NHS
Great Western Hospitals
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust Annual Report and Accounts 2025/26

Great Western Hospitals NHS Foundation Trust

Annual Report and Accounts 2025/26

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

CONTENTS

1 STATEMENT FROM OUR CHAIR AND CHIEF EXECUTIVE

Welcome to our Annual Report and Accounts for 2025/26.

We have experienced another challenging year at the Trust with significant operational pressures being managed in the context of a difficult financial environment.

This winter has seen prolonged periods of very high demand in our urgent and emergency services, and difficulty discharging patients for onward care in a timely way.

Our services have been disrupted by industrial action, and we continue to hope for a resolution in the dispute between Resident Doctors and the Government as quickly as possible.

Unfortunately, patients are waiting longer for treatment than we would like, and reducing our waiting list continues to be a real focus in 2026/27.

The NHS is operating in challenging financial circumstances and this year we delivered more than £25m in efficiency savings, although this was less than our £32.4m target. We have worked hard to strengthen our financial controls and in 2026/27 we will look for larger-scale transformation in outpatients, theatres, and urgent and emergency care to enable us to deliver even bigger efficiencies.

Despite the challenges, our staff continue to work around-the-clock to deliver high quality care to patients, and have achieved a huge amount this year.

These achievements include:

- Opening our new Pharmacy Aseptic Unit
- Opening a new Endoscopy Unit at the Community Diagnostics Centre in West Swindon
- Expanding our Neonatal Transitional Care Unit
- Seeing improvements in our annual adult inpatient survey results
- Launching our ‘Putting the hospital to bed at night’ project, which has seen improvements in how rested patients report feeling at night-time
- Relaunching our staff abuse and violence prevention campaign, Never OK
- Developing a new Green Plan to support our sustainability goals.

We continue to focus on improving the care we provide to our patients, and use our continuous improvement methodology and way of working – Improving Together – to do this in a structured and consistent way.

This year the Care Quality Commission has published two reports of inspections it carried out at GWH.
Surgery services were rated as Good, with the inspection team praising staff for treating patients with kindness, compassion and empathy, and respecting patients’ privacy and dignity.

Our Urgent and Emergency Care services were rated as Requires Improvement. Staff were found to effectively assess patients’ individual health, care, wellbeing and communication needs and they were seen to make sure patients only need to tell their story once by sharing information effectively between services. Areas for improvement related to access to timely care and treatment, and staffing challenges.

The CQC also inspected Maternity in January 2026 – at the time of writing we are awaiting the final report by the CQC.

Our Quality Accounts provide more detail on our aspirations for 2026/27 and we will focus on:

Patient safety – Safe use of Oxygen: This is a key quality priority because oxygen is a medicine, and like any medicine, it must be given in the right amount. By improving how we prescribe, monitor, and deliver oxygen, we can keep our patients safer and ensure they receive the right care at the right time.
Patient experience – To improve the patient experience of the hospital discharge process: We will work to improve the overall experience of patients being discharged, with a focus on clear communication.
Clinical effectiveness – To reduce patient harm through reduction of postpartum haemorrhage: We will focus on improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing review and learning to reduce maternal morbidity and mortality.

Our staff are our biggest asset and we use their views to help try to improve their experience, and that of our patients. This year 66 per cent of GWH staff, over 3,638 individuals, took the time to complete the annual NHS Staff Survey. Our response rate to the survey was one of the highest in the country, giving us really valuable feedback on what our staff think about working for us.

Improvements were seen in morale, recognition, teamwork and flexible working, with several areas where we need to focus more identified. Staff feedback will be instrumental in shaping our improvement work over the next 12 months, supported by the Improving Together methodology and way of working.

We are part of BSW Hospitals Group, alongside the Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust, and have worked hard to strengthen our collaboration as three care organisations to deliver care that is centred around patients.

As a Group we are working to deliver our shared Electronic Patient Record, as we work towards the go live of our new system, which will improve both patient care and staff experience.

This year we have made significant steps forward with our governance arrangements, including the appointment of our Group Leadership Team, establishing a Joint Committee, and appointing a Group Chair.

Paul von der Heyde began as Group Chair on 1 April 2026, bringing with him a wealth of experience gained over 40 years of working at Board level in both the commercial sector and NHS.

Paul will oversee a combined budget of £1.6 billion and workforce of over 17,600 colleagues, providing care to over one million people across Bath and North East Somerset, Wiltshire, Swindon and beyond

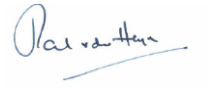
At the end of the year, Liam Coleman stood down as Chair, having made a significant contribution to our journey as an organisation and as a Group over many years.

Lisa Thomas was appointed as Managing Director of GWH, and took up the role in September 2025, at the same time as her counterparts at the RUH and SFT.

As a Board we continue to work to develop both individually and collectively and our thanks go to those Non-Executive Directors and associate Non-Executive Directors whose terms came to an end in 2025/26.

On behalf of the whole Board, we would like to say thank you to all of our staff and volunteers for their hard work, commitment, and dedication to delivering great care to the people of Swindon and Wiltshire.

You can read more about our achievements in our 'What makes us Great' book, which is available on our website, www.gwh.nhs.uk



Paul von der Heyde
Chair
Date : 25 June 2026

Cara Charles-Barks
Chief Executive Officer
Date : 25 June 2026

2 PERFORMANCE REPORT

OVERVIEW

Background and Principal Activities

Great Western Hospitals NHS Foundation Trust is a public benefit corporation authorised as an NHS Foundation Trust under the National Health Service Act 2006 on 1 December 2008. On becoming a Foundation Trust, the name of the organisation was changed from Swindon and Marlborough NHS Trust to the name we have now.

The Trust provides NHS-funded acute hospital services to the population of Swindon and the surrounding areas, delivering a wide range of emergency, elective and specialist care from Great Western Hospital.

In May 2025, Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust formed BSW Hospitals Group. To clarify BSW Hospitals Group is an operational collaboration only and does not constitute an accounting group. Each Trust remains a separate statutory body reporting independently. This Group formation brings together three NHS providers with a shared ambition to make a difference that really matters to colleagues, patients and their families, partners and wider communities across BSW and beyond.

With a combined workforce of over 17,600 colleagues, and budget of £1.6 billion the Group is united by a common purpose to deliver the best possible care to over 1 million people. Creating a heath and care system that works with them not around them. Reducing the differences people currently face in access, experience and outcomes, improving the experience of our colleagues and tackling shared challenges like sustainability and finances.

The five strategic initiatives, which are linked to the ICB initiatives over the next 5 years, the Group will focus on are:

- Transforming our models of care.
- Our people.
- Increasing sustainability.
- Delivering digital maturity.
- Developing our group.

The five priority programmes we will focus on to deliver our strategic initiatives over the next three years are:

- Transforming models of care: **Clinical services transformation** – focusing on patients and improving how healthcare services are delivered.
- Our people: **Corporate services transformation** – redesigning services around the needs of those who use them. Organisational Development and management of change programme.
- Increasing sustainability: **Recovery** – improving our performance and finances.
- Delivering digital maturity**: Implementing a single Electronic Patient Record** – bringing real time information together in one place to provide better, safer joined-up care for everyone.
- Developing our Group: getting **the right structure in place** to support us to work together effectively to truly serve our population.

This will help us to tackle the root causes of why our community doesn't always get the same quality of care or experience and means as a Group we can:

- Deliver care that is centred around patients, not organisations.
- Make sure our people and resources are focused where they can make the greatest difference.
- Create a solid foundation for the future where we can make the most of the opportunities available and be a strong voice for our community.

Operating Context

During 2025/26, the Trust operated in a sustained period of operational pressure. Demand across urgent and emergency care, elective services and diagnostics remained high throughout the year, while workforce availability and patient flow constraints continued to affect capacity.

The Trust's performance during the year reflects the pressures inherent in delivering a full range of acute services within a constrained workforce and estate, and the increasing reliance on system collaboration to maintain capacity and patient flow.

The principal risks affecting performance during the year were sustained demand, workforce availability and constraints on patient flow. Against this backdrop, the Trust prioritised maintaining patient safety, stabilising core services, strengthening operational grip and governance, and laying foundations for improvement.

Summary of performance in 2025/26

Overall Assessment

Performance during 2025/26 was mixed. The Trust did not consistently meet all national access standards; however, it maintained a strong focus on safety, strengthened governance arrangements and delivered incremental improvements in a number of areas. Overall, the year is best characterised as one of stabilisation rather than recovery.

Performance Against National Standards

The Trust did not consistently achieve the national four-hour A&E standard, the Referral to Treatment (RTT) standard or all national cancer waiting time standards during the year. Performance was affected by sustained high demand, challenges with patient flow and workforce capacity constraints. Targeted actions were taken during the year to improve performance, including strengthened senior clinical oversight, enhanced escalation processes and closer working with system partners. These actions delivered improvement in some pathways, although challenges remained at year end.

Quality, Safety and Patient Experience

Patient safety remained the Trust's overriding priority throughout 2025/26. Established arrangements for reporting, investigating and learning from patient safety incidents were maintained, and the Board received regular assurance on quality, mortality and patient experience.

No matters were identified during the year that required qualification of the Trust's quality governance arrangements. Patient feedback highlighted positive experiences of care alongside areas where improvement was required, and this feedback informed quality improvement activity.

Workforce and Capacity

Workforce availability continued to be a significant factor influencing performance. Vacancies, sickness absence and retention challenges affected capacity in a number of clinical areas and contributed to operational pressures.

The Trust progressed recruitment and retention initiatives during the year and used feedback from the NHS Staff Survey to inform workforce priorities, with a continued focus on staff wellbeing, engagement and leadership visibility.

Use of Resources

The Trust maintained a focus on productivity and value for money while operating within a challenging financial environment. Oversight of efficiency, use of resources and financial performance was maintained throughout the year. Detailed information on financial performance and efficiency delivery is set out in the Financial Review.

Direction of Travel and Future Outlook

Throughout the year, performance reflected the Trust's strategic focus on maintaining patient safety, stabilising core services and strengthening delivery through collaboration. While national standards were not consistently met, the Trust improved its operational grip and governance and laid important foundations for improvement.

The year also marked the early stages of the Trust's transition towards closer group working arrangements. This reflects a strategic response to sustained operational, workforce and capacity challenges and is intended to strengthen resilience, support improved collaboration and enable more sustainable service delivery over time. The development of group working provides an important foundation for future improvement rather than an immediate solution to current performance pressures.

The Trust's priorities for 2026/27 build on this position and focus on improving urgent and emergency care flow, accelerating elective recovery, sustaining improvements in quality and safety, strengthening workforce capacity and deepening collaboration through system and group working.

Joint Venture

The Trust had no joint ventures in 2025/26 (2024/24 Wiltshire Health & Care LLP).

Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going-concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

PERFORMANCE ANALYSIS

The Trust monitors performance using a combination of national performance standards and its Improving Together framework (ref: https://www.gwh.nhs.uk/about-us/improving-together/). National standards provide externally mandated benchmarks and statutory accountability, while Improving Together focuses on locally agreed priorities that reflect the Trust's strategy, the needs of patients and staff, and areas where improvement will have the greatest impact. Together, these measures provide a comprehensive and balanced view of performance during 2025/26.

This section sets out the Trust's performance during the year across the key domains of quality and safety, operational delivery, workforce, and finance and use of resources. Providers are categorised into performance tiers based on delivery against key priorities, such as elective and cancer targets, with Tier 1 indicating those requiring the most intensive support and higher tiers reflecting improving performance and reduced oversight; where applicable during the year, this is highlighted in the sections below.

Achievements in 2025/25

- **Demonstrated strong leadership in sustainability and environmental impact**, launching a Trust-wide Green Plan, delivering carbon savings through initiatives such as Gloves Off and inhaler recycling, and joining the national Circular Economy Healthcare Alliance.
- **Delivered major improvements in patient care and experience**, including a UNICEF Gold UK Baby Friendly Award for maternity services, the opening of a neonatal transitional care unit, and measurable improvements in night-time patient sleep following the "Putting the Hospital to Bed at Night" initiative
- **Expanded and modernised urgent and emergency services**, marking one year of the new Emergency Department with over 125,000 patients treated, increased resuscitation and major care capacity, improved privacy, and dedicated facilities for children and patients in mental health crisis.
- **Achieved national and regional recognition for quality and improvement**, with Surgery rated 'Good' by the CQC, finalist status at the HSJ Awards, and staff-led improvement work recognised in both efficiency and patient safety categories.
- **Made significant progress in digital transformation and clinical efficiency**, this includes progress on developing a shared Electronic Patient Record across the BSW Hospitals Group, which is still under development at year end, and the opening of a new on-site Pharmacy Aseptic Unit to support faster, safer cancer and specialist treatments.
- **Invested in and celebrated our people**, with high staff engagement reflected in a achieving a response rate to the staff survey of 66% (3,638 colleagues), against a national response average of 49%, national recognition for flu vaccination delivery, inclusive workforce initiatives, and award-winning teams across clinical, facilities and support services.

Performance Against Strategic Objectives

During 2025/26, the Trust continued to deliver against the strategic objectives set out in the Trust Local Strategic Direction. These objectives provided the framework for Board oversight and decision-making throughout the year and informed the Trust's response to operational, workforce and financial challenges.

Performance against these objectives was monitored through a defined set of key performance indicators (KPIs), combining national standards and locally agreed Improving Together measures. The Board received regular reports on performance against strategic priorities, supported by detailed analysis through its committee structure and assurance framework. Performance information was considered alongside the Board Assurance Framework and corporate risk registers, enabling the Board to understand how deteriorations or improvements in KPIs signalled changing levels of risk and uncertainty.

This integrated approach ensured that risks relating to quality and safety, operational delivery, workforce capacity and financial sustainability were identified, assessed and managed in a timely way, with mitigations agreed where indicators showed increased pressure or emerging uncertainty. This section therefore sets out how the Trust

performed during the year across the key domains of quality and safety, operational delivery, workforce, and finance and use of resources, and how performance was used to support effective risk management and strategic oversight.

Quality and Safety Performance

Delivering safe, high-quality care remained the Trust's highest priority throughout 2025/26 and is central to the Trust's strategic objectives. The Board maintained strong oversight of quality and safety through regular review of national quality indicators and the Trust's Improving Together quality priorities, supported by the Quality & Safety Committee and the Trust's clinical governance framework.

National quality indicators provided assurance on core aspects of patient safety and clinical effectiveness, including mortality measures, infection prevention and control, and patient experience. These indicators were reviewed routinely by the Board via the Integrated Performance Report, alongside learning from incidents, complaints, claims and feedback.

In parallel, the Improving Together framework enabled a focused and structured approach to locally identified improvement priorities. These measures supported monitoring of progress in areas requiring targeted improvement activity and assessment of the impact of quality improvement initiatives over time. Performance against these measures is set out in Table 1.

Reducing Inpatient Falls
In 2025/26 the 'breakthrough objective' continued to be reducing falls and falls with the aim for 2025/26:

Falls Prevention

Aim for 2025/26:

Trust QI Improving together methodology commenced in April 2025 with the following aims

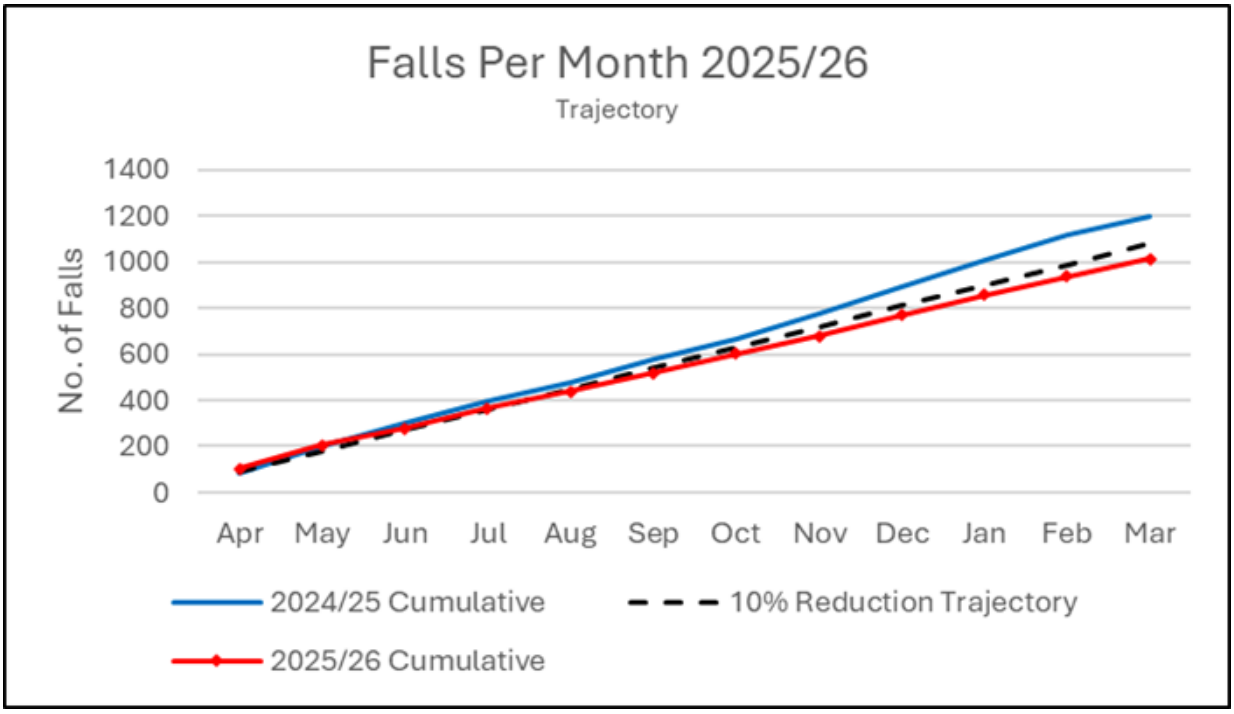
- Reduction in the number of reported inpatient falls by 10%
- Reduction in the number of inpatient falls resulting in moderate harm by 10%
- Reduction in the number of inpatient falls resulting in severe harm by 10%

As described below the results of this were positive with the organsiation achieving all metrics and notably overachieving in harm reduction.

- **Reduction in the number of reported inpatient falls by 10%**

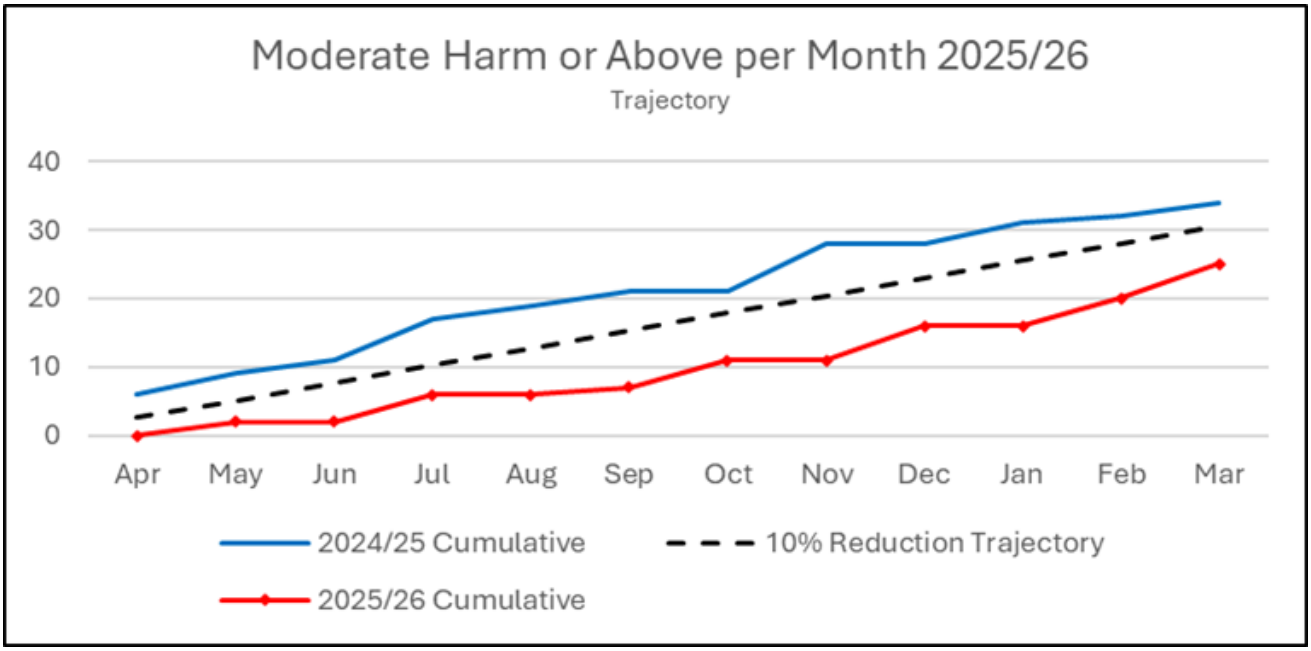
Following the implementation of the trust improving together methodology the organisation was able to reduce falls by 10% by month 3 and sustain this above target from month 5. This position continues to hold. 186 fewer inpatient falls were reported in 2025/26 compared with the previous year – a 18.4% reduction.

Based on NHS average costs per fall (2017 values: £2,600 per fall; £5,000 per moderate-harm fall), this reduction represents an estimated £483k economic benefit to the health system. When adjusted to 2026 prices (average £3,947 per fall and £7,950 per moderate-harm fall), this benefit increases to an estimated £734k.



- **Reduction in the number of inpatient falls resulting in moderate harm by 10%**

There has also been an overall reduction in moderate and above harms from falls, with a 26.5% reduction, showing improved patient safety.



To note a significant reduction in moderate harm falls helps reduce the overall harm metric, severe harm falls have been more challenging and although mainly on target they slightly breached the 10% reduction in month 9 and 12 and will remain an area of focus for the coming year.

Quality Accounts & Quality Priorities
In line with statutory requirements under the Health Act 2009 and the Health and Social Care Act 2012, the Trust produces a Quality Account annually. Each year several quality priorities are defined which are outlined in the quality accounts.

For 2025/26, alongside the quality improvement work outlined above (reducing inpatient falls), the Trust's quality priorities are as follows:-

Priority 1: Measuring and Improving Compliance with the Sepsis 6 Bundle
Outcome : Sepsis 6 bundle audit has been complete. A number of improvement actions were identified during the audit, many of which have already been delivered or are well underway.
Priority 2: "Putting the Hospital to Bed"
Outcome : Senior oversight and 'Go and See' visits completed June and November 2025 which has shown an improvement in data regarding in staff awareness of the principles of the project and the sleep monitor role Daily staffing meetings: discussing skill mix, highlight if there are concerns regarding senior cover and experience.
Priority 3: Supporting Patients to Self-administer their own Medications
Outcome: Standard Operating Procedure completed and is being worked into a new Trust policy Piloting has begun on several wards, a minimum of 60% of staff have received training before implementation on these wards Staff on Aldbourne ward have completed training.

Priorities for 2026/27 have been set as follows:-

1. Patient safety - Safe use of Oxygen
2. Patient experience - To improve patient experience of the hospital discharge process
3. Clinical effectiveness - To reduce patient harm through reduction of postpartum haemorrhage.

Further details can be found in the Quality Accounts for 2025/26 published on our website.

The accuracy and balance of the Quality Account are assured through internal review, stakeholder engagement and consultation. The Trust's Quality Accounts are available on the Trust's website: https://www.gwh.nhs.uk/media/ytzm0rx2/quality-account-2024-25-final.pdf

Further detail on quality governance and assurance is provided in the Quality Governance section of the report.

There were no formal public or stakeholder consultations during 2025/26.

Operational Performance

Operational performance during 2025/26 continued to be significantly affected by sustained demand across urgent and emergency care, elective services and diagnostics, reflecting pressures experienced across the wider NHS. Key contributory factors included:

- High bed occupancy
- Delayed discharges
- Workforce availability

Despite focused improvement activity, performance against some national operational standards remained below target during the year (table 1). These challenges were reviewed regularly at Board level, with recovery plans implemented and progress tracked through both national metrics and Improving Together measures. There has been sustained increase in the number of patients attending our Emergency Department throughout the Winter period (109.1% above 2025/26), and urgent and emergency care remains a priority area for 2026/27.

Due to the Trust experiencing sustained operational pressure aspects of Referral to Treatment (RTT) and cancer performance were managed under NHS England's Tier 2 escalation arrangements, which are applied where delivery of national standards is at risk and require enhanced oversight, additional reporting and targeted recovery actions. Tier 2 escalation enabled enhanced oversight, senior leadership focus and targeted support, including additional performance reviews, increased reporting frequency and focused improvement actions across demand management, waiting list validation and capacity expansion. While some improvement was demonstrated during the year—such as reductions in the longest waiters and stabilisation of certain cancer standards—overall performance remained constrained by system flow pressures and rising demand. Importantly, Tier 2 escalation provided a structured and transparent mechanism to manage risk, maintain patient safety oversight and ensure alignment with system partners while recovery actions continued. No further escalation beyond Tier 2 was required, and controls remained actively managed through established governance arrangements. The Trust moved out of tiering in Q2 2025/26 for elective, cancer and diagnostic services.

The Improving Together performance metric for 2025/26 was:-

(a) Non-elective average length of stay with the aim to achieve a non-elective length of stay below the 2024/25 baseline period for a minimum of six consecutive months; and
(b) To achieve and sustain a 0.5 reduction in length of stay compared to 12 months prior.

Overall, improvements were made in 2025/26 with length of stay reducing by 0.2 days over the 12 month period. Length of stay during the winter period of January to March was below the previous year for three consecutive months. The improvement to length of stay in January of 0.5 days compared to the previous year provided the equivalent of 32 additional beds for winter which helped to mitigate seasonal demand and respond to infection control pressures. The table below shows the progress over the past 12 months on non-elective stay showing that from January 2025 to June 2025 six months was achieved however a slight decrease within year in July 2025 and January 2026 broke this achievement.

Non-elective length of stay

Monthly Data

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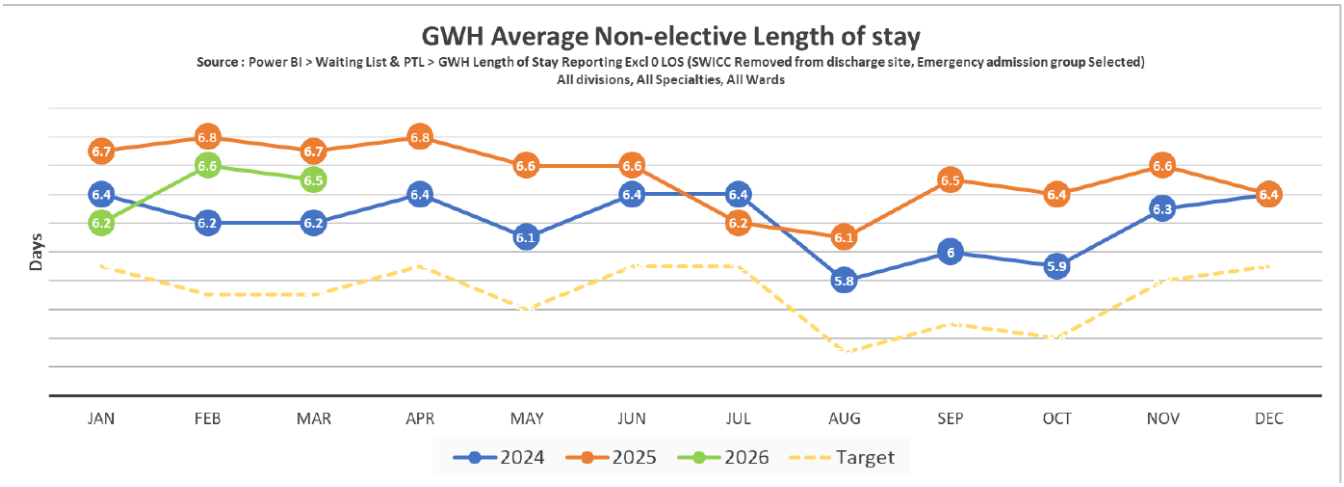
Breakthrough Objective	Aim for 2025/26: To achieve a non-elective length of stay below the 2024/25 baseline period for a minimum of six consecutive months.	March 2026



(c) Proportion of Outpatient first appointment pathways waiting less than 18 weeks with the aim to achieve and sustain the standard of 67% of RTT patients waiting less than 18 weeks for their first outpatient appointment

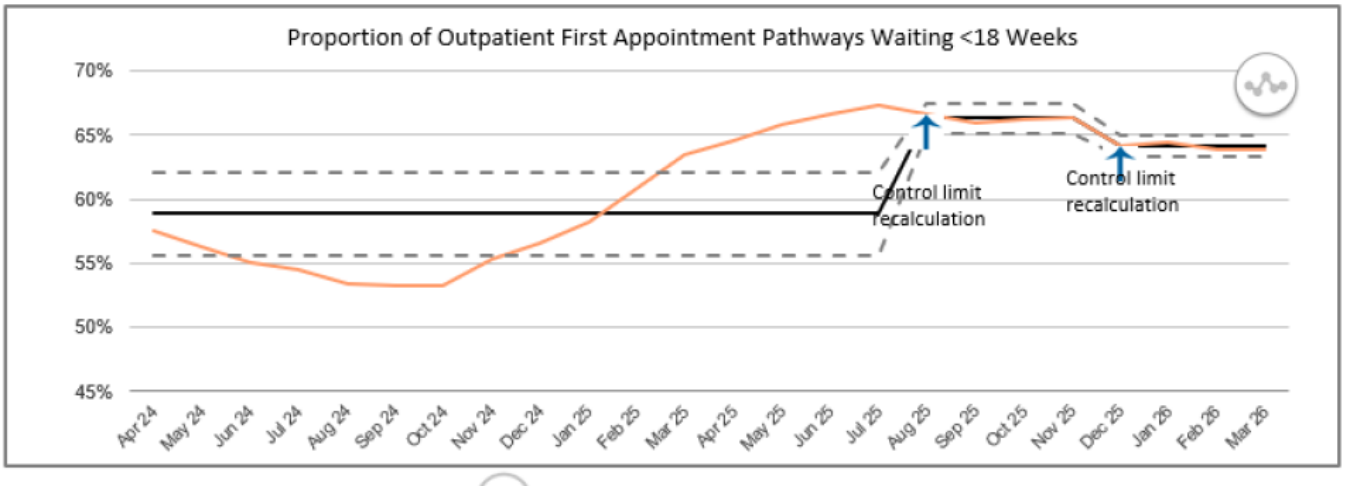
Overall, performance in 2025/26 remained fairly static. Performance for March 2026 remained at 64%, unchanged from the previous month. This continued plateau reflects a combination of operational pressures and lower-than-planned outpatient activity across the Trust. Overall new outpatient activity delivered 106% of the 2019/20 baseline, however this represented only 83% of last year's performance. The shortfall in new appointment delivery has constrained the Trust's ability to improve Time to First Appointment performance, as fewer patients were brought forward into first-seen slots than scheduled.

