
  - A three-monthly review audit demonstrated sustained improvement, with compliance increasing from 64% to 83% and now 90% (Children's Unit).
  - A first-time audit in a newly identified hotspot (Cellular Pathology) achieved an initial 65% compliance score, providing a baseline for targeted improvement actions.
- The working group is reviewing the development of a scenario-based, interactive PowerPoint to support managers in effective sickness absence management. The resource will incorporate case studies, videos and practical tools to strengthen early intervention, support constructive conversations, and reduce avoidable and prolonged sickness absence.
- Local best practice showcased through the working group included strengthened burnout prevention approaches in the Trauma Unit incorporating flexible working, enhanced staff recognition, and wellbeing engagement.
- Endoscopy are trialling further embedding of the Professional Nurse Advocate role, aiming to improve morale, engagement, and provide a more supportive working environment.
- The working group retains oversight of the monthly physiotherapy sessions being provided by the Health & Wellbeing team, providing a proactive approach to reducing musculoskeletal related sickness through early intervention, supported by wider promotion and accessible intranet resources.

Our People

Workforce Delivery Plan



		M01 Apr-25	M02 May-25	M03 Jun-25	M04 Jul-25	M05 Aug-25	M06 Sep-25	M07 Oct-25	M08 Nov-25	M09 Dec-25	M10 Jan-26	M11 Feb-26	M12 Mar-26
Total Workforce (OPP)	Plan	5,253	5,208	5,164	*5,120*	*5,075*	*5,031*	*5,042*	*5,046*	5,051	5,050	5,048	5,047
	Actual	**5,200**	**5,201**	**5,159**	**5,170**	**5,203**	**5,171**	**5,236**	**5,288**	**5,295**	**5,350**	0	0
	Variance	-53	-7	-5	50	128	*141*	*194*	*242*	*244*	*300*	-	-
Substantive	Plan	4,853	4,852	4,851	4,850	*4,848*	*4,847*	*4,846*	*4,844*	*4,843*	*4,842*	4,840	4,839
	Actual	**4,840**	**4,840**	**4,843**	**4,839**	**4,869**	**4,902**	**4,935**	**4,963**	**4,984**	**4,985**	0	0
	of which Overtime	**12**	**12**	**10**	**10**	**11**	**11**	**12**	**11**	**10**	**11**	0	0
	Variance	-13	-11	-8	-11	21	*55*	*89*	*119*	*141*	*144*	-	-
Bank	Plan	347	306	265	224	*183*	*142*	*157*	*165*	*174*	*176*	178	180
	Actual	**312**	**306**	**271**	**287**	**304**	**242**	**275**	**298**	**287**	**334**	0	0
	Variance	-36	0	5	63	121	99	118	133	114	158	-	-
Agency	Plan	52	50	48	46	*43*	*41*	*39*	*37*	*35*	*33*	30	28
	Actual	**49**	**54**	**46**	**44**	**29**	**28**	**26**	**27**	**24**	**31**	0	0
	Variance	-4	4	-2	-2	-14	-14	-13	-10	-11	-1	-	-

Performance & Counter Measure

In January, we used 5,350 WTE to deliver our services. This was an adverse variance of +300 WTE compared to our planned 5,050 WTE. Usage has increased compared to December by 55 WTE and represents our highest total YTD.

Substantive workforce remained broadly the same in January, although remains above plan at +144 WTE. This is being wholly driven by clinical staffing growth above scenario 2a, whilst our Administrative & Clerical workforce continues to overperform against plan (-17 WTE in M10).

The Trust saw further increase to its Temporary Staffing levels in January, with usage rising by 53 WTE compared to December. Agency staffing increased by 7 WTE compared to the previous month, fully attributed to increased mental health nursing within Paediatrics. Bank usage grew by 46 WTE due to largely to additional staffing required for supporting flow during critical incident, with some further pressure created by enhanced care and an increased sickness absence rate.

Total variance to plan by staff group:

- All Nursing: +218 WTE
- AHP/STT: +31 WTE
- Medical & Dental: +71 WTE
- Admin & Clerical: -17 WTE

Impact on Workforce

- EVRP continues throughout 2025/26 with heightened scrutiny on approvals / recruitment freeze. From WC 9th June, non-clinical vacancies will be presented to the Group CEO and MDs for approval, with oversight from the Region at the Recovery Board.

Risks & Mitigations

- There is risk that workforce levels continue above plan in 2025/26 worsening our financial position. The Workforce Recovery Meeting is being reestablished to support and monitor reduction plans.
- At present the Trust does not have material plans on how reductions for 2025/26 will be realised, and with continuing operational pressures there is further risk of growth.