Despite these challenges, work to improve pathway flow and reduce waiting times has continued. The redesign of Paediatric outpatient pathways has now moved into implementation including the migration of C.1500 patients following triage.

From April 2026, referrals will now be routed directly into the correct service at the point of triage rather than through the single, generic Referral Assessment Service model. Early operational feedback indicates improved clinical allocation and reduced rebooking, which is expected to generate measurable improvements in Time to First Appointment compliance later in the year as the backlog in triage and reallocation is cleared. While these benefits will materialise over the coming months, the current performance position reflects the lag between structural change and measurable impact, coupled with constrained outpatient capacity in February and March 2026.

Improving Together – Breakthrough Objectives – Operational : Proportion of Outpatient first appointment pathways waiting less than 18 weeks

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



Elective Recovery (Referral to Treatment)

During the year, Referral to Treatment (RTT) performance was managed under NHS England's Tier 2 escalation arrangements, applied where delivery of the 18-week standard was at risk and requiring enhanced oversight, senior engagement and targeted recovery actions. However in Q2 2025/26 elective performance was moved out of tiering 2.

Performance against the Referral to Treatment (RTT) standard remained below the national requirements. While elective activity levels increased during the year, demand continued to outstrip available capacity, and long waiting times remained a challenge. The Trust focussed on:-

- Reducing the longest waits
- Improving waiting list validation
- Using additional capacity where available, including system and independent sector support.

Elective recovery remains a key operational priority for the Trust.

Cancer Performance

Cancer performance during 2025/26 was variable, and the Trust did not consistently achieve all national cancer waiting time standards. As a result Cancer services were subject to Tier 2 escalation during the year, reflecting ongoing risk to delivery of national cancer waiting time standards and enabling increased scrutiny, additional reporting and focused improvement support. The national 28 day faster diagnosis standard for cancer was met as at March 2026, although further improvement is required to deliver both the 31 day treatment standard and overall 62 day performance from the point of GP referral. In Q2 2025/26 cancer performance was moved out of tiering 2.

Performance was affected by diagnostic capacity constraints and workforce challenges in specific pathways. Improvement actions were implemented during the year, aligned with system cancer recovery plans.

Cancer performance continues to receive focused oversight at Board level.

The table below shows performance comparison to February 2026.

Cancer – Performance Comparison – February 2026

National Key Performance Indicators

28D FDS	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
GWH	86.2%	83.5%	80.4%	76.8%	79.2%	74.5%	65.6%	61.4%	63.9%	61.6%	71.6%	64.9%	80.4%
BSW	78.6%	76.1%	73.2%	70.2%	75.0%	74.0%	67.2%	60.9%	67.0%	68.0%	72.4%	66.0%	79.4%
SW	81.2%	79.7%	77.2%	75.0%	78.9%	78.3%	75.4%	73.5%	76.8%	76.9%	77.6%	69.9%	79.7%
National	80.2%	78.9%	76.7%	74.8%	76.8%	76.6%	74.6%	73.9%	76.1%	76.5%	77.4%	72.8%	80.5%
Target	77.0%	77.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

31D DTT	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
GWH	93.5%	94.8%	93.2%	90.3%	87.4%	92.9%	89.8%	83.6%	83.6%	89.4%	91.4%	85.5%	85.3%
BSW	92.2%	89.9%	90.3%	88.5%	90.8%	92.1%	91.1%	87.5%	90.6%	87.3%	89.7%	86.0%	86.6%
SW	93.9%	93.4%	92.9%	92.2%	92.8%	92.9%	91.5%	92.3%	93.4%	91.9%	93.4%	91.0%	93.2%
National	91.8%	91.4%	91.3%	91.0%	91.7%	92.4%	91.6%	91.2%	92.5%	91.7%	92.5%	89.8%	93.0%
Target	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%

62D	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
GWH	73.1%	82.1%	70.8%	69.7%	78.2%	69.3%	65.5%	65.8%	67.5%	65.6%	71.1%	61.6%	60.6%
BSW	67.1%	74.4%	66.7%	65.7%	72.2%	67.7%	62.0%	61.4%	64.4%	60.7%	69.3%	58.6%	60.8%
SW	69.7%	74.6%	70.2%	70.5%	70.9%	71.3%	70.3%	69.5%	69.7%	71.1%	73.7%	68.5%	68.2%
National	67.0%	71.4%	69.9%	67.8%	67.1%	69.2%	69.1%	67.9%	68.8%	70.2%	71.9%	68.4%	68.6%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Diagnostics & Outpatients

Demand for diagnostic and outpatient services remained high throughout the year.

The Trust continued to work to reduce diagnostic waiting times and at the end of the year delivered better than planned performance on access measures for patients. High volume modalities such as MRI, CT and Dexa scanning are consistently delivering above the NHS constitutional standard for 99% of waiting times being managed within 6 weeks, and good progress is being made in modalities such as non obstetric ultrasound and endoscopy with a new community diagnostic centre opened in Swindon this year.

In outpatients, improved outpatient productivity through service redesign, improved demand and capacity planning, and reductions in unnecessary follow-up appointments has taken place. Progress was made in some areas, although challenges remained at year end.

Improving Together enabled the Trust to maintain focus on specific operational improvements within its control, while continuing to work collaboratively with partners across the Bath, Swindon and Wiltshire system to address wider system constraints impacting performance.

Table 1 *: Performance against national operational standards.*

Measure	National Target[1]	Local Target 2025/2026[2]	Performance 2024/2025	Performance 2025/2026
Emergency Department 4 hours Q1	95%	78%	75%	68.7%
Emergency Department 4 hours Q2	95%	78%	77%	68.0%
Emergency Department 4 hours Q3	95%	78%	75%	71.3%
Emergency Department 4 hours Q4	95%	78%	72%	68.6%
Referral to Treatment Waiting List	-	35,215	38,190	42,670
Referral to Treatment 52 Weeks	-	347	950	788
Diagnostics Performance Q1	99%	99%	71%	84.3%
Diagnostics Performance Q2	99%	99%	80%	90.2%
Diagnostics Performance Q3	99%	99%	85%	90.1%
Diagnostics Performance Q4	99%	99%	91%	92.3%

Measure	National Target[1]	Local Target 2025/2026[2]	Performance 2024/2025	Performance 2025/2026
Cancer Performance (62 days) Q1	85%	75%	65.2%	78.2%
Cancer Performance (62 days) Q2	85%	75%	69.7%	65.8%
Cancer Performance (62 days) Q3	85%	75%	74.0%	65.6%
Cancer Performance (62 days) Q4	85%	75%	82.1%	60.6% [3]
Cancer Performance (31 days) Q1	96%	94%	91.3%	87.3%
Cancer Performance (31 days) Q2	96%	94%	89.8%	85.7%
Cancer Performance (31 days) Q3	96%	94%	92.5%	92.2%
Cancer Performance (31 days) Q4	96%	94%	94.8%	84.0% [3]
Cancer Performance (28 day) Q1	75%	80%	65.2%	79.2%
Cancer Performance (28 day) Q2	75%	80%	78.4%	61.4%
Cancer Performance (28 day) Q3	75%	80%	79.3%	71.6%
Cancer Performance (28 day) Q4	75%	80%	83.5%	80.4% [3]

[1] National targets refer to the NHS constitutional standards.
[2] Local targets refer to the annual operating plan requirements outlined by NHS England
[3] Latest Validated position for Q4 Cancer Metrics is February 2026

Workforce

The Trust's workforce remained central to the delivery of safe and effective care throughout 2025/26. The year continued to present workforce challenges, including recruitment and retention pressures in key roles and the impact of sustained operational demand on staff wellbeing.

The Board received regular reports on workforce performance and risks, supported by data from the NHS Staff Survey and other staff engagement activity. Results from the NHS Staff Survey informed workforce priorities and improvement actions for 2026/27. Further details of the workforce KPI performance can be found in the Staff Report.

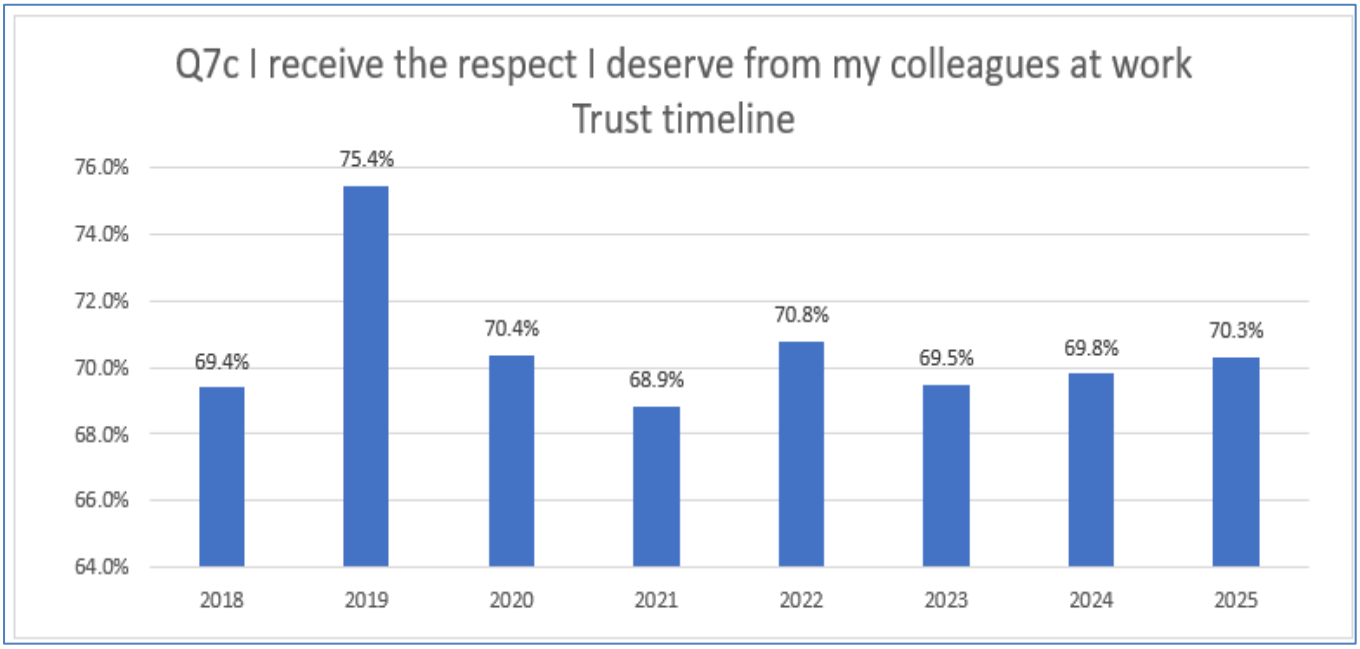
Improving Together provided a structured framework for tracking progress against locally agreed workforce priorities and for ensuring that improvement actions were aligned to the Trust's strategic objectives. In 2025/26 the 'breakthrough objective' was question Q25c from the staff survey: staff receive the respect they deserve from colleagues at work with the aim to achieve a score of 75%. The Improving Together people measures are set out in Tables 5. Overall performance demonstrated a continued improvement in the 2025 staff survey with a 0.5% year on year improvement, however, there remains a 4.7% gap to the target. In 2026/27 we will continue to focus on respect and other contributors to staff recommending the organisation. The Improving Together objective will change to the proportion of staff who agree that care is the organisation's top priority.

The Trust continued to invest in recruitment, retention and wellbeing initiatives, recognising the critical role of its workforce in delivering sustainable improvement.

The Trust also recognises its role as a major employer within the local area. Through its Improving Together priorities, the Trust continued to support local recruitment, skills development and workforce sustainability, contributing to wider place-based objectives while maintaining a clear focus on patient

In delivering quality and safety improvements, the Trust continued to consider variation in outcomes and experience across different population groups, using Improving Together priorities to support targeted improvement where inequalities were identified

Table 5 *: Improving Together –Breakthrough Objective Workforce :I receive the respect I deserve from colleagues*



Finance and Use of Resources

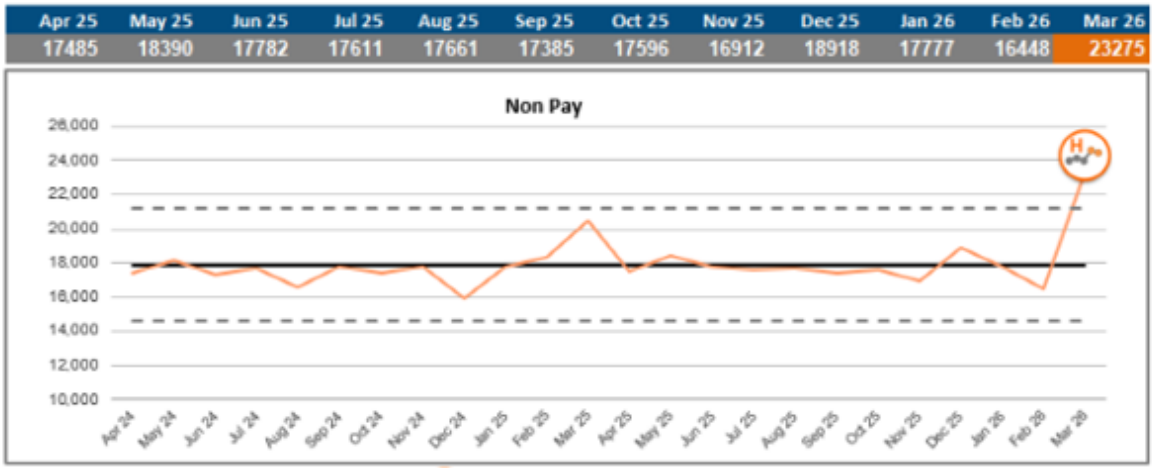
The Trust operated in a highly challenging financial environment during 2025/26. Cost pressures arising from workforce expenditure, inflation and sustained operational demand continued to impact financial performance.

The Board maintained close oversight of financial performance throughout the year, supported by robust financial governance arrangements and regular reporting. The Trust worked closely with system partners, including through emerging group arrangements, to support financial recovery and long-term sustainability.

While Improving Together includes locally agreed priorities related to efficiency and sustainability, financial performance is primarily reported through statutory financial measures. Progress against efficiency and recovery actions was monitored alongside wider Improving Together priorities to ensure alignment between financial sustainability and service quality.

In 2025/26 the ‘breakthrough objective’ was non-pay run rate stabilisation and reduction, with the aim to create a sustainable reduction below the average monthly expenditure of the previous year. The overall performance was that non-pay expenditure stabilised, reducing slightly over the 2025/26 period with a 12 month low being seen in November 2025 and February 2026. Overall, the actions have led to an increased focus on reducing expenditure in key areas of the organisation, including Orthopaedics, Theatres and Cardiology, with a recent focus on Pathology. The table below shows the run rate trend. March 2026 is out of the trend line as year end accruals are included.

Table 6 : *Improving Together –Breakthrough Objective Finance : Non-pay run rate stabilisation and reduction*



To Note : March is out of trend due to year end accruals

The Trust recognises its wider contribution to the local economy and communities it serves. During 2025/26, this was reflected in areas such as local procurement, estates management and sustainability initiatives, which supported both financial stewardship and wider system objectives.

In using resources effectively, the Trust considered population need and health inequalities, ensuring that improvement activity supported both financial sustainability and equitable access to care.

In using resources effectively during 2025/26, the Trust also continued to progress its commitments to environmental sustainability and the NHS Net Zero ambition. Activity during the year focused on reducing carbon emissions associated with estates and operations, alongside improving energy efficiency and sustainable use of resources. Progress against key sustainability and net zero metrics is set out in the section on sustainability – environmental matters.

A summary of financial performance is provided in the table below, with full detail set out in the Annual Accounts.

Financial Performance

	Trust 2025/26 £'m	**Trust 2024/25 £'m**
(Deficit) Reported in Statement of Comprehensive Income	**(28.2)**	**(13.8)**
Add back all I&E impairments / (reversals)	21.7	18.6
Remove capital donations / grants / IFRS16 PFI I&E impact	(7.4)	(3.5)
Surplus before impairments and transfers	**(13.9)**	**1.3**
Remove net impact of DHSC centrally procured inventories	0.0	0.1
Adjusted financial performance surplus	**(13.9)**	**1.4**

Long Term Financial Viability

The Trust planned for £33.7m non-recurrent transitional funding from BSW ICB in the make-up of its plan for 2025/26, as well as £9.6m deficit support funding from NHS England. The year end adjusted financial position of £13.9m deficit included £7.2m of deficit support funding and £33.7m of transitional funding.

Exiting 2025/26 on an underlying recurrent basis, the Trust has a £65.5m deficit. Key to reducing this through 2026/27 will be the recurrent delivery of transformation and improvement plans, focussing on maximising productivity. The 2026/27 plan is to breakeven on an adjusted basis. This includes a savings programme totalling £47.2m, which includes c£10.5m of recurrently undelivered savings from 2025/26. The current programme has so far identified 85% of this target (£40.4m), with the remaining £6.8m still to find associated plans.

A significant element of the Trust's underlying financial position is the structural deficit linked to the Trust's PFI contract (currently accounting for 4.7% of Trust income each year), which ends in October 2029. The Trust is planning to reach an underlying breakeven position by the end of 2028/29.

Overall Assessment of Performance - Risk Profile

During 2025/26, the Trust's risk profile was driven by sustained demand, workforce pressures, patient flow constraints and financial sustainability challenges, which affected delivery against some national standards. Risks were monitored through performance indicators alongside the Board Assurance Framework and corporate risk registers, enabling the Board to assess how changes in performance reflected changing levels of risk and uncertainty.

Over the year, some risks increased in likelihood and impact during periods of peak pressure, while others reduced as mitigating actions were implemented, including strengthened governance, escalation processes, system collaboration and financial controls. New and emerging risks, including those associated with group working arrangements, increased digital dependency and climate-related factors, were identified and incorporated into risk management processes. These risks may continue to affect delivery of the Trust's plans in future years; however, the Trust remains focused on improving resilience, maintaining patient safety and supporting sustainable performance improvement.

Other Financial Disclosures

External Audit Services
Deloitte received £262,000 in audit fees (excluding VAT) in relation to the statutory audit of the Trust and the accounts to 31 March 2026. For more details, see note 6.1 to the annual accounts.

Financial implications of any significant changes in Trust objectives and activities, including investment strategy or long-term investment
There have been no significant changes during 2025/26.

Events since 31 March 2026
Any important events since the end of the financial year affecting the Trust will be recorded as a post balance sheet event and noted in the accounts. There have been no relevant events to report in this financial year.

Details of overseas operations
None during 2025/26.

Number of Trust branches outside of the UK
The Trust does not have branches outside the UK.

Explanation of amounts included in the Annual Accounts
Explanations of amounts included in the annual accounts are provided in the supporting notes to the accounts.

Preparation of accounts
The Accounts for the period ended 31st March 2026 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form that NHS England (the Independent Regulator of NHS Foundation Trusts) with the approval of the Treasury, has directed.

Preparation of the annual report and accounts
The Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Sustainability – environment matters report

At Great Western Hospitals (GWH), sustainability is fundamental to delivering high-quality care for every patient and safeguarding our services for future generations. By embedding sustainable practices into everything we do, we strengthen and future-proof our ability to provide excellent care, even as the pressures of climate change and environmental challenges continue to grow.

A sustainable approach ensures that our services remain resilient, efficient, and responsive. It enables us to protect the health of our community today while building a system capable of meeting the needs of tomorrow.

In 2025, the Trust refreshed its Green Plan, setting out a renewed strategic vision for 2025–2028. This updated plan strengthens our commitment to sustainability and outlines the actions we will take to reduce our environmental impact, build resilience, and support a healthier future for our patients, staff, and community.

Importantly, the refreshed Green Plan also reinforces the governance and reporting processes that underpin our sustainability work. By strengthening oversight, improving transparency, and ensuring clear accountability, the plan helps the Trust track progress, demonstrate impact, and maintain momentum toward our long-term environmental goals.

The Green Plan covers nine areas of focus:

1. Estates and Facilities
2. Adaptation
3. Travel and Transport
4. Supply Chain and Procurement
5. Food, Catering and Nutrition
6. Medicines
7. Net Zero Clinical Transformation
8. Digital Transformation
9. Workforce, Networks and System Leadership.

Targets

GWH has a significant Carbon Footprint, this encompasses the main site but also community sites that the Trust operates out of. The Trust's Carbon Footprint has been measured for all scope 1 and 2 emissions and some specific scope 3 emissions (including business travel, waste, water and inhalers). The Trust is working towards measuring the Carbon Footprint plus which includes all scope 3 emissions. These scopes are defined as:

- Scope 1 - activities owned or controlled by an organisation that directly release emissions straight into the atmosphere.
- Scope 2 - emissions being released into the atmosphere associated with the consumption of purchased electricity, heat, steam and cooling.
- Scope 3 - emissions that are a consequence of operational actions, which occur at sources which an organisation does not own or control.

As part of the current Green Plan, the Trust has established carbon-reduction targets that are fully aligned with Greener NHS requirements:

- To measure our annual Carbon Footprint and set future interim targets for reduction.
- To be Net Zero Carbon by 2040 for our NHS Carbon Footprint, with an ambition to reach and 80% reduction by 2028- 2032.
- To be Net Zero Carbon by 2045 for out NHS Carbon Footprint Plus, with an ambition to reach an 80% by 2036 to 2039.

Progress for 2025/26

Below are highlights of progress made against our targets in the last financial year 2025/26 which has been spilt up by the nine areas of focus.

Estates and Facilities

- Implementation of a new compactor for dry mixed recycling which will reduce collections from 152 trips to 12 trips a year reducing the emissions from travel reducing carbon emissions by 92%.
- Offensive waste rolled out in West Swindon Health Centre.
- Bin labels have been added to all bins across the Hospital site to help improve waste segregation.

Adaptation

- The Trust has been working jointly within the BSW Hospitals Group to develop a Climate Change Risk Assessment and Adaptation Plan. This work will support GWH in strengthening its resilience to climate-related outcomes such as overheating and flooding across the estate, supply chain, medicines, patient care and workforce.

Travel and Transport

- The Bus User Group has met several times this year, strengthening collaboration between Swindon Borough Council and the bus operators serving the Town. This partnership is already delivering practical improvements for staff travel. After colleagues from North Swindon highlighted difficulties travelling to work on Sundays, a Sunday service for the number 12 route has now been introduced to support staff access to the site. Larger buses with bigger capacity have been put onto the 1/1A/1B route to accommodate as many seats as possible for staff as this is the main route into the Hospital. We have also applied for funding from the Council to upgrade our bus shelters and our real time information board. A decision on funding is expected mid-2026.
- The Trust has now replaced part of its internal combustion engine (ICE) fleet with electric vehicles, introducing 2 electric fleet cars and 5 electric fleet vans. Over the first two quarters of 2026, this shift has already delivered a carbon saving of 16 tonnes CO2e.
- Swindon Borough Council funded emergency cycle kits have been placed in the Commonhead cycle hub for staff; this gives confidence to staff when they chose to travel by bike.
- GWH hosted bike tagging and bike MOTs events to increase security on staff bikes and make sure bikes were road worthy and safe for the user.

Supply Chain and Procurement

- Re-usable tourniquets launched throughout the whole Hospital, once fully implemented it should save 96 tonnes of CO2e and saving £34,000 per year. This also improved patient care as re-usable tourniquets are less likely to pinch the patient's skin making the experience more comfortable.
- GWH has continued to collaborate with the Circular Economy Healthcare Alliance. The Alliance's focus is to reduce unnecessary use of items and switching to reusable items over single use items and ensuring end of life items are manufactured or recycled into something else.
- First social value and sustainability weightings collected to be reviewed by procurement.

Food, Catering and Nutrition

- Improvement on compliance for collecting patient food waste and making sure all three meals are put into the correct food stream and weights are recorded. This food is collected by Hills and is sent to a local anaerobic bio-digester that is converted into renewable energy to power homes.

Net Zero Clinical Transformation

- The Clinical Sustainability Group continues to meet bi-monthly, providing a forum to share learning, highlight best practice, and support the work emerging from both the wider sustainability groups and the clinically focused sustainability initiatives. This ongoing collaboration is helping to embed sustainable thinking across clinical pathways and everyday practice.
- Below is an overview of the main achievements from GWH's Sustainability Working Groups:

The Academy	• The department has been re-using and repacking catheters used during simulation training to reduce the number of catheters going into the clinical waste bin. • Updated recycling posters to help improve compliance. • Facilitated Sustainability Presentations with Clinical Teaching Fellows. • Implemented energy saving campaigns with the Academy Sustainability Champions auditing rooms to make sure computers and lights are switched off when not in use.
Critical Care	• Successful gloves off campaign with learning shared across the site. • The team have been working to switch patients from IV paracetamol to oral paracetamol. IV paracetamol needs more water to manufacture the product and when given to the patient it needs more equipment creating more wastage. • Improve segregation of waste streams and increased volumes of offensive waste compared to orange (alternative treatment) waste. • Reducing the amount of disposal cups through education with staff on bringing in their own bottles.
Endoscopy	• One of the first departments to trial the re-usable tourniquets and the first department to roll re-usable tourniquets and stopped ordering the disposal for both the main Hospital and West Swindon. • Ongoing projects to reduce syringes usage and to stop staff over preparing them when they end up in the bin. • Embedded sustainability in clinical governance days and a standing agenda item in the Endoscopy User Group. • Gloves off campaign ongoing. • Endoscopy have reviewed the glue they were ordering that didn't have a very long shelf life and was being binned regularly, they have switched supplier who can supply a glue that last a lot longer. • Removal of sheets used for gastro procedures saving 3 tonnes of carbon. • Trailed compostable aprons • Reduce single cup use by using 15,000 less cups in the last year.
Theatres	• Bins labelled within Theatres for improved segregation • Rub don't scrub initiative launched, this is estimated to save 9,792,000 litres of water per year this is equates to 3.92 Olympic swimming pools every year. • Nail picks introduced which means there is less waste from the scrubbing process. • Introduced pharmaceutical bio bins into Theatres to reduce empty pharmaceuticals being put into the sharp's bins. Bio bins are treated at a lower temperature than sharps and the waste stream is also cheaper compared to sharps.
Maternity	• Launch of re-usable theatre hats for staff and birthing partners for the two maternity theatres.

Medicines

- The Pharmacy team have been collecting all used inhalers from wards and putting them in one central bin for recycling collection. Once they have been sent to be recycled the inhalers gas is repurposed into refrigeration, plastic outing and metal cannister is crushed and recycled.

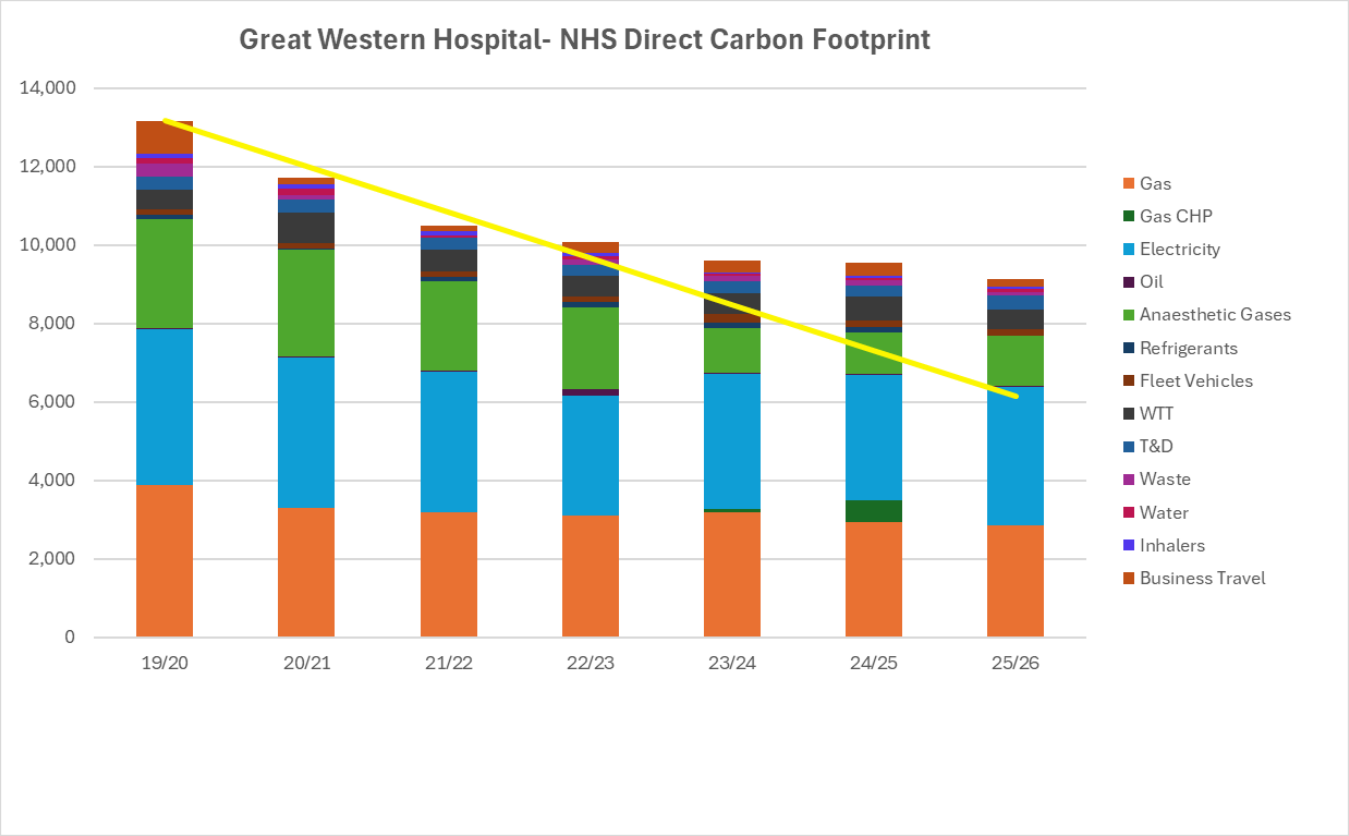
Digital Transformation

- Endoscopy and the Emergency Department have moved their leaflets over to digital QR codes.
- Endoscopy have launched digital care plans for the diagnostic unit in West Swindon Health Centre. This meant when the new unit opened the car plans did not need to be delivered and collected everyday by a van. This has avoided a minimum of 20 tonnes of CO2e.

Workforce, Networks and System Leadership

- Presentations held to doctors, student midwives and nurses.
- Increased the number of sustainability champions within GWH to 141.
- First year the Sustainability awards were included in the Staff Excellence Awards, the winners were the Endoscopy Sustainability Group.
- Green Week hosted with a variety of different activities.

GWH NHS Direct Carbon Footprint



Task Force on Climate-Related Finical Disclosures (TCFD)

NHS England has mandated that all NHS Trusts with more than 500 full time employees or a total operating income exceeding £500 million must comply with the Task Force on Climate-related Financial Disclosures (TCFD). These disclosures must be included within each Trust's annual sustainability report. The reporting requirements have been rolled out by HM Treasury through a phased approach over the past three years. The 2025/26 reporting year is the first year in which all phases of the TCFD requirements must be fully reported within the annual sustainability report.

Phase 1- Focus on governance, making disclosures on the board and management's role in overseeing climate risks.

Phase 2- Shifting focus to risk management, and metrics and targets with mainly large qualitative disclosures.

Phase 3- Full implementation with quantitative disclosures made as necessary.

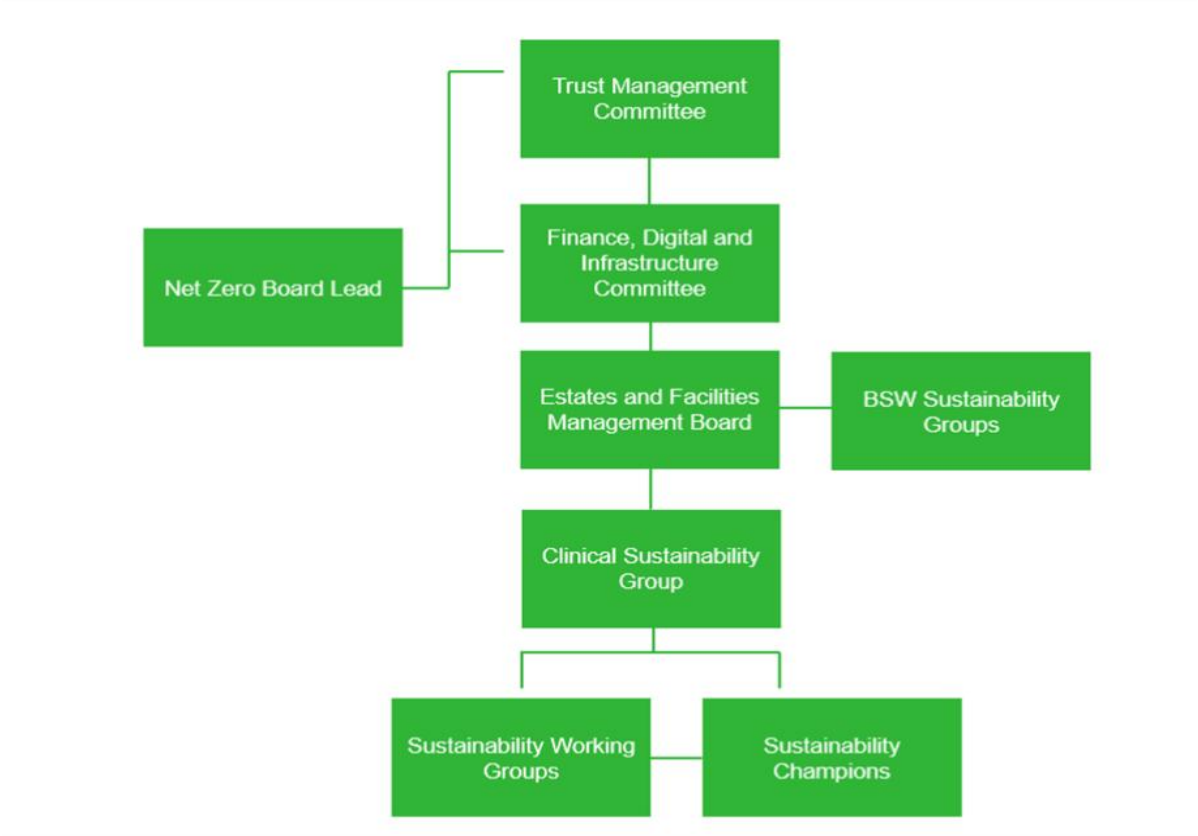
Local NHS bodies are not required to calculate or disclose their own scope 1, scope 2, or scope 3 greenhouse gas emissions for TCFD purposes. These emissions are calculated nationally by NHS England on behalf of all NHS organisations.

Governance

Within the Trust's Green Plan, there is a dedicated Adaptation section which outlines how we address and respond to climate-related risks. Progress against the Green Plan, along with any emerging climate issues, is formally reported through the Estates and Facilities Management (EFM) Board at its monthly meetings, ensuring consistent oversight and accountability. The Trust also has a designated Board-level Net Zero Lead, the Chief Financial Officer, who holds overall responsibility for the implementation of the Green Plan and the governance of all climate-related matters. This structure ensures that sustainability and climate resilience remain embedded within the Trust's strategic decision-making and corporate governance framework.

The Board considers climate-related issues as part of its review of organisational plans, ensuring that climate risks and resilience are factored into strategic decision-making, investment priorities and service sustainability. Progress against climate-related goals and targets is monitored through regular reporting on the Green Plan and sustainability metrics, with oversight provided through established governance and committee arrangements to support continuous improvement and assurance.

Below is governance structure at Great Western Hospitals for the Green Plan and climate-related risks:



Climate related issues are managed and assessed through the same channels as the Green Plan. The main updates are reported through the EFM board and cover areas below:

- The progress made on the climate adaptation plan
- New initiatives realised since the climate adaptation plan
- Issues impacted by climate related issues

We will be working further to develop a separate working group as a BSW Hospitals Group with the aim of embedding climate adaptation into multiple departments and further develop our progress on becoming more resilient to climate change.

Strategy

To comply with phase 3 of the TCFD requirements for 2025/26 GWH have created a strategy, which links very closely with our Climate Adaptation Plan and Risks Assessment created by Sustainability West Midlands. The Climate Adaptation Plan was created in collaboration between the three care organisations that make up the BSW Hospitals Group, Great Western Hospital, Sailsbury Hospital and Royal United Hospital as the group improve their collaboration to improve efficiency within the Sustainability teams.

For GWH it is essential that we as a Trust adapt to a changing climate, minimising impacts on public health and the healthcare system from more frequent and intense flooding, intense and prolonged heatwaves, longer periods of drought, and an increase in extreme events.

In line with NHS England's mandate for all NHS Trusts to comply with the Task Force on Climate-related Financial Disclosures (TCFD), this strategy sets out how the Group will strengthen climate resilience across its estate, operations, workforce, and communities. TCFD requires organisations to assess and disclose climate-related risks and opportunities across four pillars: Governance, Strategy, Risk Management, and Metrics & Targets. This adaptation strategy directly supports those requirements by providing a structured approach to identifying climate risks, planning for their impacts, and embedding resilience into decision-making.

The Group has already undertaken analysis to understand local climate risks, including climate projections, flood risk mapping, and vulnerability assessments. These exercises highlight that Swindon is likely to experience hotter, drier summers and warmer, wetter winters, alongside increased flooding and more frequent extreme weather events. These insights form the evidence base for this strategy and align with TCFD's expectation that organisations use robust climate data to inform long-term planning.

Short, Medium and Long-Term risks for GWH

As part of GWH's Climate Adaptation Risk Assessment, there has been work done to evaluate the short, medium and long-term risks to GWH with the impact.

Short Term Risks (2026 till 2030)

- Flooding risk to courtyards around the main building
- Flooding risk to the area around the Orbital offices
- Disruption to access for staff, patients and emergency vehicles due to flooding risk on Marlborough Road leading to A419 which is the only access road currently to the Hospital
- High temperatures affecting vulnerable patients and increased attendance to the Emergency Department
- Increased rainfall which can overwhelm drainage systems

Medium-Term Risk (2040- 2100) projections on a 2-degree warming scenario.

- GWH develops a low risk to flooding within the main Hospital building
- Orbital offices area becomes high risk of flooding
- Overheating in clinical and impatient areas
- Water scarcity affecting clinical operations
- Increased mould, damp and building degradation from wetter winters
- Severe surface water flooding at GWH and Orbital Offices

Long Term Risk (End of century 2100's) projections of a 4-degree warming scenario.

- Chronic overheating of buildings not designed for high temperatures
- Severe water shortages affecting sterilisation, cooling and general clinical activity
- Major disruption to supply chain
- Increase in vector-borne diseases
- Infrastructure damage from storms, flooding and heat.

Risk and Opportunities for Climate Related Issues

Risks
Some of the risks have been identified in the short, medium and long-term planning in the above section but there are still additional risks that haven't been covered, which are explained below:

1. Infrastructure Risk
    - Damage to infrastructure and drainage systems.
    - Overheating on buildings and equipment especially on IT server rooms which will cause IT failure.
    - Utility disruptions and power outage stopping critical equipment and operations working.
    - Increased wear and tear on buildings.

2. Clinical risk
    - Increased admission due to heat, flooding and storms. Heatwaves and storms drive higher emergency department demand, including heatstroke, dehydration and respiratory issues.
    - Spread of infectious diseases as higher temperatures and humidity increase risk of vector-borne diseases and hospital acquired infections.
    - Medication failure due to overheating of refrigerators or power cuts meaning the fridges won't work.
    - Reduce treatment capacity as flooded or overheated wards may become unusable, reducing bed space and delaying care.
    - Staff wellbeing and safety impacts as staff face increased workload, heat stressed and travel disruption.

3. Service Risk
    - Transport disruption for staff, patients and delivery as storms and floods can prevent access to site.
    - Supply chain disruption this can be affected by local and global climate related weather events which can delay medicines, food and equipment.
    - Catering and food safety risk as high temperatures and power cuts can spoil food.
    - Increased operational costs as more cooling, repairs and emergency responses drive up expenditure.

4. Finical risk
    - Buildings being damaged by storms meaning additional costs to repair and fix.
    - Medications, food and equipment needing be replaced, duplicating costs.
    - Rise in costs of supply chain items due to climate change impacts locally and globally.

Opportunities
There are many risks that come from climate related risks but with good collaboration and directed focus on the priority of climate related risks there are opportunities that Great Western Hospital can gain which are explained below:

- Improved infrastructure resilience**:** upgrading drainage, shading, ventilation and building design creates long-term operational savings and reduces service disruption.
- Enhanced emergency planning and preparedness**:** adaptation measures can be integrated into emergency planning, improving organisational readiness.
- Better public health outcomes**:** by addressing heat, air quality and flooding risks, the Trusts can reduce avoidable admissions and protect vulnerable populations.
- Stronger partnerships across the Integrated Care System (ICS) and region**:** this opens opportunities to collaborate with Councils, the Local Resilience Forum, and other NHS bodies.
- More efficient resource use**:** drought planning, water efficiency and cooling strategies can reduce operational costs.

Risk management

- The Trust has begun to identify and assess climate-related risks. The primary document guiding this work is the Climate Change Risk Assessment and Adaptation Plan, which outlines the key areas of vulnerability and the priority actions required to reduce risk across the organisation. Alongside the Climate Adaptation Plan, GWH has multiple Emergency Preparedness Resilience and Response (EPRR) policies to support and share communications on climate related issues such as a hot weather policy.

- Since the last report for 2024/25 the Trust have raised a risk on our risk management platform for climate change being a threat to service continuity which is monitored and reviewed by the Sustainability team and reported through channels of escalation. The path of escalation is below:

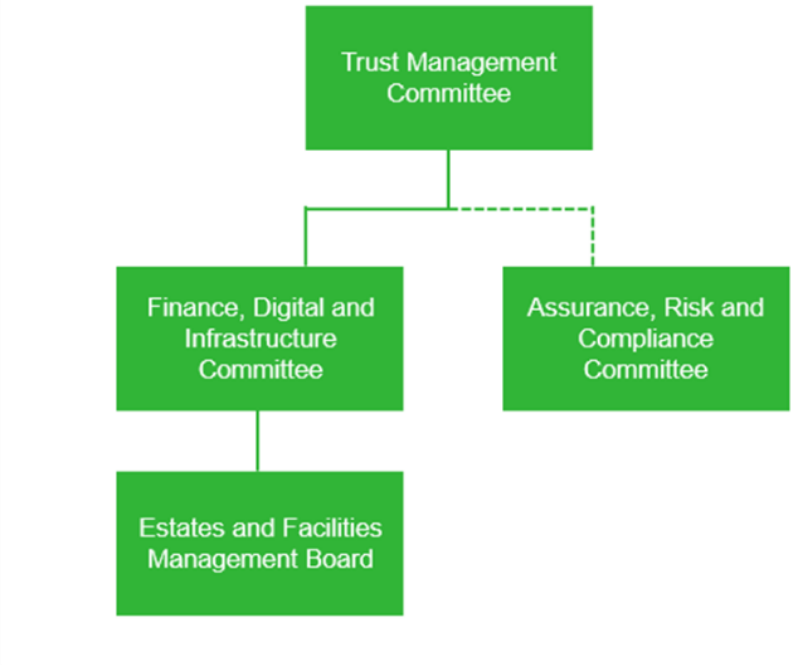


Figure 1 - Risk Management Process at Great Western Hospital.

The process of escalation of risk 290 is detailed below:

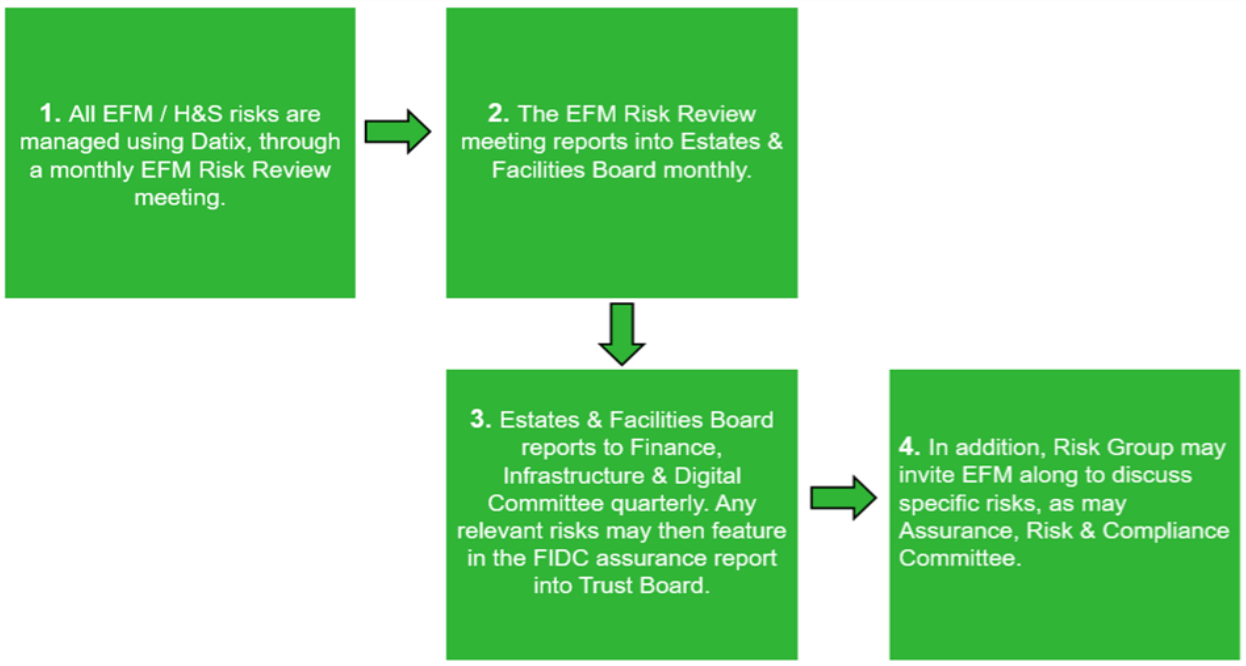


Figure 2 - Process for reporting and escalation for Risk 290.

Climate Adaptation Updates

Even though climate-adaptation was only added to the Green Plan in 2025, the Trust has already begun implementing measures to improve GWH's resilience to climate change.

- GWH has opened a new Integrated Front Door (IFD) which has been built to a climate change scenario regarding thermal modelling.
- GWH has been active in tree planting throughout the site and has adding planting to some staff break areas to increase shade cover whilst on breaks.
- Swindon Health Centre was alerted in the Climate Adaptation Plan as an area at risk of flooding in the future. As this had been highlighted the team were able to get in touch with Swindon Council to see if this had been reviewed as part of the re-design of Fleming Way. Swindon Council confirmed they have reviewed all the drainage along the road and that improved drainage that could handle more rainfall was put in, we are waiting for updated flood risk maps to make sure this change has reduced the risk to Swindon Health Centre.

Metrics and Targets

GWH remains at an early stage in implementing its response to climate-related risks, with work now underway to embed the Climate Change Adaptation Plan across the organisation and wider Group. Historically, the Trust did not disclose specific climate-related metrics or targets in its annual reports, limiting the ability to report progress in these areas. For the 2025/26 reporting year, a new suite of metrics and targets has been established to provide a clear framework for monitoring performance and strengthening accountability, with progress to be reported in the 2026/27 annual report. Although the Trust is still developing its approach to climate resilience the Climate Change Adaptation Plan provides a strong foundation through its climate risk assessment and adaptation maturity assessment, offering scores across key domains such as understanding the challenge, organisational culture and resources, planning and implementation, and collaborative working.

Metrics

Below is the first 5 metrics GWH will begin to measure for the year 2026 to 2027:

1.	% of critical buildings with overheating risk assessments completed
2.	Number of climate-related estates incidents

3.	% of adaptation plan actions completed or in progress
4.	Frequency of climate risk reporting to the EFM Board
5.	% of departments with named climate risk owners assigned

Targets

Below is a table of targets which include the priority timeframe over the next 3 years:

Theme	Action	Priority
Governance and Leadership	Establish a multi-disciplinary adaptation working group from across the group	High Priority
	Have a designated lead of Climate adaptation	High Priority
	Imbedded climate risk in departmental risk registers of areas with high risk	Medium Priority
Organisation Capability	Define clear responsibilities for stakeholders in deliver actions on climate adaptation	Medium Priority
	Identify funding to implement projects	Medium Priority
Data and Evidence	Establish a system for capturing impacts of extreme weather	Medium Priority
	Update action plan annually	High Priority
	Develop a process for prioritising adaption options	High Priority
External Suppliers and Partnerships	Develop relationships and build on collaboration with external stakeholders such as local authorities and utility companies	Medium Priority
	Engage with suppliers to improve supply chain resilience	Medium Priority
Staff Awareness and Engagement	Build and develop staff receiving weather warnings	High Priority
	Develop further on internal and external climate risk communication strategies	Medium Priority
	Provide training for senior leaders and frontline teams	Low Priority
	Run workshops to embed adaptation thinking	Low Priority
Enhance the Estate	Continue to integrate climate resilient design into all new builds and refurbishment	Medium Priority
	Prioritise critical locations for adaptation measures	High Priority
	Upgrade drainage systems to cope with increased rainfall	Medium Priority
Community Health	Ensure community emergency plans consider extreme weathers for sites we are operating services out of	Medium Priority

Conclusion

The 2025/26 reporting year marks the first full implementation of TCFD requirements for Great Western Hospitals, and the Trust has made clear progress in strengthening its governance, risk assessment and strategic approach to climate resilience. T*he Trust has begun to identify and assess climate-related risks a*nd is now embedding these into established oversight structures, including Board-level leadership and formal risk escalation pathways. Although GWH is still early in developing climate-related metrics, the introduction of the first adaptation indicators for 2026/27 provides a foundation for consistent monitoring and accountability. With work already underway to embed the Climate Change Adaptation Plan across the organisation, *work is now underway to embed the Climate Change Adaptation Plan across the organisation and Group.* GWH is well-positioned to build resilience, meet national reporting expectations, and protect the continuity of patient care in a changing climate.

Research & Innovation

Health and social care research can improve health and wellbeing, enables healthcare systems to become more effective, and promotes economic growth. Hospitals that deliver research deliver better patient care as a result. At GWH, the Research department employs a workforce to support the delivery of research across our clinical services. In finance year 2025/26, 505 participants were recruited to studies taking place at our Hospital. This includes patients, their carers, and the staff who provide their care. Of these participants, 29 were recruited to commercially sponsored research, which is essential for the development of new medicines and healthcare technologies.

Developing a balanced research portfolio

We are committed to developing a balanced research portfolio in order to enhance opportunities for research participation at GWH. One of our aims in 2025/26 was to expand our commercial activity while simultaneously maintaining activity that is non-commercially sponsored so that we can offer our patients a range of research opportunities. Table 2 shows research recruitment data for 2025/26 compared to data from 2024/25.

- The number of participants recruited to non-commercial NIHR activity has reduced, as has the weighting score for this activity (a complexity-based score used to calculate funding allocations for NIHR research studies). However, the average weighting per recruit has increased from 82 to 99, indicating a more complex non-commercial portfolio in 2025/26.
- The number of participants recruited to non-commercial non-NIHR activity has increased. This activity falls outside NIHR funding and is delivered using resource not funded via the NIHR.
- The overall number of participants recruited to commercial research also reduced in 2025/26, however the relative proportion of recruitment to interventional versus non-interventional commercial research increased (the former being more complex to deliver).

Together, this shows that we have delivered a more complex portfolio in 2025/26, Therefore, although overall recruitment numbers have reduced, we have delivered an increasingly complex non-commercial portfolio while increasing our interventional commercial portfolio. This partially meets our original aim of expand our commercial activity while simultaneously maintaining activity that is non-commercially sponsored. We have been awarded additional funds from the NIHR to further develop a balanced portfolio throughout 2026/27.

Table 2: Number of participants recruited to research at Great Western Hospital in the 2025/26 and 2024/25 business years

	2025-26	2024-25
Number of Participants Recruited to Non-Commercial NIHR Research (Activity Weighting)	395 (39,069)	541 (44,173)
Number of Participants Recruited to Non-Commercial Non-NIHR Research	81	6
Number of Participants Recruited to Interventional Commercial Research	14	7
Number of Participants Recruited to Non-Interventional Commercial Research	15	54

Equity of access to research

In 2025/26, we also aimed to explore opportunities for equity of access to research across our specialties. This requires maintaining support for research in areas with established research portfolios, while also enabling opportunities for research participation in emerging specialties. Tables 3 and 4 shows 2025/26 activity compared to 2024/25 by specialty for both non-commercial and commercial research.

- Cardiology has delivered the largest proportion of non-commercial weighted activity, increasing in 2025/26 by 4.5% to account for 25.5% of overall activity. There has also been an increase in activity in Anaesthetics (15.3%), but this is met by a reduction in both Musculoskeletal & Orthopaedics (8.5%) and Obstetrics, Maternity & Neonates (9.0%). Change in activity in all other specialties has remained within +/- 5% therefore support for emerging specialties has been limited.
- Interventional commercial activity has increased in Acute Medicine, while activity has decreased in Cardiology and Rheumatology.
- Non-interventional commercial activity has increased in Haematology and Neurology & Stroke, while activity has decreased in Cardiology and Ophthalmology.

This demonstrates that ability to achieve equity while maintaining activity in high-performing areas has proved a challenge in 2025/26 and an area for focus in 2026/27.

Table 3: Non-commercial weighted activity by Specialty, in the 2025/26 and 2024/25 business years.