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

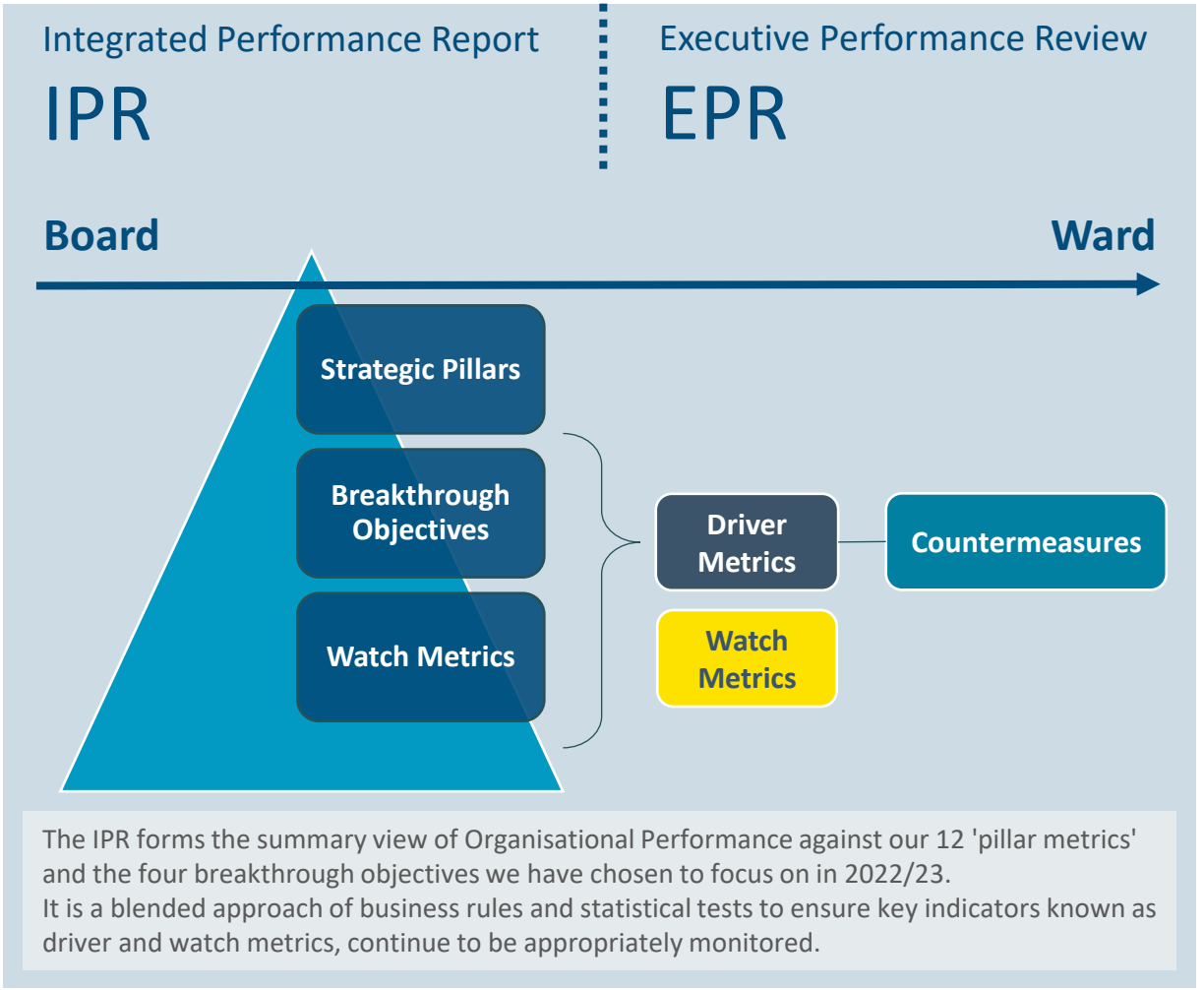
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

- Tissue viability – reducing pressure ulcers
- Emergency Attendances - Clinically Ready to Proceed (Admitted)
- Implied Productivity
- Staff Survey - I am able to make improvements happen in my area of work

We have chosen these four objectives using data to see where we can make the most significant improvements by focusing our efforts. We'll also use data to measure how much we're making a difference.

Frontline teams will lead improvements in these areas of focus. They will be supported by our Transformation and Improvement Hub, which will help give teams the training and tools they need, and our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.



The IPR forms the summary view of Organisational Performance against our 12 'pillar metrics' and the four breakthrough objectives we have chosen to focus on in 2022/23.
It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Vision

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

Our four strategic pillars

Outstanding care

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

Valued teams

Investing in training, resources, and well-being, while bringing teams together with the Improving Together approach.

Better together

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

Sustainable future

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

25/26 Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust

1 Our four strategic pillars

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

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

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

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

1	Leadership & Management Capability
2	The Way Forward Programme
3	Digital First
4	System & Place
5	Improving Together

4 Overlap

Corporate Projects

e.g.	Electronic Patient Record
e.g.	Integrated Front Door

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

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

Delivery mechanism – running the organisation

- Continuous Improvement
- Operational Management System (OMS)
- Linked through scorecards & scorecard agreement
- Strategic filtering
- Programme delivery

Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust

Continuous Improvement on Drivers

Performance Management on Driver & Watch Metrics

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

Information Flow

Information Flow

Building a culture of continuous improvement

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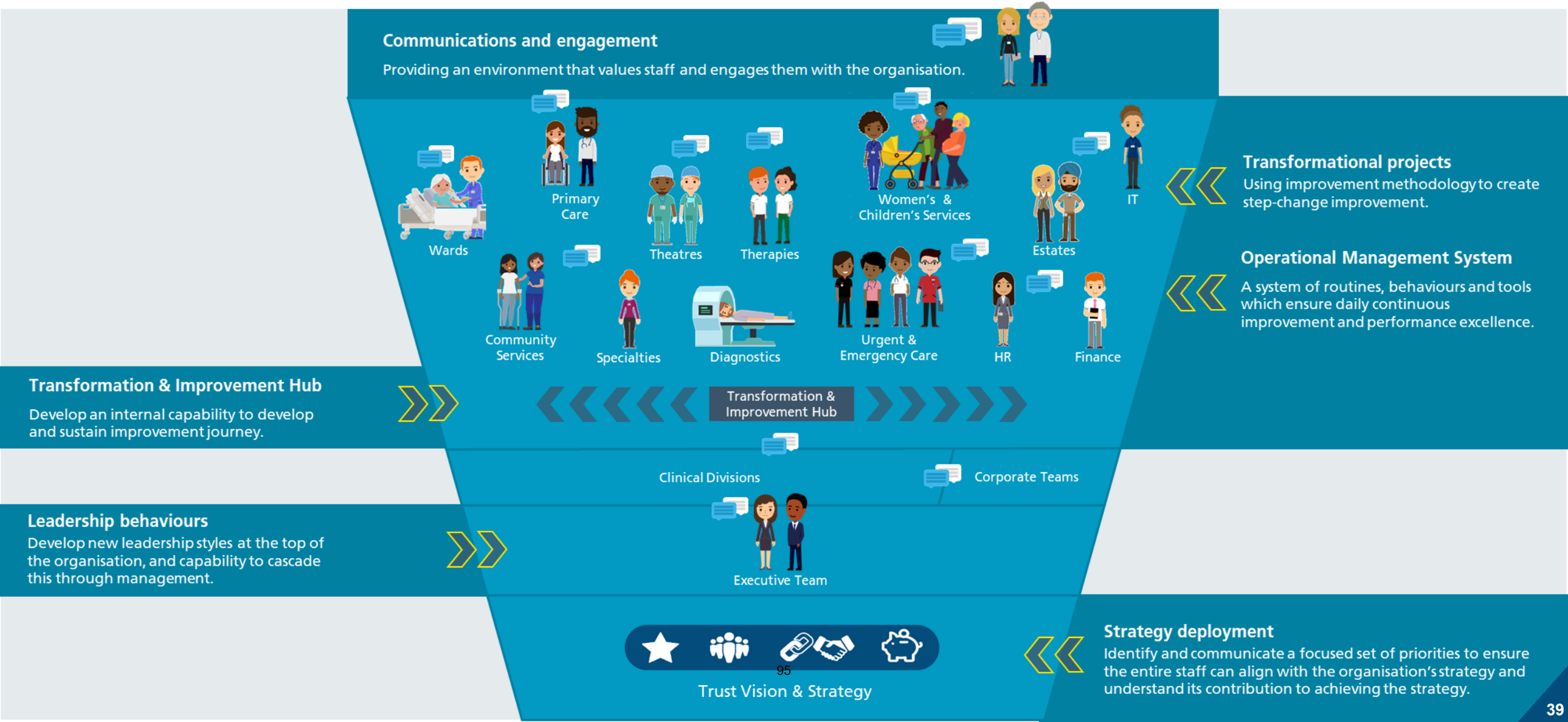


SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

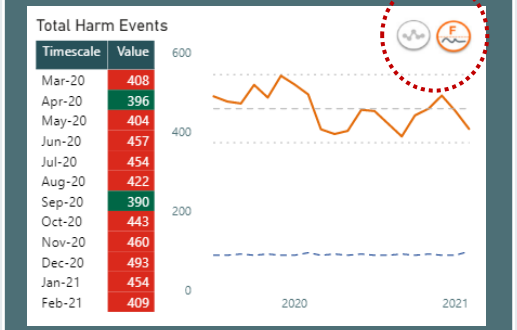
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

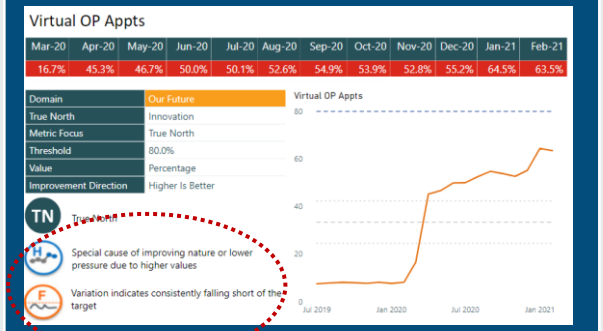
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

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

Agreed Terms

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

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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.

Board Committee Assurance Report

Committee	**Audit, Risk & Assurance Committee**
Meeting Date	19 January 2026
Committee Chair	Helen Spice, Non-Executive Director

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Corporate Departments Risk Register	Good Assurance	x
2. External Audit Plan 2025/26	Approved	x
3. Internal Audit Progress Report and Action Tracking	Partial Assurance	x
4. Internal Audit – General Ledger Final Report	Good Assurance	x
5. Internal Audit – Staff Lottery Final Report	Partial Assurance	x
6. Internal Audit – Management of IT Applications Final Report	Partial Assurance	x
7. Internal Audit – Training and Development Final Report	Partial Assurance	x
8. Local Counter Fraud Progress Report	Noted	x
9. Local Counter Fraud – Recruitment Review Report	Good Assurance	x
10. Single Tender Actions	Good Assurance	x
11. Losses and Compensation Report Q3 2025/26	Noted	x