	2025/26		**2024/25**		
Specialty (A-Z)	**Non-commercial weighted activity**	**% of overall non-commercial weighted activity**	**Non-commercial weighted activity**	**% of overall non-commercial weighted activity**	**Annual change %**
Anaesthetics	6125	15.7%	175	0.4%	15.3%
Cancer Services/Oncology	86	0.2%	1095	2.5%	-2.3%
Cardiology	9963	25.5%	9275	21.0%	4.5%
Critical Care	4938	12.6%	6196	14.0%	-1.4%
Diabetes & Endocrine	4	0.0%	864	2.0%	-1.9%
Emergency Department	115	0.3%	142	0.3%	0.0%
ENT	0	0.0%	350	0.8%	-0.8%
Gastroenterology	0	0.0%	700	1.6%	-1.6%
General Surgery	0	0.0%	145	0.3%	-0.3%
Gynaecology	525	1.3%	175	0.4%	0.9%
Musculoskeletal & Orthopaedics	3532	9.0%	7770	17.6%	-8.5%
Neurology & Stroke	3336	8.5%	3527	8.0%	0.6%
Obstetrics, Maternity & Neonates	1688	4.3%	5888	13.3%	-9.0%
Paediatrics	2323	5.9%	3461	7.8%	-1.9%
Palliative Care	1290	3.3%	0	0.0%	3.3%
Radiology Imaging	1400	3.6%	0	0.0%	3.6%
Respiratory	1819	4.7%	984	2.2%	2.4%
Rheumatology	175	0.4%	2096	4.7%	-4.3%
Urology	1750	4.5%	1400	3.2%	1.3%

Table 4: Commercial activity by Specialty, in the 2025/26 and 2024/25 business years.					
Commercial - Interventional					
	2025/26		**2024/25**		
Specialty (A-Z)	Commercial recruitment	% of overall commercial recruitment	Commercial recruitment	% of overall commercial recruitment	Annual % change
Acute Medicine	11	79%	1	14%	64%
Cardiology	0	0%	4	57%	-57%
Rheumatology	3	21%	2	29%	-7%
Commercial - Non-Interventional					
	2025/26		**2024/25**		
Specialty (A-Z)	Commercial recruitment	% of overall commercial recruitment	Commercial recruitment	% of overall commercial recruitment	Annual % change
Cardiology	1	7%	46	85%	-78%
Haematology	3	21%	3	6%	16%
Neurology & Stroke	11	79%	0	0%	79%
Ophthalmology	0	0%	5	9%	-9%

Recruitment to time and target

It is essential that research studies can answer the questions they set out to address by recruiting the target number of participants needed. We therefore aim to recruit the number of participants we have agreed to recruit to studies, within the agreed timelines. Recruitment to time and target for commercial interventional trials is also a national metric introduced by NIHR in 2025/26. Of the 24 studies that closed in 2025/26, 46% met the recruitment target. Of these, two were commercial interventional trials, achieving 100% pass rate for recruitment to time and target.

Locally-led research:

In 2025/26, an area of continued focus has been building capacity and capability to support locally-developed research. In 2025/26 two externally funded, NIHR-supported, Trust-sponsored studies opened to recruitment. The study sponsor has overall responsibility for compliance with national regulations and funding requirements, which include oversight of study data and performance. Table 5 outlines study performance as at the end of 2025/26.

In 2026/27, we will work with our Hospital Group partners to develop high-quality research grant applications to NIHR funding programmes and to extend our capacity and capabilities to act as Research Sponsor.

Table 5: Sponsored Research Performance, as of the end of business year 2025/26

Study Type	Grant Award Value	Specialty	60-day metric status	30-day metric status	Recruitment to target status	NIHR milestone status
Observational	£2,500.00	Cardiology	Target Met	Target Met	Behind Target	Off-Track
Observational	£269,838.81	Neurology	Target Not Met	Target Met	Meeting Target	On-Track
Overall Performance Achieved			50%	100%	50%	50%

Workforce Development

In order to diversify and develop a skilled research delivery workforce, we are aiming to establish a career progression pathway for research practitioners. In 2025/26, we have implemented competency-based entry-level job descriptions that provide a route into a career in research and have taken the first of these roles to advert.

In 2026/27, we will continue to implement similar competency-based job descriptions that progress through the Agenda for Change pay scales to create a workforce development pathway. Where relevant, this also provides a route for research staff to develop the required professional standards of proficiency needed to join the Healthcare Science (AHCS) Professional Standards Authority (PSA) Accredited Register for Clinical Research Practitioners. A focus for 2026/27 is to ensure that everyone engaged in research has the skills and knowledge to deliver research that meets national quality and safety standards, and we will enhance mechanisms that evaluate research integrity.

Serving our community : system-wide – integrated care system (ICB)

The Trust is part of the Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System (ICS). Bath & North East Somerset, Swindon and Wiltshire (BSW) ICS has a combined registered population of approximately 1 million people and covers an area of approximately 1500 square miles. There are three local authorities, 94 GP practices, three acute hospital trusts, a mental health provider, and an ambulance trust, as well as community services providers and many voluntary and charitable organisations.

We are actively engaged in leading work in the Integrated Care Alliance (ICA) and increasingly in 2025/26 our work has centred on the formation of the BSW Hospitals Group with the Royal United Hospitals NHS Foundation Trust in Bath and Salisbury NHS Foundation Trust. Bringing the three organisations together is supporting us to reduce variations in care, learn from each other's improvements and become more efficient through working together and differently.

As an ICS, BSW has four key purposes to:

- improve outcomes in population health and healthcare.
- tackle inequalities in outcomes.
- experience and access, enhance productivity and value for money.
- support broader social and economic development.

The BSW ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age

- getting the best from collective resources so people get care as quickly as possible.

In 2025/26 we have increasingly focused on working with partners to develop Neighbourhood Health in Swindon; this will promote a more joined up approach to health and social care supporting people in the places where they live, with support orientated around and with people, carers and families. Partnership with communities and local voluntary sector organisations are crucial to this way of working. There will be an increased focus on people living in good health every day and preventing conditions worsening. Population health information is supporting the development of the locality-based plans including health inequalities information centred around Core20plus5 areas. We have a role to facilitate access, lead secondary prevention and adapt services to cater for higher risk cohorts of our population.

Placed-based partnerships

We pride ourselves on having strong place-based relationships and 'Team Swindon' has really developed over the last few years. We now work much more closely with Swindon Borough Council and our Integrated Care Board colleagues. Place-based working has enabled us to have more focus on health inequalities – particularly important locally with Swindon being the fifth most deprived local authority out of 14 in the South West – and our role as anchor in the community.

At the start of 2025/26 many of the Trust's community services transferred to be provided by HCRG Care Group whilst the Trust remained providing some services through sub-contracts with HCRG. We have worked in partnership over the last 12 months to ensure smooth and successful transition of services for staff and patients. We continue to work positively in partnership to design and transform services for the future that provide more local and digitally enabled access for our population.

Our role as an Anchor Organisation

Anchor institutions are large, typically public sector organisations, rooted in place (hence the term 'anchor') and by the nature of their role and scale are uniquely placed to positively influence the social, economic and environmental conditions of local communities. The long term sustainability of these organisations is inextricably linked to the health and wellbeing of their populations and so there is a 'virtuous circle' in the role of these organisations leveraging their ability to impact on the wider determinants of health locally.

Given the role of our Integrated Care Alliance in improving the health and well-being of individuals, we want our constituent organisations and partnerships to play this crucial role in supporting wider social and economic development, acting as anchor institutions that contribute to the economic and social development of local communities.

Our position in the community gives us an opportunity to work to reduce health inequalities and improve life chances.

As an employer of choice, we've continued our strategic partnership with New College Swindon to support entry routes into our Trust. Successes have included our work with Swindon Borough Council on schemes such as Project Search; a one-year transition to work programme for young people with a learning disability and/or autism. Developing training facilities at the Institute of Technology at New College, North Star Campus has resulted in accessible and local centre for our staff.

Health Inequalities

The Trust is committed to providing great services for local people, at home, in the community and in hospital, which in turn will enable independent living and healthier lives – our vision, set out in the 2025-2028 strategic plan 'Our local strategic direction'. The vision is underpinned by four Pillars – Outstanding Care; Valued Teams; Better Together; and a Sustainable Future.

Our ‘Better Together’ Pillar explicitly prioritises collaborative and integrated work to address health inequalities in our local communities, where for example, men in affluent areas of Swindon live up to nine years longer than those in the most deprived quintiles. To redress these imbalances, over the past year we have been working with system partners to jointly tackle inequalities and we have commenced a programme of work to strengthen our health inequalities data. Over the past few months, we have begun working more closely as a group of hospitals with RUH Bath and Salisbury Hospital to develop a robust health inequalities partnership, working towards a ‘one team’ approach to eliminate unwanted variation – the current workstream is focussed on Referral to Treatment (RTT) pathways. This work is overseen by the Inclusion & Health Inequalities Subcommittee and the Trust Board who provide governance.

As an NHS body, the Trust fulfils its legal duty under the Public Sector Equality Duty (Equality Act 2010) and Section 13SA and Section 25 of the NHS Act by reporting on how we collect and analyse health inequalities information – a small selection of this data is provided in our annual report (see below). In addition, part of our contractual arrangements with our commissioners (Bath & Northeast Somerset, Swindon and Wiltshire (BSW) Integrated Care Board), include an obligation to support the commissioner to reduce inequalities; to implement an inequalities action plan (Schedule 2N) and to appoint a Board-level Lead on Health Inequalities to oversee the actions.

Delivering our Inequalities Action Plan 2025/26

Our Equality Diversity & Inclusion and Health Inequalities Annual Report for 2024-25 sets out the health inequalities actions that we have pursued this year. The initiatives highlighted below represent some of the work we have undertaken this year to improve patient equity.

2025/26 Data Improvements

Our 2025/26 Health Inequalities action plan identified three workstreams – improving data quality, introducing Health Inequalities training and expanding the membership of the Inclusion and Health Inequalities strategic committee to include Core20Plus5 representatives.

The Trust has been improving its data dashboards during the year. Improvements include the inclusion of patient demographics into the build of new dashboards to enable the stratification of data by key characteristics such as Ethnicity, Gender and Deprivation as standard to inform operational decision making. In addition, a bespoke suite of reporting has been established to reflect the specific metrics outlined in the NHSE Statement on Information on Health Inequalities, with a pack based on these metrics being monitored at the Trust Performance, Population and Place Committee for assurance. Also, specific metrics incorporating a Health Inequalities perspective have been included in both the Trust and BSW Group Integrated Performance Reports throughout 2025/26, ensuring visibility of these cohorts at all levels of the organisation.

GWH also has access to the BSW Integrated Care System data dashboard, which provides insights at Trust, neighbourhood, ‘place’ and system levels; this has enabled us to collectively develop the BSW system Health Inequalities Strategy 2021-24, which is currently being refreshed. We are currently delivering against the shared action outlined in this plan.

The Trust piloted Health Inequalities face-to-face training in April 2026, and training is regularly delivered by Maternity Services as part of their mandatory study day. We also offer three self-directed learning modules via our Electronic Staff Record (ESR) system which is accessible by all staff – ‘The art of honest conversations’; ‘All our health: Health disparities and equalities’; and ‘Health Inequalities – Core20Plus5’. In addition, a health inequalities workshop is delivered bi-annually at our Equality, Diversity & Inclusion and Health Inequalities conference – the next conference will take place in June 2026.

The Trust has carried forward its commitment to review membership of the Inclusion & Health Inequalities Subcommittee, the strategic group that oversee this work, to 2026/27, following the EDI conference and Board

and Executive Committee workshops, the engagement with these groups will help to shape a Health Inequalities Strategic Plan – expansion of the group will be based on these insights.

Other Health Inequality Initiatives

In addition to responding to our annualised plan, a range of initiatives to address health inequalities happen across the Trust, a few of these are noted below.

Children and Young People (CYP) Oral Health dental project

The Trust is host to the Children and Young People (CYP) Oral Health dental project. The pilot aims to support families in the most and second most deprived Lower Layer Super Output Areas (LSOAs), a small geographic unit used for statistical analysis. The project will reach an estimated 150 children over 12 months focusing on improving oral health education and treatment for children who are undergoing general anaesthetic to have teeth extracted due to decay; the service will also be open to their siblings under 16 years old. Since going live in December 2025, the project has strengthened engagement with dental commissioners, identified families requiring additional support, and supported co-design of resources with parents and community partners. Although in its early stages the project has supported 31 children; 14 of which were siblings of children attending the oral health pre-operative clinic. Follow up clinics providing fluoride varnish have just begun; whilst the rate of families not attending is high (50%) to date 30% of children have had fluoride varnish applied. We will continue to adapt the service based on family feedback during the pilot.

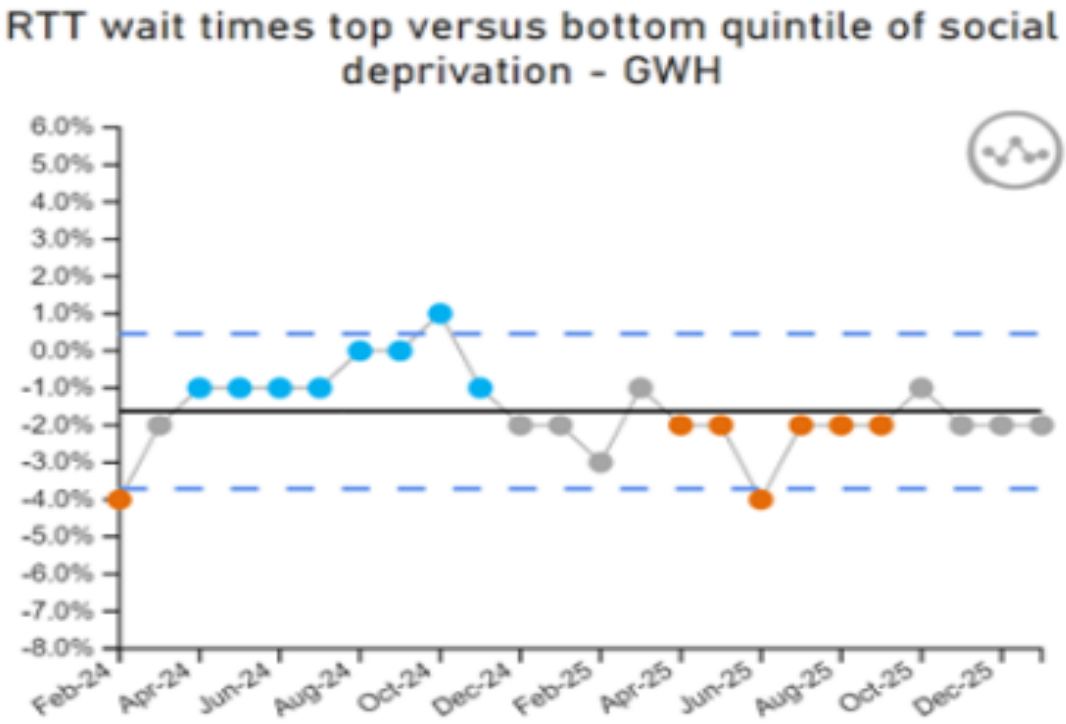
High Intensity User Programme

Our High Intensity User Programme supports patients who frequently attend the Emergency Department – more than 5 times in a year or 3+ times in a three-month period. Many of these patients experience complex health and social inequalities, including mental ill health, deprivation, chronic ill-health, housing instability and addictions. A dedicated multidisciplinary team works proactively to identify patients, develop personalised care plans and coordinate support across mental health services, primary care, safeguarding, ambulance services, the police and voluntary service partners. The approach focusses on parity of esteem, trauma-informed care and prevention; aiming to improve patient experience, reduce avoidable attendances and admissions and to strengthen collaboration across services.

The Trust currently has 238 active patients on our database, 113 of these patients have a plan in place and the remaining are being actively monitored and a plan will be developed. In one intervention, where the team have written to the GP to improve signposting, 71% of patients decreased attendance. Since the programme commenced over 1,200 patients have been reviewed.

Referral to Treatment (RTT)

As a hospital group, over the past few months we have commenced jointly monitoring RTT to enable a group approach to improving performance. Patients have a legal right to start consultant-led non-emergency treatment within a maximum of 18 weeks from referral and the Trust identifies where action is needed to reduce inappropriately long wait times; reduce inequalities between patients, in access to and outcomes from healthcare services; and to provide services in an integrated way. We review our waiting list data to understand whether patients from more deprived areas are likely to wait more time than those from less deprived areas. However, our data shows that there is no strong correlation between deprivation and how long patients wait. The chart below shows the difference in RTT waiting times between patients from the most and least deprived areas over time. A value of 0% means there is no difference, while values above or below this indicate small variations between the two groups. Overall, the results fluctuate slightly from month to month but remain within a narrow range, with no consistent pattern of one group waiting longer than the other. This suggests there is no meaningful or sustained difference in waiting times related to deprivation, and any variation observed is minor and likely due to normal operational factors rather than inequality in access



Workforce Health Inequalities

The NHS England EDI Improvement Plan, High Impact Action 4 (Develop and implement an improvement plan to address health inequalities within the workforce), directs NHS organisations to respond to health inequalities experienced by this group, our Staff Report section highlights some of the occupational health and wellbeing initiatives we undertake to support workforce health and wellbeing, we monitor the impact of these services through frameworks like the Equality Delivery System (see Staff Report), which is evaluated by staff, to ensure access is equitable and to drive continuous improvement. In September 2025, our Employee Service Record dashboard was updated to include socio-economic background information, staff will be prompted to review their data annually. Collecting this information will enable us to better understand the barriers our staff face and highlight any disparities faced by particular groups.

BSW Together

The Bath and Northeast Somerset, Swindon and Wiltshire Together is an integrated care system, made up of NHS, local authority organisations, private providers and voluntary sector organisations who work in partnership. As a group, we collectively take responsibility for improving health and wellbeing for local people and tackling health inequalities.

As a healthcare system, we have jointly completed the Equality Delivery System (EDS) review again this year. EDS is a self-assessment tool used to help NHS organisations to review and improve our performance in promoting equality and diversity and ensuring fair and inclusive healthcare services. The review for Domain 1 – Commissioned or Provider Services, was hosted by the ICB and representatives from each organisation took part in the scoring process. The ICB aligned Domain 1 with the action learning reviews. Three areas were assessed:

An area where we have limited data available – Use of the NHS App.
An area where we are performing well – Flu and covid vaccinations.
An area which is in development – Integrated neighbourhood teams (a core element of HCRG's community care contract).

Overall score for all three services was ‘Achieving’. The ICB will publish the EDS report for Domain 1 in the coming months. Note, Domain 2 and 3, Workforce Health and Wellbeing and Inclusive Leadership were scored internally at GWH (see Staff Report section), the Trust has an overall score of ‘Achieving’ activity, when all three Domains are combined.

Maternity & Neonatal Services EDS Update

In 2023, Maternity and Neonatal Services were evaluated during the Equality Delivery System (EDS) self-assessment, the resulting action plan included the implementation of the NHS England’s Three Year Delivery Plan for Maternity & Neonatal Services. An update can be read in last year’s EDS report, which can be accessed on the Trust’s website.

Delivery of equity improvements has continued to be monitored through the Maternity and Neonatal Single Delivery Plan, building on progress achieved throughout the Three-Year Plan which concluded in March 2026. Equity is embedded as a core quality and safety priority within established governance arrangements.

Targeted work to strengthen an antiracist and inclusive workplace culture has continued. A senior-led listening event explored staff lived experience, barriers to inclusion and co-produced actions to improve equity and psychological safety. Early impact includes increased use of the Professional Midwifery Advocate (PMA) service, greater confidence in accessing managerial support, improved trust in leadership, and increased engagement in professional development and career progression. This represents a positive step towards a workforce that better reflects the diversity of the local population.

Inclusive leadership capability is being further developed through participation in the NHS England Changing and Growing Together reverse mentoring programme. Engagement remains strong, with staff completing and progressing through cohorts. While cohort size limits quantitative impact measures, qualitative feedback demonstrates improved cultural awareness, leadership confidence and inclusive practice, aligned with the Ockenden recommendations and national maternity safety priorities.

Equitable access to services remains a key focus. Following concerns regarding translation accuracy, incidents are being captured via Datix, with intelligence shared with PALS and central governance. A targeted review of care records for women whose first language is not English will assess compliance with interpretation standards and identify themes for improvement.

Community insight continues to inform service development. An action plan responding to engagement with Swindon’s South Asian community addresses translation, trauma-informed baby loss care, cultural understanding and antenatal education. Delivery is overseen through the Perinatal Quality, Safety and Assurance framework.

The Equity and Patient Safety Dashboard is operational, providing Trust-level oversight of ethnicity and deprivation data. A multidisciplinary group continues to strengthen data quality and system alignment, with plans to expand the dashboard to additional protected characteristics. Demographic data highlights the population served and will be triangulated with safety and incident data to support targeted, equitable improvement in outcomes for women and babies.

The Treating Tobacco Dependency (TTD) team provide personalised care and support to all women identified as smoking at the time of booking. During 2025/26 local data represents 1.0-5.6% of women smoking at the time of birth with a national target of 6%. It has been identified that women who live in the IMD1 postcodes and who smoke at the booking of a pregnancy are overrepresented compared to the wider population. The TTD team will work with partner organisations to influence the preconceptual advice available for women who are planning a pregnancy and continue to provide personalised care for these women identified at booking.

Learning from lived experience

The Board and representatives of the organisation are able to improve their understanding of staff and patients lived experience through engagement. This happens through a series of listening events, collaborative working and site visits.

This year the Trust has worked closely with the Deaf community to improve the care we provide and to ensure equitable access to our services. A coproduction group has been established and recent improvements include introducing direct calling to the Trust through the Convo British Sign Language (BSL) app, which enables immediate contact and provides a three-way connection with a BSL interpreter; we have also added QR codes to many of our main reception desks around the Trust – when scanned they link directly to a BSL interpreter, enabling instant communication; we have also improved the process for booking BSL face to face interpreters and patients now have a direct point of contact for interpreter requests. In 2026/27, the Trust will research good practice across NHS hospitals to identify further opportunities for improvement, and we will continue to work with the coproduction group.

In November lay members took part in our annual Patient Led Assessment of Care Environment (PLACE) programme. The programme included visits to various areas around the Trust reviewing accessibility, dementia environments, food, clutter, facilities and general appearance. The programme was well attended, and results will be reviewed and an action plan for improvement developed.

A key mechanism for sharing patients lived experience is through Care Reflections. These are short films recounting patients, families and carers personal stories. These stories are reported to our Trust Board, used for staff training, personal reflection and as part of divisional and Trust wide governance meetings. A recent care reflection shared a very personal and emotional lived experience, with extremely positive feedback from a patient who had been admitted to critical care with sepsis and wanted to thank the team for the lifesaving treatment.

In October an online engagement event was held with women who had experienced using a bedpan whilst receiving hospital care. The event was part of ongoing improvement and innovation work to introduce a urinal that can be used by patients with female anatomy. The attendees, who had previously had bad experiences of using a bedpan were asked about the implementation of the Uni-wee, how it would help, what could be changed and what the important things were to consider. Their feedback and lived experience was invaluable in support the ongoing research application and case of need for further study and implementation. An adapted form of the Uni-wee remains on trial in our Emergency Department, the group were very keen to see this rolled out across the Trust.

A combination of both qualitative data and quantitative data supports effective decision making and helps us to better interpret what the data is telling us.

Accessible Information Standards

The Accessible Information Standard (AIS) applies to all NHS organisations; by applying the Standard, the Trust ensures that public information and communication with its staff and population is accessible. We are committed to following the principles of the AIS which requires a specific and consistent approach to identifying, recording, flagging and meeting people's information and communication needs, where those needs relate to a disability or sensory loss.

Patients who need reasonable adjustments currently have a 'flag' placed on their record, which alerts staff to their support needs. We are also in the process of implementing a new Electronic Patient Record (EPR) system that will be accessible across the BSW Hospitals Group that will support integration and improve patient care. The transformation programme of work that accompanies this will provide an opportunity to identify improvements.

We currently have a link on our website to advise the public of how they can inform us of any specific needs, and we are then able to add an alert to our main patient administration system to highlight this to all staff.

Health Inequalities Improvement Plan 2026/27

Looking ahead, in 2026/27 we will strengthen our approach to addressing health inequalities. We will work with staff to identify opportunities and undertake a review of national and regional policy to inform our health inequalities strategic plan and actions. Our action plan will include improving staff awareness, the provision of health inequalities training, hosting our second Equality, Diversity & Inclusion conference and the development of self-help resources for staff who want to drive local change in their departments.

We have appointed a fixed-term part-time Associate Chief Medical Officer role, the postholder will provide senior clinical leadership for partnership working and health inequalities. They will also support the Trust to deliver against the three shifts set out in the NHS Long Term Plan – hospital to community; analogue to digital; and treatment to prevention.

During 2026/27 we will focus on:

- **Children's Oral Health review**: Learning from the Children's Oral Health work and sharing good practice across the system.
- **Continue a focus in Maternity services**: The service has concluded their actions against the NHS England three-year delivery plan in March 2026, however, they will continue to drive improvements including the provision of training and building inclusive leadership capability and ensuring the patient voice is reflected in their decision-making.
- **Review our high Emergency Department attendance for mental health**: Looking at what further we can do to support these patients with a particular focus on children and young people who attend ED frequently.
- **Neighbourhood health**: Work with partners to develop neighbourhood health with a particular focus on key groups of our population:

    - **Frailty**: Swindon has younger frailty onset, the average age of Swindon's frailty cohort is 72 which is five years younger than in Wiltshire (77). There is also high rates of depression in our frail population (28.6% of frail adults also have depression).
    - **Deprivation**: there are strong links between deprivation and Long-term conditions. Swindon's Core20 population (population who live in 20% most deprived neighbourhoods nationally) are 70% more likely to have COPD, 14% more likely to have obesity and 22% more likely to have diabetes than the rest of the Swindon population. These risk factors all contribute to frailty onset.
    - **Dementia**: Swindon's care homes have a high level of dementia prevalence at 48.1% and Swindon has a lower than average dementia diagnosis rate (52%) meaning there is likely to be significant levels of undiagnosed dementia and unmet need in this group.

- **Driving evidence-based Improvements:** We will also map our existing data dashboards against the recently published NHS England Statement on Health Inequalities and start our journey towards implementing the framework. The Statement has been adopted across the NHS and will lead to a shared evidence-based improvement model. This work aligns with our 'Outstanding Care' priority, which focuses on continuous quality improvement.

- **Strategic planning:** We will work with our Board and staff and use our improved data to identify priorities and develop a strategic plan that will enable us to improve health equity for our patients and communities.

Cara Charles-Barks
Chief Executive Officer
Date: 25 June 2026

3 ACCOUNTABILITY REPORT

CONTENT

4 DIRECTORS REPORT

The role of an NHS Foundation Trust Board of Directors is to be collectively responsible for the exercise of the powers and the performance of the NHS Foundation Trust. Its role is to provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed.

Our Board is responsible for ensuring the Trust is compliant with its terms of authorisation, its constitution, mandatory guidance, relevant statutory requirements, contractual obligations and for governing the Great Western Hospitals NHS Foundation Trust effectively so that our patients, public and stakeholders have confidence that their care is in safe hands.

The quality and safety of our services are of paramount importance to us all; the Board ensures that it applies all the relevant principles and standards of clinical governance.

All members of the Board meet the NHS fit and proper person test (FPPT) framework published in August 2023.

Our authorisation from our regulator and constitution govern the operation of the Trust. The schedule of reservation and delegation of powers sets out the types of decisions that must be taken by the Board of Directors and those which can be delegated to management.

As required by the code of governance for NHS Provider Trusts (provision B 2.17), the Trust's constitution defines which decisions must be taken by the Council of Governors and how disagreements between the board and the council should be resolved and also describes how the chairman or a non-executive director role may be terminated. Further detail can be obtained from our constitution which is accessible via our website.

Our Board considers that it has complied with the requirements of the constitution relating to board composition.

The Board is satisfied that it has acted appropriately, been balanced and complete and has contained a suitable range of appropriate and complementary skills and experience.

The Board considers that all the non-executive directors are independent and the chairman was independent on appointment (as required by the code of governance for NHS Provider Trusts provision B.2.6). Where a non-executive director has served on the Board of Directors for over six years, a clear rationale for their reappointment has been made to the Council of Governors who have approved an extension to terms in each case.

The Board have undertaken a refreshed skills mix audit to evaluate the composition of the board ahead of recruitment to executive and non-executive roles. The non-executive director led remuneration committee have reviewed the succession plans for the executive directors.

The Trust maintains Directors' and Officers' liability insurance through NHS Resolution, in accordance with good governance practice.

Register of Director's Interests

The Register of Directors' Interests is available for inspection in normal office hours from the Company Secretary and is published on the Trust's website.

Well Led Framework

The Trust has had regard to NHS England's well-led framework in evaluating organisational performance and in shaping its approach to internal control, the Board Assurance Framework and the governance of quality.

In 2022/23, a successful system-wide procurement exercise was undertaken across the three BSW Acute Trusts to commission an external, independent well-led developmental review. Aqua was appointed following this process. The outcomes of this review informed the Trust's ongoing governance and leadership development arrangements. Further detail is provided within the Annual Governance Statement.

The Trust will undertake a further well-led review in 2026/27 to assess whether the governance structures established to support the evolving BSW Hospitals Group model remain effective, proportionate and fit for purpose, and to ensure that roles, responsibilities and decision-making arrangements continue to provide robust oversight and assurance.

The Trust has reviewed the consistency of its governance reporting and confirms that no material inconsistencies have been identified between the Annual Governance Statement, Corporate Governance Statement, Annual Report, or reports arising from Care Quality Commission planned and responsive inspections, including associated action plans

Trust Chair and Deputy Chair

The Chair of the Trust during 2025/26 was Liam Coleman. There were no material changes to external commitments during the year, and the Board is satisfied that the Chair devoted sufficient time to fulfil the role effectively.