POINTS OF ESCALATION	
KEY AREAS TO NOTE	The Committee received an update on the Corporate Risk Register. When this was previously considered by the Committee concern had been raised to ensure that all risks were appropriately managed and escalated appropriately across the Trust. A detailed mapping has now been prepared and the Committee were assured that all risks are being appropriately managed. The Committee are assured that good processes are in place currently. However the Committee raised a concern about the scale of change with implementing the new Group risk model and processes. This is going to be a significant change across the trust creating additional pressure in the current challenging environment. The Committee is looking for assurance that as part of the change that there is no lack of oversight and management on local Trust risk issues. The Committee received and approved the External Audit plan for 2025/26 from Deloitte. The timetable for completion of the audit is similar to prior years. It was recognised that Deloitte continue to expand their use of technology but that there will be continued focus on working with the Finance Team and the value of the on the ground work with the team. Deloitte noted that they will consider the Value for Money aspects of their work early in the process to ensure adequate time to discuss fully with the Committee. In the prior year Deloitte concluded no significant weaknesses in the Trust's value for money arrangements. The areas they will focus on in this year are the completion of CQC action plans and financial sustainability as the Trust has a high CIP target for 2025/26. The Committee received an update from KPMG on the progress of the internal audits for the year. There are currently a number of actions outstanding and it was recognised that management need to set more realistic dates not just to resolve issues but to ensure they are embedded across the trust. Actions cannot be closed until it can be seen that this takes place. Of particular note were some actions that had been outstanding for a prolonged period on EPR and so these were escalated to the Group CEO and Group Chief Transformation and Innovation Officer. The Committee Chair was assured outside the meeting that these issues were being taken seriously and would be resolved by the dates now agreed. KPMG presented the final internal audit review on Staff Lottery and General Ledger. The general ledger aspects were rated as 'Significant Assurance with minor improvements

	required' but the Staff Lottery was rated as 'Partial assurance with improvements required'. The Committee recognised the value of the staff lottery to our people but asked for urgent action to be taken to resolve the issues that had been identified on lack documentation and regulatory reporting as soon as possible. The Committee escalated the findings to the Charitable Funds Committee to ensure there is strengthened oversight going forward. KPMG presented the final internal audit review on Management of IT applications which was rated as 'Partial assurance with improvements required'. The Committee were assured that appropriate actions are in place and that processes will be improved as the management of IT applications is considered jointly across all three trusts. The Committee asked for assurance that as processes are improved jointly that this is completed jointly with procurement so that any new applications have the protocols in place to ensure they are managed and SLAs identified and the processes to monitor them are agreed during the procurement process. KPMG presented the final internal audit review on Training and Development which was rated as 'Partial assurance with improvements required'. The Committee were assured that the actions that had been identified would improve our reporting and were pleased that the timetable would ensure that the issues would be resolved quickly. The completion of the actions will be closely monitored. The Committee received the review of Recruitment processes conducted by the Local Counter Fraud Specialist. The Committee were assured that strong process are in place and being appropriately managed. The Committee received assurance that the issues identified had been resolved and there were no impacts beyond the sample. The Committee received the six monthly report on Single Tender Actions and were assured of the processes in place. The Committee noted the Losses and Compensation report for Q3 2025/26. Action is being taken by the Trust to improve stock control to reduce avoidable waste.
BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	The Internal Audit Report on Staff Lottery was referred to the Charitable Funds Committee.

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

SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.

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

Board Committee Assurance Report

Committee	**Audit, Risk & Assurance Committee**
Meeting Date	5 March 2026
Committee Chair	Helen Spice, Non-Executive Director

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Divisional Risk Report – Family & Specialist Services	Good Assurance	x
2. Board Assurance Framework	Good Assurance	x
3. 15+ Risk Register Report – March 2026	Good Assurance	x
4. July 2024 Power Failure Incident Update	Good Assurance	x
5. External Audit Interim Report 2025/26 – progress update	Noted	x
6. Estate Valuation	Noted	x
7. Annual Reporting Timetable	Noted	x
8. Internal Audit Progress Report and Action Tracking	Partial Assurance	x
9. Internal Audit – Research Governance Final Report	Good Assurance	x
10. Internal Audit Plan 2026/27	Noted	x
11. Local Counter Fraud Progress Report	Noted	x
12. Local Counter Fraud Plan 2026/27	Approved	x
13. Clinical Negligence Litigation Report Q3 2025/26	Noted	x
14. Policy on use of External Auditors for Non-Audit Services	Approved	x
15. NHS England's Code of Governance – Compliance 2025/26	Good Assurance	x
16. Documents signed under Trust seal	Noted	x
17. Internal Audit and Counter Fraud Contract Extension	Approved	x

POINTS OF ESCALATION	The Committee approved a one year extension to the contract with KPMG for the provision of Internal Audit and Counter Fraud Services. This is a multiple contract for the provision of these services with Salisbury, Bath and the ICB.
KEY AREAS TO NOTE	The Family and Specialist Division updated the Committee on their processes to manage risk and their actions in place to control and mitigate those risks. The composition of the Division has significantly transformed since they last presented to the Committee due to the divisional restructure. Through this process they have achieved good progress in simplifying the processes across the division to enable teams to increase focus on risk management rather than the process. The Committee were assured on the work that is being undertaken and were pleased to see that there were no risks out of date or with no actions and commended the Division on this. The Committee received an update on risk management processes and the 15+ Risk Register Report. The Committee commended the Trust on the excellent progress that has been made in managing this process over the last few years. The Committee raised a concern that this good position should be maintained as we transition to a Group model and recognised the impact on our resources and ensuring they have the appropriate support as we change to the new model. A final update was provided on the July 2024 Power Failure Incident and the Committee were assured that all actions are now complete and the risk processes are in place to monitor, manage and mitigate risks going forward. The management of these risks are overseen by the Finance, Infrastructure and Digital Committee and no further reports will be considered by ARAC. The Committee noted an update from Deloitte on the 2025/26 external audit and the overall annual reporting timetable. The Committee received an update from KPMG on the progress of the internal audit plan for 2025/26 which is almost complete. The Committee raised concerns as there continues

	to be a number of actions outstanding but the Committee were assured that a new process being introduced by the finance team to monitor actions and escalate them to the Care Organisation Leadership Team should improve this going forward. The Committee raised a specific concern on the actions from the Staff Lottery review on lack of documentation and regulatory reporting which had not been completed on time and completion dates had been extended without appropriate approval. Management confirmed that these issues are now being addressed urgently and will provide a report to the Committee as soon as they are complete. KPMG presented the final internal audit review on Research Governance which was rated as 'Significant Assurance with minor improvements required'. It was noted that there is no Research and Innovation strategy for the Trust that has been reviewed and approved by senior management. The Committee asked management to consider whether a group wide strategy should be considered rather than an individual Trust strategy. The Committee also referred this review to Quality and Safety Committee as the Research group reports to this Committee. The internal audit plan for 2026/27 was considered by the Committee. The Committee requested further follow up to ensure that we are balancing our focus on internal audit between the needs of the Trust and the needs of the Group. The Committee were also keen to ensure that we focused on areas for learning as well as assurance. The final plan will be reviewed and approved by email to ensure KPMG can start their work in the new year promptly. The Committee approved the Local Counter Fraud Plan for 2026/27. The plan includes two risk based reports (on overseas and private patient processes and salary overpayments), two joint reviews with internal audit and communications and workshops planned for the year. The Committee received a report on Clinical Negligence Claims activity for Q3 2025/26. The Committee welcomed the detail in the report and received assurance that issues that arise from claims are dealt with appropriately as they arise through PSIRF and escalation to the Quality and Safety Committee as required and the appropriate learning and support for our people is provided through the process. Further information on themes for claims will be brought to a future meeting. The Committee were assured that the Trust continues to be compliant with NHS England's Code of Governance for NHS Providers.
BOARD ASSURANCE FRAMEWORK & RISKS	The Committee reviewed the systems and processes around the Board Assurance Framework and the work undertaken by the Board Committees to review the BAF on a regular basis and confirmed their assurance that the BAF and its processes remain effective. The Committee noted that the Trust Board should discuss the next iteration of the Board Assurance Framework in light of the delay in transition to the group Board at the Board meeting on 12 March 2026.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	The Internal Audit Report on Research Governance was referred to the Quality and Safety Committee.

Key to committee assurance ratings **Ratings focus on overall assurance over effectiveness of controls'.** **Controls** : The measures in place to control risks and reduce the impact or likelihood of them occurring.	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Board Committee Assurance Report

Committee	**Charitable Funds Committee**
Meeting Date	4th March
Committee Chair	Julian Duxfield, Non-Executive Director

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Staff lottery audit	N/A	x
2. Financial reporting	Good	x
3. Fundraising	Partial	x
4. Cases of need	Good	x
5. Charity budget 26/27 and growth strategy	N/A	x
6. External review of Charitable funds	Partial	x
7. Charity funds rationalisation process	N/A	**x**
8. Conditional donations process	Good	**x**

POINTS OF ESCALATION	An Internal Audit Report on controls covering the Staff Lottery was referred to the Committee by ARAC. Discussions outside the Committee will determine how we should strengthen senior oversight of the Staff Lottery at the Trust. When the staff lottery was last discussed at the CF Cttee (May '24) it was understood that either the HR or Finance function would provide this oversight.
KEY AREAS TO NOTE	The total value of the Trust's overall charitable funds on 31st December 2025 were £749k of which £553k is restricted and £196k is unrestricted. Prior to the meeting the general fund's uncommitted balance stood at £27k above our agreed minimum threshold of £57,000. The core run-rate of income generation remains below last year, although expenditure is also less than budgeted as a result of staff vacancies and absences. Cases of need: Defence Medical Welfare Service (DMWS): It was agreed that funding should not be provided for the DMWS for the forthcoming year. The funding agreed last year was on the basis that the Trust would fund this into the future from savings identified from elsewhere within the Trust. In addition, the DMWS Armed Forces Welfare Service is funded by Trust budgets across the rest of the Group. Staff recognition events: There will be a continued dialogue with those who organise these events that external funding should be sought to help support these initiatives, rather than rely entirely on the Trust charitable funds. The final tranche of funding for this year's events will be considered at the May meeting. Donor research project: Funding for this was agreed on the basis that obtaining a better insight and understanding of our donors would be helpful. This project will be delivered in collaboration with the charity teams at the other two Trusts and this will help partnership working across the Group. The charity budget for 2026/27 and the proposed longer-term trajectory of our fundraising was presented. The income (£500k base) and expenditure budget for next year was agreed – this is relatively modest compared with historical levels of income generation, but it reflects a charity team with relatively new and inexperienced staff and limited major donor and corporate fundraising capacity. The Meadows Cancer appeal

	should provide a helpful high-profile and attractive campaign to stimulate significant donations within this target. The ambition outlined was to generate over £1m in income within the next 5 years – the committee agreed that we should keep this under review to identify how a more ambitious target could be achieved. Charitable Funds Rationalisation Project: Significant progress has been made in advancing this following the Divisional Directors' workshop on 4 February. The new Divisional Charitable Funds Advisory Panel structure, including membership and remit, has now been agreed across all three divisions, providing a consistent and strengthened governance model for charitable expenditure. To support implementation, a suite of core governance documents has been developed, including Terms of Reference, governance guidance, FAQs, an induction pack, and a communications plan for key stakeholders. These materials ensure clarity of roles, delegated authority, and standardised processes, aligning with the overarching aim of improving efficiency, reducing administrative burden, and enabling more strategic use of charitable funds. Introduction of dedicated short-term appeal funds to ensure accurate coding and appropriate treatment of conditional and non-conditional income: The Committee were assured that the circumstances that led to the shortfall identified at the previous meeting were specific to an historic appeal and that robust controls are now in place to safeguard conditional donations and ensure the consistent management of future appeals.
BOARD ASSURANCE FRAMEWORK & RISKS	As summarised above.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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

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

Report Title	**Resident Doctor Peer Lead Board Report**				
Meeting	**Board of Directors**				
Date	**12/03/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Dr Kathryn Bateman, Chief Medical Officer				
Report Author	Dr Eleanor Tindall & Dr Lynsey Hewitson – Chief Registrars				
Appendices					

Purpose

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

Assurance Level

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

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

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

Operational pressures are impacting on the trust's ability to provide consistent opportunities for high quality training to resident doctors. Trends in national training surveys remain of concern, including workload and clinical supervision. Progress has been made against the national 10-point plan for resident doctors, but there remain areas of required improvement.