Liam Coleman remained in post until 31 March 2026 and was therefore the serving Chair during the period covered by these Annual Report and Accounts and at the point at which they were prepared. A new Chair took up post on 1 April 2026, following Mr Coleman's departure as Chair.

Formal approval of the Annual Report and Accounts is subject to completion of the external audit, with final sign-off scheduled following the Audit, Risk & Assurance Committee on 24 June 2026. The new Chair assumed office from 1 April 2026 which accounts for the change in signature.

The Deputy Chair during the year was Faried Chopdat.

Members of the Board during 2025/26

During 2025/26, the Trust continued to develop its group model, with a number of Executive Directors undertaking roles and responsibilities that span more than one organisation within the group. While these Executive Directors may hold group-wide portfolios or responsibilities across partner organisations, they remain statutory Board members of the Trust and retain full accountability to the Trust Board for the discharge of their duties within this organisation. These arrangements are supported by aligned governance structures across the group to ensure clarity of accountability and consistency of decision-making.

To note: Profiles are included to reflect individuals who served on the Board throughout 2025/26, notwithstanding changes to voting status during the year.

Cara Charles-Barks - Group Chief Executive Officer/Accountable Officer (voting member) from 1 November 2024

Cara Charles-Barks has worked at board level within the NHS since 2008, holding senior executive roles including Chief Operating Officer and Deputy Chief Executive, and serving as Chief Executive at Salisbury NHS Foundation Trust between 2017 and 2020. Earlier in her career, she held senior healthcare management roles in Australia. In November 2024, having worked within the BSW system for eight years,

Cara was appointed Chief Executive Officer of the BSW Hospitals Group.

She holds undergraduate and postgraduate degrees in Nursing and an MBA from the University of Adelaide.
By way of declared interests, Cara is a Visiting Professor at the University of the West of England, Chair of NHS Quest, Honorary Colonel of 243 Multi-Role Medical Regiment, and a Director of Chatham Row Management Company Ltd.

Lisa Thomas - Managing Director (voting member) from 1 September 2025

As Managing Director, Lisa is responsible for the day-to-day leadership of the Trust.

She joined the Trust in September 2025 and has more than 25 years' experience of working in the NHS working across hospitals in Bath, Wiltshire, Hampshire, and Gloucestershire. Prior to joining, she was interim Managing Director at Salisbury NHS Foundation Trust.

Lisa is passionate about improving healthcare and has been involved in service and patient care improvement projects throughout her career.

Benny Goodman - Chief Operating Officer (voting member) from 25 November 2024

Benny was appointed Chief Operating Officer in November 2024 having worked in operational roles at both the Royal Berkshire NHS FT and Oxford University Hospitals NHS FT.

He joined the NHS in 2018, having first trained as an accountant in a professional services firm, then helping to start, and rapidly grow, a social enterprise, during which he developed his understanding of leadership-based clear vision and strong values born out through day-to-day interactions.

Luisa Goddard - Chief Nurse (voting member) from 1 January 2024

Luisa was appointed Chief Nurse in December 2024 after being Deputy Chief Nurse at the Trust for over three years. Having trained at Guy's Hospital, Luisa brings senior nursing experience from Oxford University Hospitals NHS FT and North Bristol NHS Trust.

Luisa's focus is on delivering high quality safe care, encompassing quality, risk, safeguarding and infection prevention and control.

As professional lead for Nursing, Midwifery and Allied Health Professionals, Luisa ensures the Trust has a dynamic, forward-thinking workforce that can deliver great care.

Jude Gray - Group Chief People Officer From 1 July 2019

Jude became the Trust's Chief People Officer in July 2019.

In addition to their role within the Trust, Jude also undertakes broader responsibilities across the group, serving as Group Chief People Officer from 1 November 2025.

Jude remains accountable to the Trust Board for the accountability for People services.

By way of background, Jude has senior people leadership experience across the public sector, including previous roles with the BBC and His Majesty's Prison and Probation Service. In her Group role, she is responsible for workforce planning, sustainability, health and wellbeing across the BSW Hospitals Group.

Kathryn Bateman Chief - Medical Officer (voting member) from 13 October 2025

Kathryn Bateman joined the Trust as our Chief Medical Officer in October 2025 from Sirona Care and Health, the community provider for NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board.

Kathryn has a wealth of clinical and leadership experience and ability from a long career in the NHS, and her previous roles include Associate Medical Director, Clinical Lead for Transformation and Clinical Chair for the Division of Medicine at University Hospitals Bristol and Weston NHS Foundation Trust.

Emily Beardshall - Acting Chief Improvement and Partnerships Officer from 1 June 2025

Emily joined the Trust in November 2022 as the Deputy Director, Improvement & Partnerships and was appointed as Acting Chief Improvement and Partnerships Officer in June 2025.

Emily has extensive experience as a Divisional Director and operational manager as well as Integrated Care Board experience leading quality improvement and delivering large scale transformation.

Emily leads our Trust Improvement approach, Improving Together, putting staff and patients at the heart of improving care, every day. Emily is passionate about working with partners and our population to promote safe, joined up and high quality care.

Simon Wade – Group Chief Financial Officer from 1 November 2020

Simon was appointed as the Trust's Chief Financial Officer in November 2020. He joined the Trust from Royal United Hospitals Bath NHS Foundation Trust, where he was Deputy Director of Finance.

In addition to their role within the Trust, Simon also undertakes broader responsibilities across the group, serving as Group Chief Financial Officer from 1 November 2025.

Simon remains accountable to the Trust Board for the financial stewardship, governance, and statutory reporting requirements of the Trust.

By way of background, Simon has extensive senior NHS finance experience.

Jonathan Hinchliffe – Group Interim Chief Digital & Information Officer from 7 April 2025

Jonathan started as Group Interim Chief Transformation and Innovation Officer in April 2025, joining from Manchester University NHS Foundation Trust.

Jonathan is responsible for the transformation of digital services, helping to ensure clinical and non-clinical care is delivered with innovation, safety and digital excellence and resources are used efficiently and effectively, to ensure a high-quality patient service. He is leading work to implement a shared Electronic Patient Record across our Trust and also the Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Other Executive Director appointments in 2025

As part of the group leadership model, several senior roles were established with responsibilities spanning multiple organisations. These individuals attend the Board as non-voting participants where appropriate but are not statutory Executive Directors of the Trust and do not hold full-time roles within the organisation.

- Andrew Hollowood – Group Chief Clinical Transformation Officer - from 1 September 2025
- Mark Ellis – Group Chief Risk Officer – from 2 February 2026
- Judy Dyos – Group Interim Chief Strategy Officer – from 2 February 2026

Other Key Executive Director changes in 2025:

- Jon Westbrook retired as Interim Managing Director on 30 June 2025. Simon Wade, Chief Financial Officer covered the Managing Director role until Lisa Thomas joined in September 2025.
- Lisa Thomas was appointed as Managing Director on 1 September 2025.
- Stephen Haig ceased as the Interim Chief Medical Director on 23 November 2025
- Kathryn Bateman was appointed as Chief Medical Officer on 13 October 2025
- Claire Thompson left as Chief Partnership and Improvement Officer on 8 June 2025
- Emily Beardshall was appointed as Acting Chief Partnership and Improvement Officer on 1 June 2025

Non-Executive Directors - Biographies

Non-executive directors have a wide variety of experience in the voluntary, public and private sectors. They are all part-time

Liam Coleman - Trust Chair
Remuneration Committee Chair
Council of Governors Cahir

Liam took over as Chair of the Trust on 1 February 2019.

Liam Coleman was appointed as Interim Joint Chair of Great Western Hospitals NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust, commencing on 1 July 2025. He stepped down from the role on 31 March 2026, having reached the end of his second term in office.

He was previously the Chief Executive of the Co-Operative Bank plc and a senior executive at Nationwide Building Society, headquartered in Swindon.

Chris Burton - Non- Executive Director

Chris qualified as a doctor in 1987 and has spent the majority of his career in the NHS, including work in Bristol and Southmead Hospitals.

After three years as Clinical Director of the Renal and Transplantation Directorate, Chris was appointed to the Board of North Bristol NHS Trust (NBT) as Executive Medical Director in 2009.

During his time on the board, the Trust successfully underwent significant change, including hospital moves and EPR modernisation.

Chris' passion is quality of patient care and he hopes his contributions to the NHS leadership will help to improve this moving forward.

Faried Chopdat -Non- Executive Director
Deputy Trust Chair
Finance, Infrastructure & Digital Committee Chair

Faried is an experienced and dynamic global leader with proven capability business transformation, risk management, and audit.

He has experience of delivering results through people-centric leadership that delivers sustainable value to all stakeholders.

His passion for coaching and mentoring others to reach their full potential led him into the world of executive coaching.

Faried is a director of his own boutique advisory and coaching business helping leaders and professionals with their transformation journeys

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Julian Duxfield - Non-Executive Director
People & Culture Committee Chair
Charitable Funds Committee Chair
Well-being Guardian

Julian joined the Trust board in May 2023. Julian has been Human Resource Director in a number of organisations including Unilever, the civil service, the security industry and latterly for the University of Oxford. He has also been an external member of the CQC remuneration committee.

In addition to his Non-Executive role at the Trust, Julian also provides executive coaching and actively pursues his passion for climbing and mountaineering.

Julian is keen to see the Trust continue to be a great place to work and ensure its staff are well supported and managed.

Julian is the Doctors disciplinary NED champion/independent member.

Sandra Gordon - Non-Executive Director

Sandra brings over 25 years of senior operational leadership experience across customer service, financial services, and the public sector in several trusted brands.
Since April 2020, Sandra has been a Director of Bristol Women in Business Charter CIC, a pioneering initiative
making Bristol the only city in the UK with its own charter focused on achieving gender equality in business.

Sandra currently serves as a Governor at City of Bristol College (since 2021), where she is Link Governor for Equality, Diversity and Inclusion, and sits on Finance & Resources and Search & Governance. She also serves as a Justice of the Peace. Sandra is driven by a commitment to equity in health outcomes for all patients and valuing colleagues to best use their experience and resources. She brings a results-driven approach combined with compassionate leadership and a strong emphasis on mentorship and organisational development.

Bernie Morley - Non-Executive Director
Performance, People & Population Committee Chair

Bernie joined the Trust Board in April 2023. A molecular geneticist by training, Bernie has worked at a number of Universities over the years, before moving to Bath in 2010 as Pro-Vice-Chancellor (Learning and Teaching). He became Deputy Vice-Chancellor (DVC) and Provost 5 years later and remained at the University until 2021 including a spell as acting Vice-Chancellor.
While at Bath, Bernie was co-chair of the highly successful £40m Institute of Coding, a collaboration between Universities and Industry partners delivering skills training at all levels and with a target of widening participation. He is now retired but is working with a number of Universities as a consultant on a wide range of education, building and planning projects, and has a passion for education and enabling students from different backgrounds to achieve their potential.

Claudia Paoloni - Non-Executive Director
Senior Independent Director
Quality & Safety Committee Chair
Freedom to Speak up Champion
Maternity Board Safety Champion

Claudia has held positions of leadership and influence in her senior medical career.

Having led and delivered major transformational service delivery and workforce projects at University Hospital Bristol and Weston Foundation Trust, she held a clinical director tenure for three years, a Divisional Board position, and currently remains Chair of the Hospital Medical Committee.

She has also held an executive member position for Hospital Consultants and Specialists Association (HCSA), and held the elected role of President - the first female president since its inception in 1948.

Passionate about the NHS, Claudia actively works towards influencing the recruitment and retention of our NHS staff for the future.

Will Smart - Non- Executive Director

Will joined the board as a Non-Executive Director in April 2023His career has been spent in digital and analytics across healthcare and the wider public sector. He is currently a Global Director for Dedalus, one of the world's largest healthcare technology companies.

Prior to joining Dedalus, he was Chief Information Officer for Health and Social Care in England, where he led the development and delivery of national strategies on information, technology and informatics.

Will has also served as CIO at the Royal Free London Hospitals Group, and has extensive experience in healthcare technology, as well as consulting widely across the UK Public sector in the areas of digital strategy and transformation, service management and outsourcing.

Helen Spice - Non- Executive Director
Audit, Risk & Assurance Committee Chair

Helen joined the Trust Board on 1 April 2021. Helen is an experienced finance professional with a 35-year career in the corporate, health and social care and not for profit sectors.

She has held a number of senior positions; most recently Helen was Chief Financial Officer of Turning Point, a social enterprise working with people to support their mental health, drug and alcohol use and people with a learning disability.

Helen is the security management NED champion and Chair of Audit, Risk & Assurance Committee

Other key Non-Executive Director changes in 2025:

- Lizzie Abderhim, Non-Executive Director left on 30 April 2025
- Chris Burton was appointed as Non-Executive Director on 3 November 2025
- Sandra Gordon was appointed as Non-Executive Director on 3 November 2025

Non-Executive Directors Terms of Officer as at 31 March 2026			
Name	**First Term**	**Second Term**	**Third Term**
Non-Executive Directors			
Liam Coleman (Chair)	01.02.19 – 31.01.22	01.02.22 – 31.01.25	01-02-25 –30-06-26
Helen Spice	01-04-21 – 31-03-24	01-04-24 – 31.03.27	
Faried Chopdat	01-04-21 – 31-03-24	01-04-24 – 31.03.27	
Claudia Paoloni	01.04.23 – 31.03.26 Extended 30-Jun-26*		
Bernie Morley	01.06.24 – 31.05.27		
Will Smart	01.04.23 – 31.03.26 Extended 30-Jun-26*		
Julian Duxfield	01.04.24 – 31.03.27		
Christopher Burton	03-11-25 – 02-10-28		
Sandra Gordon	03-11-25 – 02-10-28		
Associate Non-Executive Directors (Non-voting)			
Neil Clark	03-11-25 – 02-10-27		
Samaher Sueity	03-11-25 – 02-10-27		

**These terms of officer were extended by the Council of Governors to facilitate the recruitment of Group Non-Executive Directors moving into the Group model from 1 July 2026.*

Board meetings and committees

The Board supports the Nolan principles and makes the majority of its decisions in meetings open to the public. The Board met in public and in private eight times during 2025/26. It also held five informal board development sessions, two of which was a joint BSW Hospitals Group board to Board; this afforded the opportunity for the three Boards to build relationships and to discuss current and future plans.

The Board delegates some of its work to assurance committees. They receive a summary assurance report of these meetings. This helps the assurance committees to demonstrate a stronger audit trail of the work of their committee as well as steering their agenda in line with key risks (as identified in the board assurance framework and divisional risks). Further details of the Trust's audit committee, quality assurance committee and workforce assurance committee are contained later in this section. Attendance by directors at Board and assurance committee meetings is shown in the table below.

Committees of the Board during 2025/26

Each committee is chaired by a Non-Executive Director, ensuring independent oversight, scrutiny and constructive challenge. The terms of reference for each committee set out the committee's information requirements and how it should assess and interpret information in order to form a view on the level of assurance obtained. Where assurance cannot be robustly established, the Chair of the committee is required to escalate this to the Board of Directors.

Audit, Risk and Assurance Committee

The Audit, Risk and Assurance Committee provides independent assurance to the Board and the Accounting Officer on the adequacy and effectiveness of the Trust's systems of governance, risk management and internal control. The Committee oversees the work of Internal Audit, External Audit and Counter Fraud arrangements, reviews the Trust's risk management framework, and monitors the implementation of agreed management actions. The Committee also reviews the annual accounts, governance statement and accountability documents prior to recommendation for approval by the Board.

Remuneration Committee
The Remuneration Committee is responsible for determining the remuneration, allowances and contractual terms of Executive Directors, in line with national guidance and the Trust's Constitution. The Committee also oversees arrangements for severance and compensation, ensuring transparency, fairness and value for money.

Finance, Infrastructure and Digital Committee
The Finance, Infrastructure and Digital Committee supports the Board by providing oversight and assurance in relation to financial performance, financial planning, capital investment, estates and facilities, sustainability and digital performance. The Committee monitors delivery of the Trust's financial strategy and annual plan, oversees major capital and digital programmes, and reviews financial and infrastructure-related risks and mitigations prior to escalation to the Board where required.

Quality and Safety Committee
The Quality and Safety Committee provides assurance to the Board on the quality, safety and effectiveness of clinical services.. The Committee oversees clinical governance arrangements, patient safety, patient experience, safeguarding and regulatory compliance, and monitors progress against quality priorities and improvement programmes.

Performance, Population and Place Committee
The Performance, Population and Place Committee supports the Board by providing assurance on operational performance and delivery against the Trust's strategic objectives and annual plan, alongside oversight of the Trust's contribution to improving population health and reducing health inequalities. The Committee reviews performance against national and local targets, considers significant operational and population-level risks, and oversees partnership working at PLACE and Integrated Care System level. Matters requiring further scrutiny or action are escalated to the Board as appropriate.

Charitable Funds Committee
Meets at least four times a year to oversee the generation, management, investment and disbursement of charitable funds (Brighter Future) within the regulations required by the Charities Commission.

Trust Management Committee
The Trust Management Committee is an Executive committee that supports the Chief Executive in delivering the Trust's strategy, operational performance and organisational objectives. The Committee ensures coordination across the organisation and provides assurance that matters within delegated authority are being appropriately managed prior to escalation to the Board where required.

The Board is satisfied that the committee structure operated effectively during 2025/26 and provided appropriate scrutiny, challenge and assurance to support the Board in discharging its responsibilities.

Other Committees of the Board

Joint Committee
As part of the transition to a Group operating model, a joint committee was established at the beginning of 2025, comprising representatives from each of the constituent Trust Boards. The committee operates under formally agreed terms of reference and exercises specified functions delegated to it by each Board, while ultimate accountability continues to rest with the individual statutory Boards. The purpose of the joint committee is to support greater alignment, consistency and collaboration across the Group in areas where collective decision-making adds value, while preserving the sovereignty of each Trust and ensuring compliance with constitutional, statutory and regulatory requirements. The joint committee provides a monthly report to each Trust Board, ensuring transparency, oversight and effective assurance. The delegated arrangements are kept under regular review to ensure that the governance framework remains effective, proportionate and fit for purpose as the Group model continues to evolve.

Membership Attendance at meetings of the Board of Directors and Trust Committees

1 April 2025 – 31 March 2026

Committee Meeting	Trust Board	Audit, Risk & Assurance Committee	Quality & Safety Committee	Finance, Infrastructure & Digital Committee (FIDC)	People & Culture Committee	Performance, Population & Place Committee (PPPC)	Charitable Funds Committee	Remuneration Committee
Chair	**Liam Coleman**	**Helen Spice**	**Claudie Paoloni**	**Faried Chopdat**	**Julian Duxfield**	**Bernie Morley**	**Julian Duxfield**	**Liam Coleman**
Membership Attendance (actual/maximum)								
Non-Executive Directors								
Liam Coleman (Chair)	8/8	n/a	n/a	n/a	n/a	n/a	n/a	1/1
Chris Burton	3/4	n/a	¾	n/a	n/a	n/a	n/a	n/a
Faried Chopdat	6/8	4/4	n/a	11/12	4/5	n/a	n/a	1/1
Julian Duxfield	7/7	n/a	n/a	n/a	5/5	5/7	4/4	1/1
Sandra Gordon	4/4	n/a	n/a	n/a	1/1	n/a	n/a	n/a
Bernie Morley	7/8	n/a	12/12	n/a	n/a	7/7	4/4	0/1
Claudia Paoloni	8/8	3/4	11/12	n/a	n/a	n/a	n/a	1/1
Will Smart	7/8	4/4	n/a	10/12	n/a	n/a	4/4	1/1
Helen Spice	6/8	3/4	11/12	9/12	n/a	n/a	n/a	1/1
Executive Directors								
Cara Charles-Barks	7/8	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Kathyn Bateman	5/5	n/a	3/5	n/a	n/a	n/a	n/a	n/a
Emily Beardshall	7/7	n/a	n/a	11/11	n/a	4/5	2/3	n/a
Luisa Goddard	8/8	n/a	11/12	n/a	n/a	n/a	n/a	n/a
Jude Gray	6/8	n/a	n/a	n/a	4/5	n/a	n/a	n/a
Benny Goodman	8/8	n/a	n/a	9/12	n/a	5/7	n/a	n/a
Steve Haig	2/3	n/a	4/7	n/a	n/a	n/a	n/a	n/a
Jonathan Hinchliffe	7/8	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Claire Thompson	1/1	n/a	n/a	1/1	n/a	2/2	1/1	n/a
Simon Wade	6/8	n/a	n/a	11/12	n/a	n/a	3/3	n/a
Jon Westbrook	1/1	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Role and Responsibilities

The Audit, Risk and Assurance Committee supports the Board of Directors and the Accounting Officer by providing independent assurance on the effectiveness of the Trust's arrangements for governance, risk management, internal control and assurance.

On behalf of the Board, the Committee is responsible for:

- reviewing the Trust's systems of governance, risk management, internal control and assurance;
- monitoring the integrity of the annual financial statements and related reports, including consideration of significant financial reporting issues and areas of management judgement;
- approving and reviewing the programme and effectiveness of Internal Audit; and
- overseeing the Trust's relationship with its External Auditor, including auditor independence and objectivity.

Reporting to the Board

Throughout 2025/26, the Committee reported regularly to the Board of Directors on the nature and outcomes of its work through a Chair's Board Assurance Report following each Committee meeting. These reports highlighted any matters requiring the Board's attention or further action.

No Internal Audit reviews concluded during 2025/26 resulted in a limited assurance opinion.

The Committee promotes an open, constructive and transparent relationship with both Internal and External Audit. The Committee Chair met separately with both auditors in advance of each meeting to support independence, effective dialogue and robust assurance.

Internal Audit

During the year, the Committee was supported by the Internal Audit service, provided by KPMG LLP, which undertook a programme of independent reviews to evaluate the adequacy and effectiveness of the Trust's framework of governance, risk management and internal control.

Internal Audit findings were reported to the Committee, including assessments of key controls and recommendations for improvement where risks were identified. The table below shows the internal audit ratings for 2025/26:-

	Internal audit	Assurance rating	
09/24	DSP Toolkit (2024/25)	Significant assurance with minor improvement opportunities	
01/25	Artificial Intelligence	Advisory – no rating	
02/25	Patient Complaints	Partial assurance with improvements required	
03/25	Discharge	Significant assurance with minor improvement opportunities	
04/25	Management of IT Applications	Partial assurance with improvements required	
05/25	Financial Controls – General Ledger (GL) & Staff Lottery (SL)	Significant assurance with minor improvement opportunities (GL)	Partial assurance with improvements required (SL)
06/25	Training and Development	Partial assurance with improvements required	
07/25	Research Governance	Significant assurance with minor improvement opportunities	
08/25	BAF / Strategic Risk	Significant assurance with minor improvement opportunities	
09/25	DSP Toolkit (2025/26)	Significant assurance with minor improvement opportunities	

The Committee approved the Internal Audit plan for 2025/26 and received quarterly progress and action-tracking reports. Particular scrutiny was applied to any reviews identifying higher-risk findings, with the Committee requiring clear management action plans and assurance on implementation.

The Head of Internal Audit's Annual Opinion for 2025/26 provided an annual conclusion over four components aligned to the Global Internal Audit Standards (GIAS): governance; risk management and control; financial reporting and management; and data captured and used by the organisation.with the following conclusions:

Rating	Component	Overall Finding
Amber Green	Governance	Overall findings on design show some controls to be effectively designed with some exceptions. Testing showed some controls to be operating effectively and others could be more consistently applied.
Amber Green	Risk management and control	
Amber Green	Financial reporting and management	
Amber Red	Data captured and used by the organisation	Overall findings on design show some controls to be effectively designed with some exceptions. Testing showed the need to improve the operating effectiveness of controls

Actions arising from audit recommendations were monitored throughout the year. Improvements were progressed to strengthen systems and processes, including addressing issues identified in procurement and data quality reviews. Progress against agreed actions will continue to be monitored during 2026/27.

Counter Fraud Arrangements

The Trust has an established Anti-Fraud, Bribery and Corruption Policy, supported by access to the local Counter Fraud service provided by KPMG LLP. The Committee is responsible for satisfying itself that appropriate arrangements are in place to prevent, detect and respond to fraud, bribery and corruption.

The Committee received regular progress reports and an annual report from the Counter Fraud service during the year, providing assurance on activity, outcomes and emerging risks. Reviews undertaken during 2025/26, including work on job planning & rostering – Radiology and Pathology; recruitment; core financial systems and research governance. There were no high-risk areas of concern identified.

External audit

Deloitte continued as the Trust's External Auditor and attended all Committee meetings as required. The Committee reviewed and agreed the External Audit Plan for 2025/26 and considered progress and interim findings throughout the year.

All significant matters arising from External Audit work were discussed by the Committee, with management responses reviewed and, where appropriate, actions taken to strengthen controls.

The Committee also reviewed External Audit fees, the scope of work undertaken, and confirmed that no material non-audit services were provided during the year that could compromise auditor independence. The effectiveness, objectivity and independence of External Audit were kept under review.

The Independent Auditor's Report forms part of the Annual Report and Accounts.

Composition of the Audit, Risk & Assurance Committee

The Audit, Risk & Assurance Committee operates in accordance with the terms of reference agreed by the Board. It has met on four occasions in 2025/26.

The Committee membership comprises solely of Non-Executive Directors, including one with “recent and relevant financial experience”. The Chair of Audit, Risk & Assurance Committee is a qualified accountant.

Member (Name & Designation)	Attendance Rate
Helen Spice, Non-Executive Director (Chair)	3/4
Faried Chopdat, Non-Executive Director	4/4
Claudia Paoloni, Non-Executive Director	3/4
Will Smart, Non-Executive Director	4/4

In addition to the above members, standing invitations are extended to the Chief Financial Officer, Company Secretary, the Chief Executive (for specific items), Internal Auditors, External Auditors, Local Counter Fraud Specialist and Deputy Chief Financial Officer. Other officers of the Trust may be invited to the Committee to answer any points which may arise.

Committee Activity during the Year

The Committee considered a wide range of matters during 2025/26, including:

- Internal and External Audit plans, progress reports and findings;
- review of divisional and corporate risk management arrangements;
- oversight of financial processes, losses and special payments;
- consideration of financial reporting and annual governance documents;
- cyber security, information governance and data quality assurance;
- review of the Board Assurance Framework and principal risks;
- monitoring of counter fraud activity and reporting culture.

The Committee operated to a rolling work programme, reviewed regularly by the Chair to ensure all statutory and governance responsibilities were discharged effectively.

Effectiveness and Forward Look

The effectiveness of the Audit, Risk and Assurance Committee was reviewed during the year, and the Board is satisfied that the Committee functioned effectively and provided appropriate assurance to support informed decision-making.

Looking ahead to 2026/27, the Committee will continue to focus on emerging risks and opportunities associated with the development of the BSW Hospitals Group, ensuring that governance, risk management and control arrangements remain robust and fit for purpose.

Stakeholder Relationships

Oxford University Hospitals NHS Foundation Trust

Our partnership with Oxford University Hospitals NHS Foundation Trust (OUH) has been successful and work was completed in 2022 on the Swindon Radiotherapy Centre, an OUH-run service on the Great Western Hospital site. This partnership delivers real benefits for patients who would otherwise have had to travel from Swindon to Oxford to receive radiotherapy.

Increasingly we are also looking to develop and strengthen relationships with other organisations outside of the health and care sector who we recognise we can work with to improve both health outcomes and life chances for people within our community.

Clinical Networks

We work in partnership at place (Swindon Integrated Care Alliance) and at system (BSW Integrated Care System and our provider collaborative, the Acute Hospital Alliance (now BSW Hospitals Group), we are also part of regional or sub-regional partnerships. These nationally mandated clinical networks are of growing importance, as NHS England seeks to promote equity, drive out unwarranted clinical variation and ensure sustainability of more specialist services through operation at scale. The following table outlines the clinical networks GWH are part of:-

Collaboration	Footprint
Major Trauma Network (Adult)	Severn Region
South West Critical Care Network	Peninsular and Severn
South West Paediatric Critical Care Network	Peninsular and Severn
South West neonatal network	South West England
South West & South Wales Congenital Heart Disease Network	South West England & South Wales
Severn Spinal Network	Severn Region
Surgery in Children ODN	Peninsular and Severn
Radiotherapy	Oxford/Swindon
South paediatric neurosciences ODN	Southwest, Thames Valley & Wessex
Pathology network	South 4
Imaging Network	West of England
Thames Valley Cancer Alliance	Thames Valley

Health and Overview Scrutiny Committees (HOSCs)

HOSCs (known as the Adults' Health, Adults' Care and Housing in Swindon and the Health Select Committee in Wiltshire) are a statutory function of Local Authorities comprising elected representatives whose role it is to scrutinise decisions and changes that impact on health services in the area. In 2025/26 the Chief Executive, or a deputy, attended each of the Swindon meetings to present the key issues relating to the Trust.