Report

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

Ongoing operational pressures are exacerbating an already high workload – as reported in national training surveys and on local benchmarking within the ICB – among the resident doctor workforce. This represents as ongoing risk to the training experience and wellbeing of resident doctors at GWH, patient safety and future workforce retention. However, the Trust has engaged senior and educational leadership – with successes highlighted in this report – and has the potential to be an excellent training organisation across all specialities if these pressures can be addressed.

Key Requests for the Board

- Support for work to address the reasons for persistent issues flagged around high workload and supervision of resident doctors.
- Develop a clear educational strategy for locally employed doctors, in keeping with national trends. There is the opportunity to be a regional leader in this emerging national issue and to attract these resident doctors as senior clinicians of the future.
- Develop a robust assurance framework for monitoring finalised work schedule issuing and payroll errors. This would include resolving the issue of multiple payslip assignment numbers for resident doctors with dual/secondment posts.

Positive Achievements

- GWH has an active trust-wide resident doctor forum, which is well engaged with by both resident doctors and senior leaders in the trust. This model has propagated to individual departments, championed by postgraduate medical education.
- Engagement and execution of the 10-point plan is in line with other trusts in the Southwest region. Changes have been made in response to the recommendations in some areas, but GWH has started from a good baseline.

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

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

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	Risk register access pending	TBC
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Discussions with CMO, Medical Senior Staffing Group, RDF, Chief Registrars	
Next Steps		

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

Explanation of above analysis:

The trust employs a significant number of locally employed resident doctors, in addition to those in a national training program. National data suggests locally employed doctors are more likely to be international medical graduates. The report identifies a lack of unified educational strategy for these doctors and recommends the development of one.

Recommendation / Action Required

The Board/Committee/Group is requested to:

- For Board to approve this report for submission to Trust Board
- For Board to consider multiple payslip assignments to be addressed in the work on monitoring and rectifying payroll errors

Accountable Lead Signature	Approved by Dr Kathryn Bateman
Date	**22/01/2026**

INTRODUCTION

GWH employs more than 400 resident doctors, approximately 75% are in national training programmes and 25% are locally employed by the trust. The 10-point plan for resident doctors, published in August 2025, is a national initiative aimed at improved the working lives of resident doctors. The Resident Doctor Peer Lead (RDPL) role was established to ensure that resident doctors are meaningfully represented, that their concerns are heard, and that their insights inform organisational decision making. Following discussions with the CMO and the Resident Doctor Forum (RDF), the Chief Registrars have been appointed to the role until August 2026. This is the first of the planned quarterly reports to the Board. While some areas intersect with the 10-point plan, this report focuses specifically on workforce experience, training and operational concerns.

OPERATIONAL PRESSURES AND IMPACT ON TRAINING

The Trust continues to operate under significant and prolonged operational pressure, evidenced by high bed occupancy levels consistently around 99%, long Emergency Department wait times, routine use of Treatment Escalation Spaces, and prolonged waits in ambulatory chair areas for patients requiring admission (GWH Risk 1). High numbers of patients awaiting onward care further compound these pressures.

These conditions are being felt across all staff groups, including resident doctors, particularly from the perspective of workload and training capacity. Cancellation of routine activity to support operational pressures – for example, theatre lists and outpatient activity – also has an impact on trainees' ability to gain sufficient experience to meet required competencies for training programmes. This has also been exemplified in the recent implementation of W45 in the Emergency Department, where trainees have made a formal deanery complaint regarding the impact of operational pressures on their training.

Two national surveys provide insight into resident doctor experience: the GMC National Training Survey and the National Education and Training Survey (NETs). In the most recent GMC survey, the Trust was identified as a negative outlier across several domains, particularly workload, clinical supervision, rota design and local teaching: in some areas ranking in the lowest 5% nationally. Lower consultant to trainee ratios and a higher proportion of less than full time (LTFT) trainees (as referenced in previous board reports) likely contribute to these results. Benchmarking against RUH and SFT, GWH also has a higher number of daily attendances per resident doctor and potentially up to a 50% higher workload on this basis. Safety concerns have recently been raised via the Resident Doctor Forum regarding the levels of medical staffing at the weekend to cover acute admissions. This likely reflects sustained increase in demand over time. Improvement work to understand this fully is underway.

Medical patients continue to outlie on surgical wards. Saturn and half of Woodpecker remain predominantly staffed by locum general medical consultants, without the support of a specialty department. Resident doctors have consistently raised concerns about training quality and protracted inpatient stays on these wards. For example, patients have remained in hospital for

radiological investigations, that could otherwise be managed as an outpatient, due to concerns about reliability of follow up for key results (including CT scans for possible cancer) if discharged.

Operational pressure not only pose significant patient risks, but also risk worsening training quality and satisfaction among resident doctors. Workload and clinical supervision are already flagged as outliers in national training survey results. This situation is only likely to deteriorate in future results, unless measures to address operational and senior medical workforce capacity are enacted, as already highlighted in previous reports. Ultimately, the risks of not addressing this include patient safety concerns and reputational damage to the trust, including future recruitment of these resident doctors as senior clinicians. In the more immediate future, sustained poor performance in these survey reports risks enhanced monitoring and approval conditions on training programmes by the regulator.

WORKFORCE AND ROTA ISSUES

Work Schedule Issuing and Rota Compliance

- Resident doctor contracts stipulate issuing of work schedules 8 weeks in advance (6 weeks for LTFT). While compliance with these timelines may be achieved for initial schedule issuing, the current monitoring process does not capture disputes or rota inaccuracies that are not resolved within this timeframe. Multiple rotation start dates throughout the year create a near continuous cycle of monitoring and adjustment. The 10-point plan requires the trust to report compliance to NHS England and therefore a robust process for measuring performance of issuing finalised work schedules is required.
- In response to concerns raised through the RDF, there is now a formal escalation pathway for delays in issuing or missing work schedules, which has been positively received.

Payroll Errors and Governance Requirements

- The 10-point plan also required the establishment of a governance framework for reporting payroll errors. Inaccuracies in resident doctor pay often result from errors in work schedules, reinforcing the need for a high-quality rostering process.
- Clinicians with roles spanning multiple departments – for example, resident doctors with a clinical role and a secondment in Postgraduate Medical Education – are usually issued multiple payroll assignments and payslips. This can have adverse implications for personal finances, such as incorrect PAYE tax implications and reduced mortgage eligibility. There is evidence that clinicians may decline secondment or development opportunities because of these financial risks. A manual cross charging solution exists that enables a single payslip to be issued, however this is not standard practice.

Annual Leave Processes

- Annual leave approval processes vary significant between departments, creating frustration for rotating resident doctors. This is particularly evident over Christmas, where differing approaches to leave allocation are a recurrent source of dissatisfaction.

The Trust's leave policy is currently being updated to include a dedicated section on resident doctor leave, which will hopefully help standardise practice and reduce inequity.

TRAINING, EDUCATION AND WELLBEING

Teaching Programmes, Access to Education and Infrastructure

- The Trust delivers a range of teaching programmes for resident doctors, including grade specific sessions and departmental teaching. Many training programmes require a minimum attendance level for progression, meaning that missed sessions potentially affect training advancement as well as professional development.
- Work schedules are currently being updated to reflect the full range of educational opportunities available within each specialty. This is intended to support accurate exception reporting when educational opportunities are missed and facilitate reinstatement where feasible. Senior leaders have strongly endorsed this approach through the RDF.
- The limited availability of teaching space remains a barrier to high quality training. The academy is frequently block-booked more than a year in advance, with recent requests for a regional teaching day in 2027 already declined. Offsite venues are often impractical for both resident doctors and educators with clinical commitments, resulting in lost educational opportunities. Similar barriers to achieving adequate training exist due to the lack of outpatient clinic room space, particularly in outpatient predominant specialities. Infrastructure development plans and additional outpatient space are required.

Locally Employed Doctors (LEDs)

- Though LEDs constitute a substantial proportion of the resident doctor workforce, there is no trust-wide unified strategy for their supervision of education. Trainees with a national training number, attract an educational tariff from the deanery to fund their training and education, including educational supervision which should be job planned for consultants. LEDs do not currently have any external educational funding. LEDs report consideration variation in supervision and access to training. Many do not receive the same educational opportunities as their trainee counterparts and may lack named clinical and educational supervisors.
- While funding constraints and consultant to trainee ratios limit capacity, the national direction of travel – noted in Phase 1 of the Medical Training Review – suggests increasing reliance on local training and consultant certification via portfolio pathways.
- This presents a strategic opportunity for the Trust to develop structured local training pathways and position itself as a regional leader in this area. Recent work by a London NHS Trust, reported by the Royal College of Physicians, demonstrates that alternative local pathways are feasible, offering a potential model for GWH.
- GWH already has enthusiastic and highly experienced educators, who are already trying to support some of these doctors, but this remains driven by goodwill rather than a defined educational strategy. Investment in this area could support long term workforce retention and development of the "consultants of the future" for the Trust.

Resident Doctor Forum (RDF)

- The monthly trust-wide RDF continues to be well-attended, supported by senior leaders and viewed positively by resident doctors. It provides a safe and effective mechanism for raising concerns, tracking progress and collaborative problem solving.
- Several departments also run speciality specific RDFs. Some of these have been established recently, in response to training concerns and triggered deanery visits, including in acute medicine and paediatrics. Alongside strong senior engagement, the RDFs have helped drive improvements within these areas.

Wellbeing

- The GMC survey also reports areas of strong performance. Core Surgical Training and Otolaryngology were identified as green outliers (top 5%) in several domains.
- NETs results place the Trust in the lower quartile for feedback on bullying, discrimination, sexual safety and wellbeing, though not as a significant outlier. The Trust has begun addressing these issues, including the rollout of active bystander training.
- Rest facilities remain an area of inequity. Some specialities have access to dedicated quiet rest spaces overnight, while others do not. Despite discussions with the space utilisation group, there has been no progress towards equitable access. Contractual obligations for rest facilities are met with the doctors' mess and departmental staff rooms: however, these spaces are not conducive to undisturbed rest. Improving the access to overnight rest facilities presents the opportunity to make a positive difference to the wellbeing of resident doctors as well as patient safety.
- "Too tired to drive" provisions continue to be a significant concern. While Downsview House is the default option, availability is often limited. Alternative accommodation is often difficult to secure at short notice and frequently leads to resident doctors driving home even when they may feel too tired to do so. In a recent RDF survey, 10 of 12 respondents were unable to book a room at Downsview: only 2 of these managed to book a local hotel and 8 gave up and drove home tired. The Trust's geographical position at the edge of the deanery exacerbates this issue due to long travel distances for many trainees. Work is underway to secure pre-booked rooms at Downsview, which would be welcomed by the resident doctor body. Looking ahead, resident doctors strongly support prioritising adequate rest and recovery facilities within plans for new accommodation development.