Local Healthwatch organisations

We continue to engage with the local Healthwatch organisations in the Trust's geographical area and in particular for Swindon and Wiltshire.

Public and patient involvement activities

There were no formal public or stakeholder consultations in 2025/26.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or valid invoice, whichever is later.

There has been a marked improvement in the Better Payment Practice Code deliverables in relation to NHS Payables over the year. This follows on from the work to tightly manage cash, ensure sufficient funds are available and to improve the payment of creditors as they fall due in order to ensure the ongoing continuation of services.

Non-NHS Payables	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Total non-NHS trade invoices paid in the year	68,751	321,680	66,127	318,499
Total non-NHS trade invoices paid within target	65,316	311899	62,171	304,915
Percentage of non-NHS trade invoices paid within target	95.0%	97.0%	94.0%	95.7%
NHS Payables				
Total NHS trade invoices paid in the year	2,009	19,230	1,594	15,709
Total NHS trade invoices paid within target	1,545	15,306	1,183	10,662
Percentage of NHS trade invoices paid within target	76.9%	79.6%	74.2%	67.9%

Council of Governors

The Council of Governors (CoG) is comprised of elected and appointed Governors who represent the interests of the Trust's members, patients and the wider public. The Council plays a key role within the NHS Foundation Trust governance framework, holding the Board of Directors to account, principally through the Non-Executive Directors, and ensuring that the Trust remains accountable to the communities it serves.

As a statutory body, the Council of Governors has an important role in influencing the development of services so that they meet the needs of patients, members and the local population. The Council supports the Trust in ensuring that these needs and perspectives are appropriately reflected in strategic decision-making and service planning.

At the end of 2025/26, the Council of Governors comprised 16 Governor seats, including:

- 10 public Governors, representing the public constituencies;
- 3 staff Governors, representing the staff constituencies;
- 1 appointed Governors, nominated by partner organisations (New College Swindon); and
- 2 Local Authority Governors, representing Swindon and Wiltshire.

The Trust Chair also serves as Chair of the Council of Governors, and the Chief Executive normally attends formal meetings. Other Executive Directors, Non-Executive Directors and senior managers attend as appropriate, depending on the matters under consideration. Many Governors dedicate significant additional time outside of formal meetings, including participation in working groups and engagement activity, to effectively represent the views of their constituencies.

Recognising the importance and responsibility of the Governor role, the Trust has established a structured induction programme to support Governors in developing a clear understanding of their statutory duties and the governance framework within which they operate. This is complemented by an ongoing Governor development programme, including internally delivered training, access to external development opportunities and a comprehensive Governor Handbook.

Role of the Council of Governors
The Council of Governors holds the Board of Directors to account for the performance of the Trust and represents the interests of the Trust's members and the public. In doing so, the Council supports the Board's commitment to delivering high-quality services and improving patient experience.

The Council also plays an important role in influencing the Trust's strategic direction, ensuring that the views of members, the local community and key stakeholders are considered in the development and delivery of the Trust's strategy.

In accordance with its statutory responsibilities, the Council of Governors is responsible for:

- holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors;
- appointing and, where appropriate, removing the Chair and Non-Executive Directors;
- appointing or removing the Trust's External Auditors;
- approving significant transactions; and
- approving amendments to the Trust's Constitution.

During the year, the Council of Governors fulfilled its statutory duties by canvassing the views of Trust members, the public and, where applicable, the organisations they represent on the Trust's forward plan, including its objectives, priorities and strategy, and formally communicating these views to the Board of Directors to inform its decision-making.

Elections

The Governor election process takes place between August and October each year, when required, with each Governor serving a three-year term of office.

The number of public Governor positions must be more than half of the total membership of the Council of Governors.

The constituencies are periodically reviewed to ensure they reflect the Trust's geographical area and populations.

Governors are elected by members of those constituencies in accordance with the election rules stated in the Trust's Constitution using the "first past the post" voting system. Elections are carried out on behalf of the Trust by an independent organisation, Civica Electoral Reform Services Ltd. In the event of an elected governor's seat falling vacant for any reason before the end of a term of office, it shall be filled by the second (or third) place candidate in the last held election for that seat provided they achieved at least five percent of the vote and they will be known as reserve governors.

All elected Governors have a three-year term of office. The last elections for appointment as an elected Governor was completed in November 2025.

The 2025 governor election process commenced in August 2025 with scheduled pre-election workshops to support those wishing to nominate themselves by providing more information about the role of a Governor, the commitment and opportunities available, and an overview of the election process. The 2025 Election saw seven public governor vacancies and three staff governor vacancies.

Public governors elected:

- Swindon — Raana Bodman (re-elected)
  Ashish Channawar (re-elected)
  Vivien Coppen (re-elected) resigned January 2026 due to constituency move, replaced by Tim Poole in February 2026
  Lesley Hemmingway (re-elected)
  Mary Day
  Gordon Wilson
  Leanne Stevenson
- Wiltshire Northern — Chandra Verma
  Sarah Marshall resigned March 2026

Staff governor elected

- Administrators, Maintenance, Auxiliary & Volunteers — Chris Shepherd (re-elected)
- Hospital Nursing & Therapy — Harrison Darley
- Doctors & Dentists — Vacancy

Committees and working groups

The Council of Governors has one formal Committee, Nominations & Remuneration Committee and three working groups. Each Council Committee is made up of public, nominated and staff Governors, with Governor Chairs being formally agreed at a formal council meeting. As part of continued development, Governors periodically rotate their membership of committees. The Trust Chair chairs the Nomination and Remuneration Committee.

Nominations and Remuneration Committee : The Committee is responsible for advising and / or making recommendations to the Council of Governors relating to:

- the evaluation of the performance of the Chair and Non-Executives Directors;
- the remuneration, allowances and other terms and conditions of the Chair and Non- Executives Directors; and to
- determine and direct the process for recruitment, re-appointment, or removal of the office of Chair and other Non-Executive Directors.

Engagement and Membership Working Group : The remit of the Engagement & Membership Working Group is to concentrate on supporting the Council of Governors in fulfilling its duty to engage with and represent Trust members, including staff and the public. There has been a significant amount of work undertaken to enhance the Trust's membership agenda, which has included continued focus on membership recruitment, with the implementation of two membership coffee mornings with dedicated presentations and interaction with both the Falls Team and Tissue Viability. The new Trust's Membership Development Strategy 2026 – 2029 has also been aligned to the new key objectives and is due for approval and implementation in Q4 of 2026. The actions that sit under the strategy are reviewed regularly by the group.

People's Experience & Quality Working Group : The primary remit of the People's Experience & Quality Working Group is to gain assurance that feedback gained by the Trust from quality visits, complaints and PALS support improvements across the Trust and that Non-Executive Directors address areas of concern relating to quality of patient care and staff experience. It will highlight any issues to the Council of Governors which require further information or are of concern which should be drawn to the attention of the Board.

Business & Planning Working Group : The primary remit of the Business & Planning Working Group is to identify key issues to address in relation to Trust finances and business planning and to highlight any issues to the Council of Governors which require further information or are of concern which should be drawn to the attention of the Board.

Board and Council Engagement

The Trust Chair serves as Chair of both the Board of Directors and the Council of Governors, providing a clear and formal link between the two statutory bodies. To support transparency and effective engagement, both Executive and Non-Executive Directors are invited to attend formal meetings of the Council of Governors.

To enable Governors to fulfil their role in holding the Board to account, the Council of Governors receives regular updates on progress against the Trust's Strategy and Business Plan, together with key communications from system partners, at quarterly meetings. Governors are also encouraged to attend the Trust Board's monthly meetings held in public, providing visibility of how Non-Executive Directors challenge and scrutinise the Executive Team.

Non-Executive Directors attend all meetings of the Council of Governors and its working groups and provide assurance to Governors on how they have held the Executive to account and reviewed organisational performance. While Executive Directors are not required to attend every Council meeting, the Chief Executive and other Executive Directors routinely attend to provide information, respond to questions and support effective engagement. The Chair works closely with the Lead Governor to review and progress relevant matters between meetings.

A standing agenda item at each Board meeting enables the Chair to report formally on matters raised by the Council of Governors and on the Council's activities and discussions, ensuring effective two-way communication and accountability.

In the event of a dispute between the Council of Governors and the Board of Directors, the dispute resolution process set out in the Trust's Constitution would be followed. This process has not been required. Governors may also raise concerns at any time through any Director of the Trust or via the Company Secretary, who maintains a formal record of Governor enquiries.

Regular opportunities are provided for Governors to meet with Directors, including formal meetings between Non-Executive Directors and Governors, as well as informal engagement with the Chair or Senior Independent Director. Governors also meet independently as a body four times each year to support collective working.

Effective information flow between the Board of Directors, the Council of Governors and its working groups is recognised as an essential component of good governance. Clear cycles of business, supported by forward plans approved by the Council of Governors, ensure that information is shared in a timely and structured manner and that respective responsibilities are discharged effectively.

Declaration of interests

All Governors have a responsibility to declare relevant interest as defined in our Constitution. These declarations are made to the Company Secretary and are subsequently entered into a register. The register is available on request from the Company Secretary.

Council of Governor meetings

There were 7 meetings of the Council of Governors in 2025/26, which included 1 extraordinary meeting and a circular approval :-

Date	Meeting
16 April 2025	Council of Governors
17 June 2025	Council of Governors
29 September 2025	Council Circular Appointment of NEDs and ADNEDs
07 October 2025	Annual Members

Date	Meeting
25 November 2025	Council of Governors
05 March 2025	Council of Governors
13 March 2026	Council of Governors – Extraordinary meeting to Support Group NED Model

A forward plan, detailing the cycle of business for the Council, is prepared in line with the Board of Director's business and development programme to ensure consistency of reporting and to enable Governors to input into the development of Trust strategies. Decisions and matters undertaken by the Council include the appointment of the external auditors, the appointment of Non-Executive Directors and formal receipt of the Trust's Annual Report and Accounts. The Trust also maintains a formal policy for the resolution of disagreements between the Council of Governors and Board of Directors.

Training and Development

The S151(5)of the Health and Social Care Act Health 2012 requires training of governors to ensure they are equipped with the skills and knowledge they need to undertake their role. The following table summarises the training and learning outcomes in 2024/25.

Learning outcomes : 1 – Knowledge of our Trust / 2 – Learning about specific services / 3 – Knowledge and skills for the Governor Role / 4 – Networking Opportunities / Benchmarking / other organisations / 5 – Corporate Induction /6 – Specific skills

Development & Insight Activities that assist in the development, understanding and knowledge of the Trust	**Date Provided**	**Learning Outcome**
Public Lectures		
Supporting Teens / ADHD/ Autism	21 May 2025	1 & 2
Health & Wellbeing	4 November 2025	
Carers in GWH	28 January 2026	
Governor Board Visits		
Dove / Trauma	20 April 2026	1 & 2 & 3
ENT	29 April 2026	
Council of Governor Meeting Presentations		
System Plan 2025/26 Strategy and Community Transfer Quality Account Priorities 2025/26	16 April 2025	1 & 2
Staff Survey CQC visits update BSW Joint Chair Role approval	17 June 2025	
NED recruitment approval	29 September 2025	
PFI Expiry CQC visit update Elections BSW Hospitals Group Joint Committee Briefing Decisions made via CoG circular	25 November 2025	
Quality Accounts BSW Group update	05 March 2026	
Group NED model	13 March 2026	
BSW Joint Nomination Committee		
Agree SID, ToR for committee	15 July 2025	1&2
Procurement Process of External Recruitment approval	04 September 2025	
Agree Recruitment Process for BSW Hospitals Chair (interim)	13 February 2026	
Review Interim Group Chair Candidates	18 February 2026	

Interview outcome Group Chair	09 March 2026	
Approve ToR & Group NED recruitment process approval	20 March 2026	
BSW Hospitals Group Council of Governors		
Development and Group Discussion	05 August 2025	1&2
	01 October 2025	
	21 October 2025	
	02 December 2025	
	03 February 2026	
Business & Planning Working Group – discussion topics at meetings		
Finance Board Report and FDIC Risk reports	All meetings	1 & 2
People's Experience & Quality Working Group - discussion topics at meetings		
Falls update Quality Account Priorities update	09 June 2025	1 & 2
Get Connected update EPR update Negligence & Compensation Process in GWH Patient Safety – Board visits	10 September 2025	
Martha's Rule	03 December 2025	
EPR update	18 March 2026	
Others		
Governwell – Introduction to the role of governor - zoom	23 October 2025	
Governor Focus Conference – zoom	5 June 2025	
In-house Finance Training	10 June 2025	
National Armed Forces Update	10 November 2025	
Governwell Induction	4 December 2025	
Governwell Induction	25 March 2026	
Governwell webinar – What the 10 year healthplan means for your governors	3 March 2026	
Learning from Deaths meetings	Quarterly	
Integrated Care Partnership & Board meeting	29 July 2025	
Member Coffee mornings	14 July 2025 17 March 2026	

The Governors were also involved in:-

- Annual reviews of the Trust Chair and Non-Executive Directors performance
- Considered and approved the approach in the recruitment of the Group Joint Chair role
- Holding the Non-Executive Directors to account on a number of issues such as recovery plans, financial management, site development.
- Considered the Quality Account's quality indictors
- Input views and observations into the developments of the new GWH Trust Strategy 'local strategic direction 2025 – 2028 and planning 2025/26
- The Lead Governor & Deputy Lead Governor met with the Lead Governors of the other two acute trusts in the BSW Hospitals Group to develop relationships and share best practice
- Received the Trust's Annual Report and Accounts at the Annual Members Meeting on 7 October 2025.

In 2025/26 the Council of Governors did not exercise its power to require one or more of the Directors to attend a Governors' meeting for the purpose of obtaining information about the Foundations Trust's performance of its function or the Directors' performance of their duties.

Council of Governor's Composition and Attendance 2025/26

Governor	Constituency	Number of Terms	Current Term of Office (date ending)	Attendance Council of Governor meetings
Public Constituencies – Elected Governors				
Ashish Channawar	Swindon	3	3 years (re-elected term ends Nov-28)	3/5
Mary Day	Swindon	1	3 years (term ends Nov-28)	2/3
Tim Poole	Swindon	1	3 years (term ends Nov-28)	2/2
Leanne Stevenson	Swindon	1	3 years (term ends Nov-28)	1/3
Gordon Wilson	Swindon	1	3 years (term ends Nov-28)	3/3
Raana Bodman	Swindon	2	3 years (re-elected term ends Nov-28)	2/5
Lesley Hemingway	Swindon	2	3 years *(term ends Nov-28)*	5/5
Chris Callow	Central Wiltshire	2	3 years *(term ends Nov-25)*	5/5
Sarah Marshall (until March 26)	Wiltshire Northern	1	3 years (*term ends Nov-27)*	3/5
Chandra Verma	Wiltshire Northern	1	3 years *(term ends Nov-28)*	1/3
Vivien Coppen (until Jan 26)	Swindon	2	3 years *(term ends Nov-28)*	3/3
Stephen Baldwin	West Berks & Oxford	1	3 years (*term ends Nov-27)*	3/5
Staff Constituency – Elected Governors				
Chris Shepherd	Administrators, Maintenance, Auxiliary & Volunteers	3	3 years *(re-elected term ends Nov-28)*	4/5
Caroline Borishade	Allied Health Professionals	1	3 year term *(ending Nov-27)*	0/5
Harrison Darley	Hospital Nursing and Therapy Staff	1	3 year term *(ending Nov-28)*	4/4
Vacancy	Doctors & Dentists			
External Stakeholders - Appointed Governors				
Leah Palmer	New College, Swindon	2	3 year term *(ending Jan-29)*	2/5
Ray Ballman	Local Authority – Swindon Borough Council	1	Term ends May 2026	0/5
Sam Pearce-Kearney	Local Authority – Wiltshire Council	2	3 year term *(ending Jul 27)*	4/25

As at 31 March 2025 vacancies remained as follows:-
Wiltshire Northern – 1 seat
Wiltshire Central & Southern – 1 seat
Rest of England & Wales – 1 seat
Doctors & Dentists – 1 seat

Director attendance at Council of Governor Meetings 2025/26

The Board of Directors and Council of Governors seek to work together effectively. During the year the Non-Executive Directors and Chief Executive attend meetings of the Council of Governors and the table below shows

the attendance at those meetings. The Executive Directors are invited to attend as observers and take part when further information is required. The Company Secretary is also in attendance.

Attendees at Council of Governors (Non-Executive Directors)	Attendance from 3 Council of Governor meetings
Liam Coleman (Chair)	5/5
Lizzie Abderrahim	1/2
Faried Chopdat	2/4
Claudia Paoloni	1/4
Helen Spice	4/4
Will Smart	4/4
Julian Duxfield	0/4
Bernie Morley	4/4
Chris Burton	2/2
Samaher Sweity	1/2
Neil Clark	2/2
Sandra Gordon	1/2
Attendees at Council of Governors (other)	
Caroline Coles (Company Secretary)	5/5

Lead and Deputy Lead Governors

The Lead Governor and Deputy Lead Governor in place during 2025/26 were:

Lead Governor :
Natalie Titcombe (April to October 2025)
Chris Callow (November 2025 to present)

Deputy Lead Governor :
Chris Callow (April to October 2025)
Vivien Coppen(November 2025 to January 2026)
Stephen Baldwin (January 2026 to present)

The Lead Governor is responsible for receiving from Governors and communicating to the Chair any comments, observations and concerns expressed by Governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business. The Deputy Lead Governor is responsible for supporting the Lead Governor in their role and for performing the responsibilities of the Lead Governor if they are unavailable. The Lead Governors regularly meets with the Chair of the Trust both formally and informally. In addition, the Lead Governor communicates with other Governors by way of regular email correspondence and Governor only sessions.

Biography of individual Governors

A biography of each Governor is included on the Trust's website.

Membership

The Trust's membership comprises public and staff members, as well as affiliates or stakeholder groups. To become a public member and/ or a governor, you must be at least 16 years of age. Colleagues employed by the Trust are automatically opted into membership when they join. Governors also play a role in engaging with Trust members to discharge their responsibility to represent the views and interests of members.

Members can only be a member of one constituency; therefore local people and patients can only be a member of one public constituency. Staff can only be members of one sub-class in the staff constituency. Members are able to vote and stand in elections for the Council of Governors provided they are 18 years old and over.

In October 2025, all Members were invited to the virtual Annual Members' Meeting to hear about the Trust's performance during the year and receive the Annual Report and Accounts. We communicate and engage with members, patients, carers and the public regularly and use a variety of channels to do that. These include:

- Great Western Hospitals NHS Foundation Trust website
- E-communications
- Social Media – Twitter, Facebook
- 'Meet your Governor' events – Public Health Talks, Member coffee morning
- WI Talks
- Annual Members' Meetings

Membership Figures

Being a member of our Foundation Trust gives local people opportunities to become involved and have their say in how our services are developed.

Staff numbers are refreshed quarterly, the last refresh took place on 21 April 2026.

Total Number of Members across all Constituencies	2024/25	2025/26
Swindon	2731	2587
North Wiltshire	1023	993
Central & Southern Wiltshire	614	583
West Berkshire and Oxfordshire,	612	321
Out of Trust Area	5	5
Rest of England and Wales	625	281
Staff	6,992	6,527
TOTAL	**11,990**	**11,297**

Public Constituency	2024/25	2025/26
At year start (1 April)	5,054	4,998
New Members	90	65
Members leaving	146	293
At year end (31 March)	4,998	4,770

This shows a decrease in public members of 293, a combination of deceased and database refresh.

Staff Constituency	2024/25	2025/26
At year start (1 April)	6.840	6,992
At year end (31 March)	**6,992**	**6,527**

Numbers of members by age ethnicity and gender

The groupings of the members in the public constituency are as follows:

Age	Public 2025/26	Staff 2025/26	Total 2025/26
0-16	0	0	0
17-21	101	27	38

Age	Public 2025/26	Staff 2025/26	Total 2025/26
22+	4719	6500	11219
Unknown	40	0	40
Total	**4,770**	**6,527**	11,297

Ethnicity	Public 2025/26	Staff 2025/26	Total 2025/26
White	2,681	6	2,687
Mixed	30	1	31
Asian or Asian British	251	6	257
Black or Black British	48	2	51
Other	25	0	25
Unknown	1734	6512	8,246
Total	**4,770**	**6,527**	**11,297**
Gender	**Public 2025/26**	**Staff 2025/26**	**Total 2025/26**
Male	1,606	143	1,749
Female	2,671	860	3531
Unspecified	491	5,524	6,015
Transgender	2	0	2
Total	**4,770**	**6,527**	**11,296**

The Trust uses information from the Office of National Statistics (Census 2012) to build up a picture of the population size and ethnicity for each constituency. This helps the Trust in its aims to make the membership reflective of its population. The Trust has also determined the socio-economic breakdown of its membership and the population from its catchment area.

Membership Strategy

To encourage membership, the Trust has in place a Membership Strategy to ensure that it reflects the needs of the members. The Membership Strategy's has been under review in 2025/26 and will be approved in Q3 2026/27.

The Council of Governors has established a sub-group, known as the Engagement & Membership Working Group, which aims to increase and promote membership. The group meets quarterly and deliberates mechanisms to increase membership, as well as how to market membership, including tangible benefits that can be offered, and monitor the action plans to deliver the Membership Strategy.

Membership recruitment proposed for 2026/27

We are confident we will maintain member numbers and we will continue to communicate key information to all our members when required.

Our first face to face member/governor coffee morning was successful and there are plans to run further themed sessions

Contacting the Governors and Directors

If any constituency member or member of the public generally wishes to communicate with a Governor or a Director, they can do so by emailing the Foundation Trust email address: foundation.trust@gwh.nhs.uk. This email address is checked daily by the Membership & Governance Administrator who will forward the email to the correct Governor and/or Director. Alternatively, a message can be left for a Governor by ringing the Membership & Governance Administrator on 01793 604185 or for a Director by ringing the Company Secretary on 01793 605171

or by sending a letter to: Company Secretary, the Great Western Hospital, FREEPOST (RRKZ-KAYR-YRRU), Swindon, SN3 6BB.

Statement as to disclosures to auditors

For each individual Director, so far as the Director is aware, there is no relevant information of which the Great Western Hospitals NHS Foundation Trust's auditor is unaware and that each Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Great Western Hospitals NHS Foundation Trust's auditor is aware of that information.

Relevant audit information means information needed by the auditor in connection with preparing their report. In taking all steps the Directors have made such enquiries of their fellow Directors and of the Trust's auditors for that purpose and they have taken such other steps for that purpose as are required by their duty as a Director of the Trust to exercise reasonable care, skill and diligence. This confirmation is given and should be interpreted in accordance with the provisions of s418 of the Companies Act 2006.

Income disclosures
The income the Trust receives from the provision of goods and services for the purposes other than health care does not exceed the income it receives from the provision of goods and services for the provision of health.

Other income
Other income totals £41.3m (2024/25, £34.3m) and includes income received for non-patient related activities. It includes income received for
* education and training for clinical staff £20.1m (2024/25, £19.6m),
* research and development £1.0m (2024/25, £0.9m),
* car parking income, pharmacy sales and accommodation £2.8m (2024/25, £2.7m),
* income from charitable fund incoming resources £0.5m (2024/25 £0.6m),
* income from services provided to other organisations £9.7m (2024/25, £4.1m) and
* £7.2m other is derived from services provided in support of health care (2024/25, £6.4m).

Accounting policies for pensions and other retirement benefits
Accounting policies for pensions and other retirement benefits are set out in Note 9 to the accounts and details of senior employees' remuneration can be found in the Remuneration Report.

Cost allocation and charging requirements
The Trust has complied with the cost allocation and charging requirement set out in HM Treasury and Office of Public Sector Information Guidance.

Political donations
There were no political donations during 2025/26 (nil in 2024/25).

Cara Charles-Barks
Chief Executive Officer
Date: 25 June 2026

5 REMUNERATION REPORT

The remuneration report describes how the Trust has applied the principles of good corporate governance in relation to directors' remuneration as required by the Companies Act 2006, Regulation 11 and the code of governance for NHS provider Trusts.

The Remuneration Committee acts with delegated authority from the Board of Directors on all matters relating to the recruitment, remuneration, allowances and other terms and conditions of service of the Chief Executive and Executive Directors. The Committee operates within approved terms of reference and in accordance with relevant national guidance and contractual arrangements.

All Directors of the Trust are subject to an annual performance review. This includes the setting and agreement of clear objectives for a twelve-month period from 1 April to 31 March. Performance against these objectives forms part of the Committee's consideration of remuneration and professional development.

Details of salary, allowances, pension entitlements and other benefits for Directors are disclosed in the statutory tables of salaries and pension benefits included within this section of the Annual Report. Remuneration for Non-Executive Directors is also disclosed in this section and within the Full Statutory Accounts.

Membership of Remuneration Committee

During 2025/26, the membership of the Remuneration Committee comprised:

- the Trust Chair (who serves as Chair of the Committee);
- all Non-Executive Directors and Associate Non-Executive Directors; and
- the Chief Executive, except when their own remuneration or terms and conditions were under consideration

The Chief People Officer attends meetings in an advisory capacity, providing expert workforce and reward advice, and the Company Secretary attends to support governance arrangements and maintain an accurate record of proceedings.

Role of the Remuneration Committee

The Remuneration Committee is responsible for identifying suitable candidates for appointment as Executive Directors, including the Chief Executive, and for determining appropriate remuneration, contractual terms and conditions of service. In doing so, the Committee ensures that Executive Directors are rewarded fairly and responsibly for their individual contribution, having due regard to the Trust's performance, financial position and affordability, and to relevant national pay frameworks.

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The Committee's responsibilities include consideration of:

- all elements of remuneration, including salary and any performance-related arrangements;
- pension provision and other benefits;
- contractual terms, including arrangements for termination of employment and severance, with due consideration of associated risks.
  has regard for each individual's performance and contribution to the Trust and the performance of the Trust itself;

- takes into account benchmark information relating to the remuneration of Executive Directors;
- seeks professional advice from the Chief People Officer; and
- complies with the Public Sector Equality Duty under the Equality Act 2010 with equality and diversity requirements of the NHS Constitution and Care Quality Commission and the standards set within the Trust Equality, Diversity and Inclusion Policy Inclusion Policy

Group Arrangements

In 2025/26, reflecting the development of the BSW Hospitals Group model, the Remuneration Committees of the three acute Trusts within the Group operated as Remuneration Committees-in-Common. This arrangement supported aligned decision making in relation to the appointment and remuneration of shared executive roles, while ensuring that each Trust continued to meet its individual statutory, governance and accountability responsibilities.

The work undertaken through these arrangements is described further in the Annual Statement of the Remuneration Committee Report.

Attendance at Remuneration Committee meetings

During 2025/26 the Remuneration Committee met on six occasions; one as GWH Remuneration Committee, and 5 times as BSW Group Hospitals Remuneration Committees-in-Common*.

Record of attendance at each meeting
(✓ = attended ✗ = did not attend n/a = was not a member)

2025	**GWH**
Members Name	**30-Jul**
Non-Executive Director	
Liam Coleman (Chair)	✓
Faried Chopdat	✓
Julian Duxfield	✓
Claudia Paoloni	✓
Helen Spice	✓
Bernie Morley	✗
Will Smart	✓
Executive Directors	
Cara Charles-Barks	✓
Simon Wade, Acting MD	✓
In attendance	
Chief People Officer	✓
Company Secretary	✓

*All formal meetings of the Remuneration Committees-in-Common during the year were quorate for each participating Trust. Where meetings could not be convened and a decision was time critical, the Committees agreed to take decisions by written circulation in accordance with the approved Terms of Reference. Decisions taken in this way were supported by full papers, confirmed by a quorum of members from each Trust, and subsequently noted to ensure a complete audit trail.

Remuneration of very senior managers (Executive and Non-Voting Board Directors)

The definition of 'very senior managers (VSM)' is "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust". At the Trust this includes the Executive Directors (voting and non-voting).

The Trust does not have a variable pay scheme for Executive Directors. Instead, each is paid a basic salary.

In 2025/26 the Remuneration Committee undertook its annual review of remuneration of Executive and non-voting Board Directors. The Remuneration Committee wishes to ensure that Directors' remuneration reflects current market levels, thus enabling the Trust to continue to recruit and retain high calibre Directors. The annual remuneration review was conducted in July 2025 and the Committee approved the recommended pay award of 3.5% to VSM in line with the recommendation from NHS England.

Pension - The pension and other benefits for Executive and Non-Voting Board Directors is payable according to the NHS Pension Scheme and the Trust's Expenses Policy.

Claw back - Provisions for the recovery of sums paid to Directors, i.e. claw back provisions, are included in Executive and Non-Voting Board Directors contracts.

Earn back – Provision has been introduced to VSM contracts whereby 10% of the salary will be placed at risk, pending an annual review of individual performance against objectives.

Policy - The difference between the Trust's policy on very senior manager's remuneration and its general policy on employee's remuneration is that the Executive and Non-Voting Board Directors are on spot salaries whereas the rest of the organisation is on a pay scale with increments.

In considering Executive and Non-Voting Board Directors (VSM) pay, the margins in pay between senior manager and VSM pay were also taken into account. There was no consultation with employees when preparing the Executive and Non-Voting Board Directors remuneration policy.

Service contract obligations

There are no service contract obligations.

Performance of very senior managers

The appraisal process for the Chief Executive and Executive Directors involves an annual review of the objectives set and performance against those objectives. These are agreed by the Trust Chair and Manging Director respectively and reported through the Remuneration Committee. The Committee receives a summary report from the Manging Director into the performance of each Executive Director. This review was conducted at its meeting on 30 July 2025.

Board of Directors' employment / engagement terms

Executive Directors
The Chief Executive and the other Executive Directors are appointed by the Non-Executive Directors, this is undertaken by the Remuneration Committee, and that the appointment of the Chief Executive requires the approval of the Council of Governors.

The Chief Executive and Executive Directors have a contract with no time limit and the contract can be terminated by either party with six months' notice as per NHS Employers standard Director contract. These contracts are subject to usual employment legislation. Executive Director contracts include claw back clauses for any variable payment and fit and proper person disqualification provisions.

Non-Executive Directors
The Non-Executive Directors, including the Trust Chair, are nominated for appointment by a Nominations & Remuneration Committee consisting of Governors. The Council of Governors approves the Chief Executive and Non-Executive Director appointments, including the Trust Chair.

The term of office for non-executive directors at the Trust is 3 years (to a maximum of 9 consecutive years). Non-executive director reappointments are managed in accordance with NHS England's code of governance, i.e., any term beyond six years (two three-year terms) will be subject to rigorous review and subject to annual reappointment. The term of each non-executive director is included in the Directors Report.

The process for the removal of the chair or non-executive director will be in accordance with the Trust's constitution. Any proposal for removal must be proposed by a governor and

The Trust's Constitution sets out the circumstances under which any Board Director may be disqualified from office. The policy for loss of office payment is that the Trust would normally pay no more than contractual notice period. Any exceptions would be considered at the Remuneration Committee on a case by case basis.

The Trust is mindful of a broad range of factors in setting their approach to recruitment including the equality, diversity and inclusion agenda.

Very senior managers with additional duties

The following Remuneration table disclose the single total figure of remuneration for each person occupying a Director post. This includes all remuneration paid by the Trust to the individual in respect of their service for the Trust, including remuneration for duties that are not part of their management role.

Note that the element of remuneration from the Trust which relates to any clinical role is included. Where any individual received part of their remuneration from another body, the Trust's share of the individual's remuneration is listed only.

Group Director remuneration arrangements
Group Directors are employed under joint arrangements across the BSW Hospitals Group. Where an individual undertakes a Group-level role, their remuneration is apportioned and charged across the three participating foundation trusts in line with agreed cost-sharing arrangements which is 30 (SFT) / 35 (GWH)/ 35 (RUH) split. Each Trust discloses only the proportion of remuneration that relates to services provided to that Trust during the financial year. The total remuneration paid to each individual across the Group is determined in accordance with the NHS Very Senior Manager Pay Framework and relevant local approvals.

Remuneration of Non-Executive Directors

A governor Nominations and Remuneration Committee, consisting of Governors makes recommendations on allowances to the Council of Governors which sets the allowances for the Non-Executive Directors. The additional allowances reflect the continued complexities and challenges of the Trust, particularly around the financial position and the creation of an integrated healthcare system. These were in recognition of the role and not as individuals and would be reviewed at the end of the appointed period.

In June 2025, the Council of Governors approved the appointment of Liam Coleman as Interim Joint Chair of the Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust, commencing on 1 July 2025, on a time-limited basis. The role is shared across both organisations, with remuneration costs apportioned equally between the two trusts (50:50). The Council of Governors also approved the new remuneration for the Deputy-Chair of £24,500 pa with effect from 1 July 2025.

The Non-Executive Directors are paid an annual allowance, together with responsibility allowances for specific roles as set out in the table below: -

Role	Annual Remuneration
Chair (to 30/06/25)	£45,000
Interim Joint Chair (from 01/07/25)*	£40,000
Vice-chair (from 01/07/25)	£24,500
Non-Executive Director	£13,000
Senior Independent Director additional payment	£1,000
Chair of Audit and Risk Committee additional payment	£1,000
Chair of other Board Committees additional payment (maximum one payment)	£1,000

*The Interim Joint Chair role is shared with another NHS foundation trust. Remuneration disclosed reflects the amount paid by the Great Western Hospitals NHS Foundation Trust.

Remuneration Policy

The Trust's remuneration policy in respect of salary, pension and benefits is outlined in the following table.

	Salary	Pension and benefits
Purpose and link to strategy	To provide a core reward for the role. Salary is set at a level appropriate to secure and retain the high calibre individuals needed to deliver the Trust's strategic priorities, without paying more than is necessary.	NHS Pension Scheme arrangements provide a competitive level of retirement income. Life assurance/death in service benefits may be provided as part of an individual's pension arrangements.

	Salary	Pension and benefits
Operation	When determining salary levels, an individual's role, experience and performance, and independently sourced data for relevant comparator groups are considered. Executive director salaries are inclusive of a high cost area supplement. Salary increases typically take effect from 1 April each year.	Executive directors are eligible to receive pension and benefits in line with the policy for other employees. Pension arrangements are in accordance with the NHS Pension Scheme. There is no cash alternative. The NHS Pension Scheme is made up of the 1995/2008 Section legacy membership and the 2015 Section for all from 01/04/2022. New executive directors are entitled to join the 2015 Section, which is a career average revalued earnings scheme.

	Salary	Pension and benefits
Opportunity	There is no formal maximum limit, however salary increases will ordinarily be in line with increases for the wider NHS workforce (not including incremental progression increases) as recommended by the NHS Pay Review Body. Increases may be higher to reflect a change in the scope of an individual's role, responsibilities or experience. Where a new executive director has been appointed to the Board on a salary lower than the typical Trust level for such a role, the salary may be reviewed as the executive director becomes established in the role. Salary adjustments may also reflect wider external market conditions. Salary levels for 2024/25 are set out in the single total figure table in the annual report on remuneration.	Existing executive directors are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Details of the 2025/26 pension benefits of individual executive directors are available in the single total figure table in the annual report on remuneration. Total pension entitlement for each executive director is available in the total pension entitlement table. A new external recruit will be eligible to join the NHS Pension Scheme. The main features of the 2015 Scheme include: •a career average revalued earnings (CARE) scheme with benefits based on a proportion of pensionable earnings each year during the individual's career •a build-up rate of 1/54th of each year's pensionable earnings with no limit on the number of years that can be taken into account. This is a higher build-up rate than the 1995/2008 Scheme •revaluation of active members' benefits in line with inflation, currently the Consumer Price Index (CPI) plus 1.5% per annum •a normal pension age at which benefits can be claimed without reduction for early payment linked to the state pension age. In accordance with NHS Pension Scheme rules, the employer contribution rate is 23.7%.
Performance Measures	The overall performance of the individual is a consideration when reviewing salaries.	None.

Annual Statement of the Remuneration Committee summarising the financial year 2025/26

During the year the Committee agreed the following. Where meetings could not be convened and a decision was time critical, the Committees agreed to take decisions by written circulation in accordance with the approved Terms of Reference and ratified at the following meeting.

GWH Remuneration Committee:-

- 2 May 2025 (via email) – The Committee approved the appointment of the GWH Managing Director.
- 12 May 2025 (via email) – The Committee approved the appointment of the Chief Medical Officer.
- 30 July 2025 – The Committee considered the Executive Director's appraisals for 2024/25 and also its committee effectiveness review. The Committee also approved the application of the 2025/26 national Very Senior Manager pay award to the Executive Directors, in line with national guidance.

BSW Hospitals Group Remuneration Committees in Common:-

- 30 July 2025 – The Committees approved the application of the 2025/26 national Very Senior Manager pay award to the Group Chief Executive Officer, in line with national guidance. The Committees also agreed that future pay awards for Group roles should be explicitly linked to appraisal outcomes and the setting of clear annual objectives.
- 30 July 2025 – The Committees considered the development of the Group executive leadership structure, approving revised job descriptions and remuneration frameworks for Group executive roles and noting the introduction of interim arrangements to support delivery of the Group operating model. This included initial review of executive portfolios and alignment to the national VSM framework.
- 29 September 2025 – The Committees approved the appointment and remuneration of the Group Strategic Clinical Transformation Director, with effect from 1 September 2025 following an internal recruitment process, and noted that the postholder would remain on existing contractual terms in line with agreed arrangements.
- 22 October 2025 – Following completion of consultation on the Group leadership model, the Committees approved the appointment and remuneration of the Group Chief Finance Officer and Group Chief People Officer, with effect from 1 November 2025. The Committees also approved associated changes to executive roles and responsibilities and approved revisions to job descriptions to reflect updated Group portfolios.
- 22 October 2025 – The Committees reviewed the structure and balance of Group executive roles and approved updates to executive job titles and portfolios, including clarification of responsibilities across strategy, transformation, digital, clinical transformation and people functions. These changes clarified responsibilities and strengthened the separation of assurance, delivery and leadership roles within the Group executive structure.
- 17 December 2025 – The Committees approved the establishment of a new Group Chief Risk Officer role, including the role purpose, recruitment approach and remuneration framework. At the same meeting, the Committees approved progression to open competition for the Group Chief Strategy Officer role following review of interim arrangements and approved further refinements to Group executive portfolios and role titles.
- 19 January 2026 – The Committees approved interim executive arrangements to support continuity of strategic leadership pending substantive recruitment, confirming the parameters and duration of interim cover in line with the approved governance framework.
- January 2026 (by email) – approval of the appointment and remuneration of the Group Chief Risk Officer, following completion of the agreed interview process.
- February 2026 (by email)– approval to proceed with external recruitment for the Group Chief Digital and Information Officer role, including approval of the associated remuneration level, following prior approval of the role description.

Compliance with the NHS Very Senior Managers Pay Framework

The Trust is required to comply with the NHS Very Senior Managers (VSM) Pay Framework, as set out by NHS England, which applies to Board-level directors and other very senior managerial posts.

During the reporting period, the Trust has complied with the requirements of the VSM Pay Framework. All remuneration packages for Very Senior Managers were determined and applied in accordance with the framework, including national pay bands, pay controls and approval processes.

Group Director remuneration arrangements

Group directors are employed under joint arrangements across the BSW Hospitals Group. Where an individual undertakes a Group-level role, their remuneration is apportioned and charged across the three participating foundation trusts in line with agreed cost-sharing arrangements. Each Trust discloses only the proportion of remuneration that relates to services provided to that Trust during the financial year. The total remuneration paid to each individual across the Group is determined in accordance with the NHS Very Senior Manager Pay Framework and relevant local approvals.

Remuneration Tables – 2025/26

Information subject to audit

The information subject to audit, which includes Governors' expenses, Senior Manager's salaries, compensations, non-cash benefits, pension, compensations and retention of earnings for Non-Executive Directors, is set out in the tables below.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Remuneration Tables 2025/26

Name	Title	Salary (bands of £5,000)	All taxable benefits (total to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (a to e) (bands of £5,000)
Lizzie Abderrahim (2)	Non Executive Director	0-5	100	0	0	0	0-5
Faried Chopdat	Non Executive Director	20-25	200	0	0	0	20-25
Liam Coleman (10)	Chairman	40-45	600	0	0	0	40-45
Claudia Paoloni	Non Executive Director	10-15	0	0	0	0	10-15
Bernie Morley	Non Executive Director	10-15	500	0	0	0	10-15
Chris Burton (3)	Non Executive Director	5-10	100	0	0	0	5-10
Sandra Gordon (3)	Non Executive Director	5-10	100	0	0	0	5-10
Neil Clark (3)	Associate Non-Executive Director	0-5	100	0	0	0	0-5
Samaher Swelty (3)	Associate Non-Executive Director	0-5	0	0	0	0	0-5
William Smart	Non Executive Director	10-15	400	0	0	0	10-15
Julian Duxfield	Non Executive Director	10-15	400	0	0	0	10-15
Helen Spice	Non Executive Director	10-15	300	0	0	0	10-15
Emily Beardshall (6)	Acting Chief Improvement and Partnerships Officer	115-120	0	0	0	32.5-35	150-155
Kathryn Bateman (6)	Chief Medical Officer	75-80	0	0	0	55-57.5	130-135
Luisa Goddard	Chief Nurse	125-130	0	0	0	77.5-80	205-210
Lisa Thomas (6)	Managing Director	110-115	0	0	0	47.5-50	160-165
Benny Goodman	Chief Operating Officer	130-135	0	0	0	35-37.5	170-175
Claire Thompson (4)	Chief Officer of Improvement and Partnerships	20-25	0	0	0	0-2.5	25-30
Jon Westbrook (1), (4)	Interim Managing Director	45-50	0	0	0	0	45-50
Stephen Haig (5)	Acting Medical Director	110-115	0	0	0	0	110-115
Cara Charles-Barks (8), (9)	Group Chief Executive Officer / Accountantable Offcer	95-100	700	0	0	165-167.5	260-265
Judy Dyos (8), (9)	Interim Group Chief Strategy Officer (2 days per week)	0-5	0	0	0	50-52.5	55-60
Mark Ellis (8), (9)	Group Chief Risk Officer	5-10	0	0	0	50-52.5	65-70
Judith Gray (7), (8), (9)	Group Chief People Officer	100-105	0	0	0	40-42.5	145-150
Jonathan Hinchcliffe (8), (9)	Interim Group Chief Digital & Information Officer	125-130	0	0	0	0	125-130
Andrew Hollowood (6), (8), (9)	Group Chief Clinical Transformation Officer	45-50	0	0	0	60-62.5	105-110
S Sethi (8), (9)	Group Director of Elective Recovery	50-55	0	0	0	20.5-21	70-75
Simon Wade (7), (8), (9)	Group Chief Finance Officer	110-115	0	0	0	92.5-95	200-205

1) NEST Pension scheme - Jon Westbrook has opted out.

2) Lizzie Abderrahim ceased as a NED on the 30th April 2025

3) Chris Burton & Sandra Gordon started as NEDS and Neil Clark & Samamher Sueity started as Associate NEDS on the 3rd November 2025

4) Jon Westbrook left on 30th June 2025, Claire Thompson left 8th June 2025

5) Dr Stephen Haig ceased as the Interim Medical Director on 23rd November 2025. He was paid £86k for this role with the remainder of his salary coming from his consultant duties.

6) Kathryn Bateman started on 13th October 2025, Lisa Thomas started 1st September 2025, Andrew Hollowood started 1st September 2025, Emily Beardshall started 1st June 2025

7) Simon Wade became Group CFO and Jude Gray became Group Chief People Officer on 1st November 2025.

8) The following BSW Group roles - Chief Executive, Chief Finance Officer, Strategic Clinical Transformation Director, Chief People Officer, Chief Strategic Officer, Chief Risk Officer, Chief Transformation & Innovation Officer (interim) and Director of Elective Recovery - provide executive leadership across RUH, SFT and GWH under a shared leadership agreement.

In accordance with HM Treasury's Financial Reporting Manual and the NHS Group Accounting Manual, the salaries for Group roles have been apportioned on the following basis: RUH 35%, GWH 35% and SFT 30%. This may mean Group roles do not identify as the highest paid roles within the Trust reporting.

9) The full salaries of Group roles are as follows: Cara Charles-Barks (£270 - 275k), Simon Wade (£60-65k), Jude Gray (£55-60k), Jonathan Hinchcliffe (£370 - 375k), Andrew Hollowood (£130 - 135k), Mark Ellis (£25 - 30k), S Sethi (£145 - 150k) and Judy Dyos (£10 - 15k)

10) In June 2025, the Council of Governors approved the appointment of Liam Coleman as Interim Joint Chair of the Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust, commencing on 1 July 2025, on a time limited basis. He left his post on the 31st March 2026. The role is shared across both organisations, with remuneration costs apportioned equally between the two trusts (50:50).

Remuneration 2024/25

Name	Title	Salary (bands of £5,000)	All taxable benefits (total to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (a to e) (bands of £5,000)
Lizzie Abderrahim	Non Executive Director	10-15	0	0	0	0	10-15
Faried Chopdat	Non Executive Director	10-15	0	0	0	0	10-15
Liam Coleman	Chair	40-45	0	0	0	0	40-45
Claudia Paoloni	Non Executive Director	10-15	0	0	0	0	10-15
Bernie Morley	Non Executive Director	10-15	0	0	0	0	10-15
William Smart	Non Executive Director	10-15	0	0	0	0	10-15
Julian Duxfield	Non Executive Director	10-15	0	0	0	0	10-15
Claire Lehman	Associate Non-Executive Director	5-10	0	0	0	0	5-10
Rommel Ravanan	Associate Non-Executive Director	5-10	0	0	0	0	5-10
Helen Spice	Non Executive Director	10-15	0	0	0	0	10-15
Cara Charles-Barks	Joint Chief Executive Officer / Accountable Officer	40-45	0	0	0	142.5-145	180-185
Lisa Cheek	Chief Nurse	95-100	0	0	0	0	95-100
Luisa Goddard	Chief Nurse	40-45	0	0	0	50-52.5	95-100
Felicity Taylor-Drewe	Chief Operating Officer	80-85	0	0	0	17.5-20	100-105
Rob Presland	Acting Chief Operating Officer	10-15	0	0	0	2.5-5	10-15
Benny Goodman	Chief Operating Officer	45-50	0	0	0	10-12.5	55-60
Simon Wade	Chief Finance Officer & Acting Deputy CEO	155-160	0	0	0	47.5-50	205-210
Judith Gray	Chief People Officer	145-150	0	0	0	37.5-40	185-190
Claire Thompson	Chief Officer of Improvement and Partnerships	130-135	0	0	0	17.5-20	145-150
Jon Westbrook	Chief medical Officer, Acting Chief Executive and Interim Managing Director	195-200	0	0	0	0	195-200
Stephen Haig	Acting Chief Medical Officer	180-185	0	0	0	162.5-165	345-350

1) NEST Pension scheme. Jon Westbrook has opted out.
2) Jon Westbrook ceased as the Chief Executive and started as the Interim Managing director on 1st November 2024
3) Cara Charles-Barks started on 1st November 2024, Luisa Goddard started 1st December 2024, Benny Goodman started 25th November 2024
4) Lisa Cheek left the Trust on 30th November 2024
5) Felicity Taylor-Drewe left the Trust on 25th October 2024
6) Rob Presland started on 26th October 2024 and left on 24th November 2024
7) Cara Charles-Barks salary is split across RUH, SFT and GWH at 35%, 35% and 30% of her full salary costs (£275-280k) starting from 1 November 2024, however all her pension costs are being reported through each organisation for completeness.
8) Lisa Cheek pension related benefits are zero as benefits have been claimed early

Pension Benefits 2025/26

Name	Title	Real increase in pension at Pension Age (Bands of £2,500)	Real increase in Pension Lump Sum at Pension Age (Bands of £2,500)	Total Accrued Pension at Pension Age at 31 March 2026 (Bands of £5,000)	Lump Sum at Pension Age related to Accrued Pension at 31 March 2026 (Bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employer's Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Emily Beardshall	Partnerships Officer	0-2.5	0-2.5	35-40	75-80	608	25	656	0
Kathryn Bateman	Chief Medical Officer	2.5-5	10-12.5	50-55	125-130	1,011	58	1,156	0
Luisa Goddard	Chief Nurse	2.5-5	5-7.5	55-60	150-155	1,296	93	1,405	0
Lisa Thomas	Managing Director	2.5-5	2.5-5	65-70	160-165	1,234	45	1,335	0
Benny Goodman	Chief Operating Officer	2.5-5	0	15-20	0-5	183	20	220	0
Claire Thompson	Chief Officer of Improvement and	0-2.5	0	45-50	115-120	1010	0	1025	0
Jon Westbrook	Interim Managing Director	0	0	0	0	0	0	0	0
Stephen Haig (1)	Acting Medical Director	Not available							
Cara Charles-Barks	Group Chief Executive Officer / Accountantable Offcer	7.5 - 10	12.5 - 15	65 - 70	140 - 145	1,239	165	1,439	0
Judy Dyos	Interim Group Chief Strategy Officer (2 days per week)	2.5-5	0-2.5	50-55	120-125	1,038	54	1,110	0
Mark Ellis	Group Chief Risk Officer	2.5-5	0-2.5	35-40	85-90	645	40	703	0
Judith Gray	Group Chief People Officer	2.5-5	0-2.5	15-20	0-5	266	36	322	0
Jonathan Hinchliffe	Interim Group Chief Digital & Information Officer	0	0	0	0	0	0	0	0
Andrew Hollowood	Group Chief Clinical Transformation Officer	2.5-5	0-2.5	110-115	285-290	2,575	86	2,691	0
Simon Sethi	Group Director of Elective Recovery	0-2.5	0-2.5	40-45	90-95	708	37	763	0
Simon Wade	Group Chief Finance Officer	5-7.5	5-7.5	60-65	145-150	1,185	95	1,300	0

(1) Missing pension information is due to an error by NHS Business Services Authority, which they have been unable to rectify in time for publication of the accounts.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the NHS Pension scheme. They also include any additional years of pension service in the scheme at their own cost.

The real increase in CETV represents the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the year.

Pension Benefits 2024/25

Name	Title	Real increase in pension at Pension Age (Bands of £2,500)	Real increase in Pension Lump Sum at Pension Age (Bands of £2,500)	Total Accrued Pension at Pension Age at 31 March 2025 (Bands of £5,000)	Lump Sum at Pension Age related to Accrued Pension at 31 March 2025 (Bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Cara Charles-Barks	Joint Chief Executive Officer / Accountantable Offcer	7.5-10	10-12.5	55-60	125-130	1,048	140	1,219	0
Lisa Cheek	Chief Nurse	0	0	65-70	170-175	1,680	0	0	0
Luisa Goddard	Chief Nurse	2.5-5	15-17.5	50-55	140-145	1,018	62	1,274	0
Felicity Taylor-Drewe	Chief Operating Officer	0-2.5	0	35-40	0	466	22	535	0
Rob Presland	Acting Chief Operating Officer	0-2.5	0	30-35	0	390	4	469	0
Benny Goodman	Chief Operating Officer	0-2.5	0	10-15	0	140	10	180	0
Simon Wade	Chief Finance Officer & Acting Deputy CEO	2.5-5	0-2.5	50-55	135-140	1,028	68	1,165	0
Judith Gray	Chief People Officer	2.5-5	0	15-20	0	200	48	262	0
Claire Thompson	Chief Officer of Improvement and Partnerships	0-2.5	0	45-50	115-120	896	37	994	0
Jon Westbrook	Chief medical Officer, Acting Chief Executive and Interim Managing Director	0	0	0	0	0	0	0	0
Stephen Haig	Acting Chief Medical Officer	7.5-10	15-17.5	60-65	155-160	1,108	186	1,369	0

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the NHS Pension scheme. They also include any additional years of pension service in the scheme at their own cost.

The real increase in CETV represents the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the year.

Expenses of Directors and Governors 2025/26

Expense Disclosure	Total number in Office 2024/25	Total number in Office 2025/26	Total Receiving Expenses 2024/25	Total Receiving Expenses 2025/26	Aggregated sum of expenses paid 2024/25 (£00)	Aggregated sum of expenses paid 2025/26 (£00)
Directors	21	23	14	21	103	98
Governors	18	18	0	2	0	0

- Non-Executive Directors do not receive pensionable remuneration.
- There are no Executive Directors who serve elsewhere as Non-Executive Directors and, therefore, there is no statement on retention of associated earnings.
- Salary includes employer NI and pension contributions. The above figures do not include any final bonus/performance related pay increase which is subject to agreement by Remuneration Committee.
- The accounting policies for pensions and other retirement benefits and key management compensation are set out in the Note 9 to the accounts.
- The Remuneration Committee considered that the level of remuneration paid to Executive Directors needed to be sufficient to attract and retain Directors of the calibre and value required to run a foundation trust successfully.

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at any one time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangements when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures show the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of the scheme at their own cost. CETV's are calculated within the guidelines and frameworks prescribed by the Institute and Faculty of Actuaries. The CETV is based on actual contributions to 31 March 2026.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses the common market valuation factors from the start and end of the period.

Fair Pay Multiply (subject to audit)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2025/26 was £190,000 - £195,000 (2024-25, £195,000 - £200,000). This is a reduction between years of 2.53%. This is paid on payments made to the director during the year.

Executive Name and Title	Total Remuneration	
	2025/26 £'000	2024/25 £'000
Managing Director – Lisa Thomas / Jon Westbrook*	190-195	195-200

*Jon Westbrook retired 30th June 2025 with Lisa Thomas starting 1st September 2025

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The following BSW group roles, Chief Executive Officer, Chief Financial Officer, Chief Clinical Transformation Officer, Chief People Officer, Chief Strategic Officer (interim), Chief Risk Officer, Chief Transformation & Innovation Officer (interim) and Director of Elective Recovery provide executive leadership across the RUH, SFT and GWH under a shared leadership arrangement. In accordance with HM Treasury's Financial Reporting Manual and the NHS Group Accounting manual, the salaries for the group roles have been apportioned in the following basis, RUH 35%, GWH 35%, SFT 30%. This may mean group roles will not identify as the highest paid roles within the Trust reporting.

The following steps were taken to ensure that the Committee satisfied itself that it was reasonable to pay one or more senior managers more than £150,000: -

- Comparison made of salaries of similar roles in similar organisations
- Consideration of vacancies across the NHS for similar roles
- Consideration of the likelihood of recruiting and retaining individuals in the current market

The Committee was satisfied that the salaries were reasonable for these roles in this organisation.

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £3,696 to £448,769. The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 6.4%. There were 19 Clinical staff that have received payments for additional activity/WLI's that took their annual pay over the Top Directors Pay. Their basic salary however, remained below the highest paid Director).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2025/26	25th percentile £	Median £	75th percentile £
Salary component of pay	30,395	42,402	57,251
Total pay and benefits excluding pension benefits	30,395	42,402	57,251
Pay and benefits excluding pension:pay ratio for highest paid director	6.28	4.50	3.34

2024/25	25th percentile £	Median £	75th percentile £
Salary component of pay	25,674	36,483	51,873
Total pay and benefits excluding pension benefits	29,048	39,514	53,614
Pay and benefits excluding pension: pay ratio for highest paid director	6.73	4.95	3.65

Payments for Loss of Office

There were no payments made for loss of office during 2025/26.

Payments to past senior managers

Ill-health retirements

During 2025/26 there were 10 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £318k (£214k in 2024/25).

Cara Charles-Barks
Chief Executive Officer
Date: 25 June 2026

6 STAFF REPORT

Introduction

This section of the annual report presents a summary of workforce development activity at Great Western Hospitals NHS Foundation Trust for the 12-month period from April 2025 to March 2026. It demonstrates how the Trust has engaged and involved staff in shaping, delivering, and improving services, in alignment with our People Strategy and the core principles of the NHS People Promise.

In line with the NHS Foundation Trust Annual Reporting Manual (2025/26), this report fulfils the requirement to provide a clear and transparent overview of:

- Staff involvement in Trust performance and decision-making, including a summary of results from the 2025 NHS Staff Survey, feedback mechanisms, joint consultation processes, and action planning.
- Progress against our Equality, Diversity and Inclusion (EDI) ambitions, with detail on workforce demographics, policy development, training activity, and inclusive practice improvements aligned with the EDI Strategy.
- Monitoring of staff wellbeing and attendance, including sickness absence trends, the Trust's approach to health, safety and wellbeing, and our commitment to creating a restorative, learning culture.
- Governance and oversight of workforce-related risk, including processes to identify and mitigate fraud and corruption, manage additional workforce expenditure, and report on Trade Union facility time and consultancy use.

2025/26 has been a significant year of change for the Trust, with a strong focus on supporting our people through this period of transformation. Corporate colleagues and functions have played a key role in the Corporate Transformation Programme, contributing to the Group Alignment of the Care Organisations at GWH, RUH and SFT and supporting the development of the BSW Group model of healthcare services for the region.