Report Title	**Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance**				
Meeting	**Trust Board**				
Date	**12/03/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Benny Goodman, Chief Operating Officer				
Report Author	Rob Presland, Deputy COO Phil Ralls, Head of EPRR				
Appendices	EPRR Assurance Report & ICB Assurance Letter				

Purpose

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

Assurance Level

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

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

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

60/62 standards are fully complaint and we have been rated as Substantially Compliant overall.

Report

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

The purpose of this report is to provide the Board with assurance on Trust compliance with the EPRR core standards following completion of the annual assurance process.

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England.

Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.
Providers and commissioners of NHS-funded services complete an assurance self-assessment based on the EPRR core standards. This assurance process is led nationally and regionally by NHS England and locally by Integrated Care Boards (ICBs).

The NHS core standards for EPRR cover 10 domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

The assurance letter attached includes a summary of the Trust's activity to comply with the standards in 2025 and the priority areas for improvement in 2026/27.

Two areas of partial compliance are in business continuity analysis and business continuity planning. The work programme for 2026/27 includes plans to make this fully compliant in the next annual assessment (due in September 2026).

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

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

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	Risk 1269 We have seen multiple estates and IT issues and do not have good oversight of what impacts may be and what risks we are carrying due to non-compliance against BIAs	12
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Reviewed at PPPC	
Next Steps		

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

Recommendation / Action Required	
The Board/Committee/Group is requested to:	
The implementation of the assurance plan will be monitored through the EPRR Steering Group. The Board is requested to note the substantial compliance for EPRR standards in 2025.	
Accountable Lead Signature	Benny Goodman, Chief Operating Officer
Date	**05/03/2026**

28 November 2025

Via Email

Dear Benny

Great Western Hospital NHS Foundation Trust - EPRR Core Standard Assurance Summary 2024

Many thanks for preparing the self-assessment, supporting evidence and your engagement at the EPRR assurance review meeting held on 26th September. This letter summarises the outcomes from the meeting, capturing agreed actions and points from our discussions.

The Core Standards have been reviewed and in addition to the Core standards self-assessment, you provided a comprehensive report detailing the achieved EPRR portfolio in the last year and at the assurance review meeting Phil provided a detailed update reflecting on the year and the look forward.

It was agreed that two core standards remain partially compliant following learning from the major incident declaration in 2024 following a full power outage at GWH, work is progressing and the initial phase of revision of implementation of BIAs continues, and plans may meet minimum standards however the continued work with the BIAs will ensure robust plans are in place.

Core Standard	Standard	Organisational Comment	Timescale
CS 46	Business Continuity Impact Assessment	A Business Continuity Working Group has been established to take this work forward.	End Q2 2026/27
CS47	Business Continuity Plans	Further develop BCPs following gaps highlighted by BIAS	End Q2 2026/27

Compliance level

Organisation	2021	2022	2023	2024	2025
GWH	Substantial	Substantial	Full	Substantial	Substantial

GWH have assessed themselves substantially compliant with detailed narrative to support their submission.

HeadlinesThere have been organisational changes from November 2024 with Benny Goodman commencing in role as Chief Operating Officer and Accountable Emergency Officer. Sarah Orr left the post of Head of EPRR in August to undertake a new role with the medicine division and Phil Ralls has taken the role of interim Head of EPRR from July from his role as EPRR Manager.

During 2025 there has been continued development to embed Business Continuity Impact Assessment (BIAs) within all divisions, this work has been slower than planned but now has traction with support of the COO and DCOO, with key milestones in place.

The EPRR team supported significant projects across the trust, most significantly the Integrated Front Door (IFD) project providing oversight and structure for go live and exercising the adoption of a newly revised mass casualty internal distribution plan. GWH have had several business continuity incidents and critical incident responses relating to operational and estates issues and most recently the GWH pathology LIMs incident which is now in recovery.

Significant examples of collaborative working have been demonstrated including at RIAT, LHRP Risk Working Group, Swindon Borough Council Channel Panel, Wiltshire Mortuary plan, Dorset and Wiltshire Fire evacuation exercise within theatres and Swindon Borough Council for shelter and evacuation planning.

Looking forward to 2026 there are plans to:

- Fully adopt the new business impact analysis process across the organisation with the aim to introduce electronic system to provide better oversight and collaborative incident planning.
- Deliver against the training needs analysis so that staff at all levels of response have had training in incident response.
- Introduce exercise planning tool for divisions to support themselves with ensuring their business continuity and incident response for reporting back to the EPRR Steering group.

The outcomes of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHS England South West. The ICB will be required to present a system summary of the assurance process to the LHRP. NHS England will produce and submit a regional report to the NHS England National Team by end of December 2025.

Finally, thank you to you and the EPRR team for your hard work over the last year, while managing other concurrent issues and incidents.

Yours sincerely

Rachael Backler
Chief Delivery Officer
NHS Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board