This period of change has also provided an important opportunity to listen, reflect and reset our approach to supporting our workforce. The Trust's People Strategy (2020–2025) has been reviewed and refreshed, resulting in an interim GWH People Plan (2025–2027). This plan places our people at its heart, with a clear focus on fostering a Great Culture, enabling Great Innovation, and strengthening Great Collaboration; ensuring our workforce is supported to meet the evolving demands of a modern, transformational healthcare service.

Central to this has been a renewed commitment to staff voice and engagement. Through the Trust-wide *"Let's Talk Behaviours"* conversation, colleagues have been invited to share their experiences and shape the behaviours that define how we work together. This has informed the development of refreshed behaviours aligned to our STAR Values, helping to create a more inclusive, supportive and high-performing culture where our people feel valued, heard and empowered to deliver the best possible care.

What follows is a summary of key achievements, learning, and areas for further development. It offers assurance of our progress and sets the direction for the next stage of workforce transformation at the Trust.

Governance – Fraud, Corruption, and Bribery

GWH has an accredited counter fraud team and service provided through KPMG, and contracted to undertake proactive counter fraud reviews, investigations and awareness activities in line with the NHS Counter Fraud Authority (NHSCFA) Strategy for 2023-2026.

GWH has a Fraud and Corruption Policy which includes a response plan for detected or suspected fraud, corruption, or bribery. In addition, the Board endorses the NHS Counter Fraud Authority Strategy and guidance. One of the basic principles of public sector organisations is the proper use of public funds. The National Health Service (NHS) is a publicly funded organisation and consequently it is important that every employee and associated person acting for, or on behalf of, the Great Western Hospitals NHS Foundation Trust (the Trust) is aware of:

- The risk of fraud, corruption and bribery;
- The rules relating to fraud, corruption and bribery and
- The process for reporting their suspicions and the enforcement of these rules.

The Fraud and Corruption policy has the endorsement of the Executive Board and the organisation does not tolerate any form of fraud or bribery by its employees or bribery of its employees, associates or any person or body acting on its behalf.

To ensure that any arising allegations of fraud and bribery are kept to a minimum, expert advice is sought without delay from KPMG, all allegations are investigated thoroughly and the strongest sanctions, including criminal sanctions, are taken against any employee or any external party found to be committing, or having committed, an offence of fraud or bribery.

This policy reflects the Board's wish to embed a culture of best practice in anti-fraud, anti-corruption and anti-bribery measures, and enforcement of this policy will reduce the risk that the Trust or any employees, contractors, volunteers, students, governors, or persons working for the Trust will incur any criminal liability or reputational damage. Procedures are in place to reduce the likelihood of fraud, corruption and/or bribery occurring. These include the Standing Financial Instructions, other documented procedures, a system of internal control, and a system of risk assessment.

The Board seeks to ensure that a risk awareness culture exists in the Trust, which includes fraud, corruption and bribery awareness and has complied with the Secretary of State's Directions in nominating a Local Counter Fraud Specialist (LCFS). The local counter fraud specialist undertakes an annual work plan to support the Trust in ensuring compliance with the national Functional Standards for Counter Fraud and, where necessary, conducts investigations as directed by the NHS Counter Fraud and Corruption Manual. In 2025/26 the LCFS team's proactive focus was on job planning and rostering in Radiology and Pathology and Recruitment.

The LCFS team undertakes an annual assessment against its compliance with the standards and NHS requirements for counter fraud by submitting a Counter Fraud Functional Standard Return to the NHSCFA at the end of the year. The Trust's rating for the 2025/26 return is green overall.

The Economic Crime and Corporate Transparency Bill received Royal Assent on the 26 of October 2023 and introduced a new offence of failure to prevent fraud, which is in effect from 1 September 2025. This offence holds organisations including the Trust, to account in the event of the Trust benefiting from fraud carried out by an employee, agent or other 'associated' person, with the intention of deriving a benefit for the Trust, where the Trust did not have reasonable fraud prevention procedures in place.

As a result, the Trust has an obligation to make all reasonable efforts to prevent fraud occurring regardless of the beneficiary. In 2025/26 the LCFS worked with the Trust to assess the potential impact on the Trust and implement

minor changes to ensure the Trust complies with the NHS Counter Fraud Authority's guidance on the new legislation.

Freedom to Speak Up

The Trust continues to develop our mechanisms to foster an open and supportive culture that encourages staff to raise concerns about patient care, quality, or safety. Central to this is the Trust's Freedom to Speak Up (FTSU) Policy.

Since appointing a dedicated Lead Guardian in 2024, the Trust has strengthened its approach to speaking up, by aligning its process with national frameworks. The Lead Guardian has undertaken a review of the speaking up process, including engaging with staff, evaluating old cases and benchmarking the service against other Trusts in the local and Southwest region. The Lead Guardian has also strengthened collaboration and sits on key strategic committees and working groups that address cultural change including supporting the roll out of the Trust's new Behavioural framework and the relaunch of the Never OK campaign that addresses violence and abuse against staff.

Staff have several 'speaking up' channels which they can use to raise concerns particularly those relating to quality of care, patient safety, and bullying or harassment. The Trust encourages and invites staff to speak up and contribute to discussions and activities to improve both patient and staff experience.

Information on Freedom to Speak Up cases is reported to the Trust Board, Patient Safety and Trust Management Committee and quarterly reports and returns are submitted to the Executive Directors and National Guardian's Office.

Key areas for development in 2026/27 include stakeholder engagement, the Lead Guardian will support the Equality, Diversity and Inclusion (EDI) service to engage with staff to understand their lived experience in relation to inclusion and belonging and work more closely with other People professionals to jointly address issues. This partnership will enable practitioners to identify themes and design interventions based on concerns raised via the FTSU process.

Expenditure on consultancy
Expenditure on consultancy in 2025/26 was zero (2024/25 was £72,000).

Off Payroll Engagements
An off payroll engagement is where the Trust employs a worker via an agency or third party rather than via the payroll and where they are in post for 6 months or more and earn more than £245 per day.

The Trust only uses off-payroll arrangements in exceptional circumstances. The Trust does not use off-payroll arrangements for members of the Board of Directors and/ or senior officials with significant financial responsibility. In exceptional circumstances where off-payroll arrangements are used the Trust follows its own policy, Standing Financial Instructions, and all relevant HM Treasury guidance.

There have been no off-payroll engagements in respect of Board members or senior officials with significant financial responsibility in the year ended 31 March 2026. The number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year is 28. These individuals are set out in the Remuneration Report.

TABLE 1: Highly paid off-payroll engagements as at 31 March 2026, earning £245 per day or greater

	Number
No. of existing engagements as of 31 March 2026	0
Of which:	0
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting	0
	Number
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting.	0

TABLE 2: Highly paid off-payroll engagements as at 31 March 2025, earning £245 per day or greater

	Number
No. of existing engagements as of 31 March 2025	0
Of which:	0
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting.	0

TABLE 3 ： off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026

	Number
No. of off payroll engagements of Board members, and/or senior officials with significant financial responsibility during the financial year	0
No. of individuals that have been deemed “Board members, and/or senior officials with significant financial responsibility” during the financial year. This figure must include both off-payroll and on-payroll engagements	28

Workforce Overview: staff numbers, costs and composition

Workforce Key Performance Indicators (KPI’s)

Trust workforce performance is measured across core Key Performance Indicators (KPI), as presented in Table 1. Dashboards are prepared and published by the Workforce Insights, Systems, and Planning Department, recording progress in month and reported from data across all People and Workforce systems.

Regulatory governance of workforce performance is assured through presentation of the monthly Trust Workforce Integrated Performance Report (IPR) to the Executive Committee and Public Board members. Divisional workforce performance is also monitored and reported through the monthly IPR reporting process at Divisional performance

meetings. The provision of KPI data for our workforce drives a culture of data informed monitoring, management and performance improvement and is inclusive of all medical and non-medical professional groups.

The core workforce KPIs are outlined below with the Trust compliance target and performance for the most recently available data period:

Table 1 – Trust Core Workforce KPI Range

Core Workforce KPI	Trust Target	Performance	Data
Sickness Absence	3.5%	3.8%	Mar-26
Turnover (Voluntary)	11%	10%	Mar-26
Vacancy Factor	7%	0.4%	Mar-26
Mandatory Training	85%	91%	Mar-26
Appraisal	85%	80%	Mar-26
Agency Spend as % Total Spend	4.5%	1.5%	2025/26

Further information can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Sickness Absence

The Trust's focus throughout 2025/26 was the strengthening of sickness absence management through the monthly *Improving Attendance* working group. This group was established to reduce sickness levels, particularly in short-term absence hotspot areas.

Over the past 12 months, overall absence has decreased from 4.4% to 3.8% (March 2026), representing a return to pre-COVID levels.

During this period, the working group has maintained strong managerial engagement and has become a key forum for shared learning, improved consistency, and enhanced capability in managing attendance and supporting staff wellbeing. Key outcomes and impacts from the past 12 months include:

Strengthening the Sickness Management Framework
Alignment of the Sickness Management policy to meet organisational need was completed in February 2025, informed by manager feedback through the group and consultation. Changes include strengthened guidance to ensure managers feel confident applying the framework.

Expert Input and Manager Development
Guest speakers from clinical, operational, and leadership teams have delivered valuable insights into resilience, organisational culture, Active Bystander approaches, and the promotion of best practice through shared learning.

Managers have been supported through the working group with practical tools to strengthen attendance management, encourage collaborative learning, and improve access to policy training and guidance. Additionally, the People Operations team has provided face-to-face support across departments, offering hands-on guidance and ensuring consistent application of best practice.

Implementation and Resource Deployment

The Working Group has focused on equipping managers with practical tools to support staff wellbeing and reduce sickness absence, ensuring colleagues feel supported and empowered in their roles.

Key initiatives in 2025 include:

- New guidance for colleagues with long-term health conditions or impairments
- Health Passport rollout to support personalised care and adjustments
- Health & Wellbeing Champions placed in all high-demand areas
- Proactive burnout-prevention plan to maintain staff resilience
- Mental Health First Aid (MHFA) training for managers
- Expanded self-paced wellbeing resources for all staff
- MSK warm-ups, Happiness Calendar, and “In the Moment” support to promote daily wellbeing
- QR-based sickness reporting for medical and dental staff to streamline processes

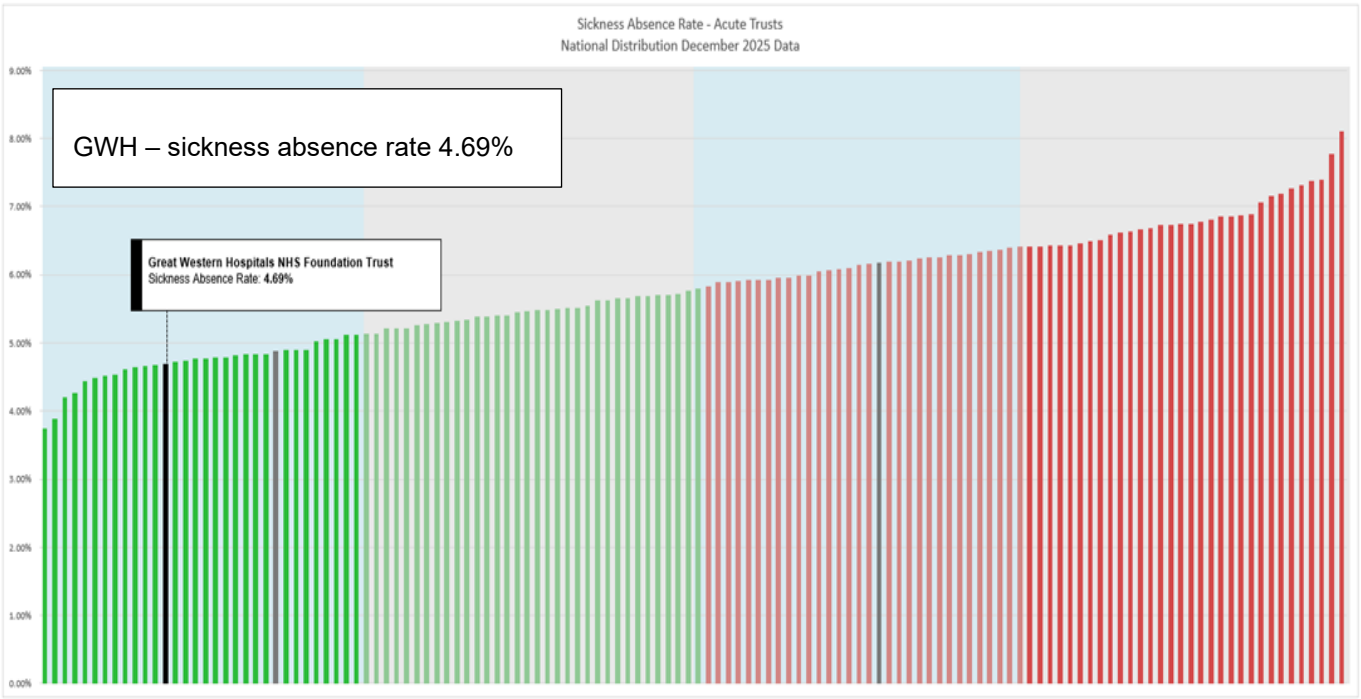
In addition, scenario-based training is being developed to give managers confidence and consistency when handling complex attendance-related conversations. These initiatives reflect the Trust’s commitment to creating a healthy, supportive, and inclusive workplace where colleagues can thrive.

Benchmarking and Trust Position

This table presents the most recent Model Hospital National Distribution Data Set for Sickness Absence Rates across Acute Trusts published February 2026.

Great Western Hospitals NHS Foundation Trust achieved a sickness absence rate of 4.69% in this period, ranked in the lowest quartile for Acute Trusts.

Sickness Absence Rate – Acute Trusts – National Distribution December 2025 data



Benchmarking has consistently placed the Trust firmly within the lower quartile nationally, representing a very strong comparative position and a significant achievement given the continued operational pressures across the

NHS and GWH. This is an important positive indicator of the impact of targeted work within the teams and evidence that the working group is establishing momentum with the Trust's approach to attendance and staff wellbeing.

National Sickness Absence Rates can be found publicly online: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/

Staff Costs

Staff costs are included in Note 8 of the Accounts Section.

Agency Spend
The Trust set stretching reductions on agency spend in 2025/26, aiming to reduce the overall spend to £1.8m. At year end, a total of £5.1m was spent on agency workers, which whilst above the target was a reduction on spend in 2024/25 of £0.6m.

Staff Exit Packages
No disclosable staff exit packages requiring treasury approval were paid in 2025/26.

This table discloses the number of non-compulsory departures which attracted an exit package in 2025/26 and the values of associated payments made in year:

	Agreements Number	Total Value of Agreements £
Voluntary redundancies including early retirement contractual costs	2	£19,521
Mutually agreed resignations (MARS) contractual costs	9	£148,679
Early retirements in the efficiency of the service contractual costs	0	£0
Contractual payments in lieu of notice	4	£47,946
Exit payments following Employment Tribunals or court orders	1	£5,000
Non-contractual payments requiring HMT approval *	0	0.0
Total	**16**	**£221,146**
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	£0

Workforce Profile

Breakdown of the Trust workforce profile as at March 2026

Employee Group (Average WTE)	2025/26	2024/25	2023/24	2022/23	2021/20
Medical and Dental	723	689	681	650	632
Ambulance staff	13	17	18	17	18
Administration and estates	1,007	1,093	1,062	511	515
Healthcare assistants and other support staff	1,018	1,132	1,170	1,582	1,496
Nursing, midwifery and health visiting staff	1,653	1,770	1,658	1,563	1,540

Employee Group (Average WTE)	2025/26	2024/25	2023/24	2022/23	2021/20
Scientific, therapeutic and technical staff	501	564	507	513	506
Substantive Total	**4,915**	**5,265**	**5,094**	**4,837**	**4,707**
Agency and contract staff	34	46	78	119	109
Bank staff	299	331	351	333	329
Other	0	0	0	0	0
Total Average Numbers	**5,248**	**5,643**	**5,523**	**5,289**	**5,145**

Workforce Demographic Profile

The Trust employs 5,699 staff of which 3,335 (59%) are full-time and 2,364 (41%) are part-time. A profile of the workforce demographics is provided below:

	Female	Male	Total
Directors (Executive)	4	3	7
Directors (NED)	3	6	9
Other senior managers (8A+)	181	82	263
Total Employees	4,958	1,212	6,170

The Trust Board includes seven executives and nine non-executive directors. Seven (44%) are female and nine (56%) male, three (19%) are from an ethnic minority background and one (6%) is disabled or living with a long-term health condition.

Board appointments

The Trust actively takes steps to diversify the Board, including Equality Diversity & Inclusion (EDI) representation during the recruitment process and succession planning process that consider skills and demographic mix. Associate Non-Executive Director roles provide a development opportunity for people from minoritised backgrounds to gain valuable board experience and provide a future pipeline for the Board.

All Board appointments are approved by the Remuneration Committee and NED appointments are approved by the Council of Governors. The Board complete annual appraisals in accordance with guidance – NHS Leadership Competency Framework for board level leaders.

There is a clear succession plan for Board Members using the Scope for Growth approach to identify future talent.

Workforce Profile

Year	Female	Male	BME	White	Disabled	Not Disabled	LGB	Hetero-sexual	Religion / Belief
2022	82%	18%	24%	68%	3%*	76%*	2%	65%	
2023	82%	18%	27%	65%	4%	77%	2%	67%	54%
2024	82%	18%	30%	63%	5%	78%	2%	70%	57%
2025	**80%**	**20%**	**32%***	**59%***	**5%**	**81%**	**2%**	**69%**	**57%**

*Please note: totals may not equal 100% due to undeclared or unknown responses.

Workforce Policy

The Trust has a comprehensive set of workforce policies that promote fair, consistent, and values-driven management across all staff groups. These policies guide decision-making, support effective governance, and ensure compliance with employment law and NHS standards.

They are reviewed every three years by the HR department, with additional updates made when legislation, national guidance, or best practice changes.

Policy development is carried out in partnership with Trade Union representatives, with drafts reviewed by the Employee Partnership Forum (EPF) Policy Sub-Group and approved at monthly EPF meetings. This collaborative approach ensures transparency and reflects staff perspectives.

In 2025, the Trust introduced and updated policies across key areas, including staff wellbeing, people management, safe and inclusive working, workforce planning, learning and development, and medical staffing.

This work included updating 17 policies for the Agenda for Change workforce and 5 policies for the Medical and Dental workforce. In addition, the Trust has adopted several policies from the National Policy Framework, including Mandatory Training, Flexible Working, and Sexual Misconduct.

Overall, these policies demonstrate the Trust's commitment to a supportive, inclusive workplace, strong governance, and active staff involvement in shaping workforce practices.

Staff Turnover

Information on staff turnover can be found via NHS workforce figures published by NHS Digital and can be accessed via this link:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Retention

April 2025 concluded the 12-month period of national funding (Cohort 2) for the People Promise Manager, the appointed manager developed and delivered initiatives to improve staff experience and retention across the seven NHS People Promise commitments. Evaluation of the success of this programme is measured through the following key deliverables during 2025:

- **Safe and Healthy:** Launched a comprehensive Sexual Misconduct Policy supported by ESR eLearning and a Trust-wide communications campaign, with ongoing quarterly promotion throughout 2025.

- **Voice that Counts:** Launched an ESR-integrated digital Exit Conversation process and Stay Conversations framework, supported by quarterly leaver data dashboards shared with managers via Workforce Intelligence and People Operations.

- **Working Flexibly:** Digitalised the Flexible Working application process via ESR, with toolkits and guidance for staff and managers, and established a dashboard to monitor uptake and progress.

- **Recognised and Rewarded:** Delivered pension and financial wellbeing workshops with external partners (9 sessions, 106 attendees), hosted three Long Service Awards events (45 attendees), aligned new leadership behaviours for the July 2026 Staff Excellence Awards, and progressed plans for Great West Fest in September 2026.

Recruiting, Developing, Supporting and Including Our Workforce

Staff Survey Report 2025/26

The NHS England mandated annual Staff Survey 2025/26 was open from September to November 2025 and the Trust participated across all professional staff groups, providing the option of a paper-based survey for colleagues without IT access and those based in a community setting. Bank workers also completed a tailored survey relevant to their experience.

The Trust response rate was 66% of staff, equating to over 3,600 employees responding to the survey (71% 2024).

Key highlights include:

- 32 questions scored significantly better (29%) compared to sector
- Overall, 54 Questions improved, 41 declined and 5 remained the same compared to 2024 survey results.
- All People Promises/Themes scored better than the benchmarking average, with 6 (67%) scoring significantly better than the average
- The People Promise "We work flexibly is significantly better than sector score

People Promise Scores

Indicators	2025/26		2024/25		2023/24	
People Promise / theme	Trust Score	Bench-marking group score	Trust Score	Bench-marking group score	Trust Score	Bench-marking group score
We are compassionate and inclusive	7.29	7.28	7.23	7.21	7.25	7.24
We are recognised and rewarded	5.96	5.87	5.92	5.92	5.91	5.94
We each have a voice that counts	6.68	6.60	6.69	6.67	6.71	6.70
We are safe and healthy	6.17	6.07	6.14	6.09	6.11	6.08
We are always learning	5.69	5.57	5.71	5.64	5.69	5.62
We work flexibly	6.49	6.22	6.42	6.24	6.41	6.20
We are a team	6.79	6.75	6.77	6.74	6.78	6.75
Staff engagement	6.81	6.74	6.82	6.84	6.85	6.91
Morale	5.96	5.84	5.93	5.93	5.91	5.90

The Improving Together approach, the Trust's continuous improvement methodology, helps turn staff survey feedback into meaningful action across the Trust and divisions. This work is supported by the Trust Staff Survey Working Group, which brings together colleagues from People Services teams, divisional representatives, and the Equality, Diversity and Inclusion (EDI) Lead. The group reviews survey findings, agrees impacting themes, and works collaboratively to develop practical improvement actions. By encouraging divisional ownership and shared responsibility, it supports positive cultural change and alignment with our wider People and Culture priorities. The group reports to the People & Culture Subcommittee, providing oversight and assurance that actions to improve staff experience are inclusive, evidence-based, and deliver measurable impact.

Staff Survey Improvement Plan

The Trust strategic pillar relating to staff is “Staff and Volunteers feeling valued and involved in helping improve quality of care for patients”. The Trust pillar metric to ensure performance against this strategic pillar is the staff survey question “I would recommend my organisation as a place to work”. As a result, 59% of staff in the 2025 Staff Survey felt they agreed/strongly agreed with this question against a national benchmark average of 58%.

Following a review of staff survey performance in the 2024 Survey, the Trust retained a focus on ‘Team Working’ as an area of opportunity to drive performance against our Pillar Metric of ‘Recommending as a place to work.’ Latest survey data was used to inform newly targeted actions and improve the staff survey question 7C (“I receive the respect I deserve from my colleagues at work”) and drive further improvement in the 2025 Staff Survey.

The Trust achieved a 0.5% improvement on the previous year bringing the response in line with the national average for this question at 70% in the 2025 Staff Survey. Additional questions were included in the quarterly pulse survey to better understand what staff feel are drivers of respect at work and initiatives were introduced during 2025 which have supported improvement in staff experience of receiving respect. These include:

- **Health and safety culture**: A ‘Never OK’ campaign was re-launched across the Trust to promote a culture of respect between patients, service users, and colleagues. A high-profile collaboration with Wiltshire Police included ‘listening events’, awareness raising, dedicated training to hotspot teams, and a structured response action plan was published. The 2025 results reflect improvement in questions relating to staff reporting experiences of abuse and harassment at work and this work will continue to be embedded in 2026.
- **Teams**: Over 930 managers (end March 2026) have attended the Expectations of Line Managers training, which is designed to embed and support good people management, Trust behaviours, equality, diversity and inclusion, and improve line management capability.
- **Inclusion and equality**: Inclusive Recruitment and EDI Champion numbers have grown by 36% and 18% respectively, these staff promote equality and inclusivity in the workplace and in recruitment processes. The Leadership conference in June 2025, which was attended by circa 100 staff, included a focus on system leadership to socialise working across organisation boundaries, racial equity and Active Bystander training to equip staff to respond to unprofessional behaviours.

Culture and Engagement

Culture and engagement are central to effective Organisational Development (OD) because they create the conditions for people to support and sustain change. When staff feel connected, valued, and aligned to organisational values, they are more willing to adopt new ways of working. Over the past year the OD Team have:

- Co-created a new suite of behaviours through the ‘Let’s Talk Behaviours’ initiative. This engagement gathered insights from over 600 staff and volunteers, generating more than 5,200 contributions, which defined our eight Trust behaviours that articulate the organisation’s STAR values. These behaviours have been embedded into everyday practice through the work of a dedicated Task and Finish Group and Engagement Group, and have been fully integrated into appraisals, induction, leadership programmes and recognition processes, supported by the introduction of new behaviour e-cards.
- Enhanced Organisational development processes through the introduction of a standard approach with a marked increase in use of the NHS Team Engagement and Development (TED) tool, designed to help teams understand how effectively they work together and engage team members in creating actions which improve their effectiveness. 122 team surveys have been created, generating 642 responses.
- Talent development also progressed, with increased uptake of Scope for Growth career conversations. Feedback/outcomes from conversations has resulted in promotion, staff undertaking Apprenticeships, internal & external leadership development programmes, coaching, mentoring and successfully applying for a secondment.

Recruitment

Over the past year, the Recruitment Team has delivered strong results, appointing 1,502 new starters across Medical and Dental / Agenda for Change roles, along with 92 Bank starters, from 31,404 applications. Despite a reduced application volume compared to the previous year (34,258) the team maintained high-quality recruitment outcomes. At the end of the 24/25 year the Trust had an overall vacancy position of 167.40 whole time equivalents this has significantly reduced to a total Trust vacancy of 37.36 whole time equivalent.

An objective of the Recruitment team was to continue to maintain the Trust's 46-day Time to Hire target. The Team consistently delivered this objective every month in the 2025/26 financial year which is a significant achievement. This sustained excellence led to the team being recognised in February 2026, achieving second place in the Southwest region for Time to Hire performance.

During 2025/26, the Recruitment Team worked closely with the Academy to strengthen internal development pathways and expand progression opportunities through apprenticeship routes from Band 2 to Band 5 nursing.

This included the ongoing Nursing Associate Higher Apprenticeship, now in its fourth year, and the successful launch of the Registered Nurse Degree Apprenticeship (Level 6) in January 2026. This new pathway enables Assistant Practitioners and Nursing Associates to progress into Band 5 Registered Nursing. The programmes have generated strong interest, with 15 applicants for the SNA pathway and 10 for the RNDA in September 2025.

The team also continued to deliver the Supplementary Information from Employers (SIFE) programme, this programme supports individuals who currently work as Health Care Support Workers (HCSWs) but were practising Nurses in their home countries, undertake a training programme and meet the requirements of the Nursing and Midwifery Council (NMC) to become a Band 5 registered nurse for GWH, it is a 6-8 month training programme. The programme is now in its third year, recruiting 10 candidates in 2025 and maintaining a 100% success rate.

Inclusive Recruitment

The Trust commits to interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them based on their capabilities. The Trust makes every effort when employees become disabled to make sure they stay in employment through reasonable adjustment and redeployment support if appropriate. People Services staff work with Occupational Health Specialist Advisers and line managers to identify appropriate roles for staff following a change in circumstances. As a Disability Confident Leader, the organisation is recognised for ensuring applicants and colleagues have opportunities to fulfil their potential and realise their aspirations.

In 2025/26, the Trust attended three Career Transition Partnership (CTP) Recruitment Events designed to support military personnel as they transition into civilian life. These events provided valuable opportunities to connect with service leavers, showcase the career pathways available within our organisation, and demonstrate our commitment to our Armed Forces Covenant Gold Membership by helping military colleagues build successful post-service careers.

In February 2026, we hosted our third Swindon Community Careers Fair, designed to provide a platform for healthcare providers and local employers to connect with job seekers across the community. The event brought together over eight organisations and welcomed 108 attendees, reinforcing our commitment to supporting local employment and showcasing our role as a major employer and Anchor Institution within Swindon.

Postgraduate & Undergraduate Medical Recruitment

In 2025 the Trust continued with the recruitment of final year medical students from Charles University in Prague into Clinical Fellow F1 posts. As with previous years, the Trust received a high number of applications, and three individuals were successful in joining us in August 2025 to undertake a one-year placement with the Trust.

Additionally, we strengthened our teaching resource by recruiting 35 Clinical Teaching Fellows. The posts are funded through the Medical Undergraduate Tariff (MUT) which we earn based on the number of students we teach.

During 2025/26, the Recruitment Team continued to focus on filling hard-to-recruit Consultant posts across the Trust and successfully appointed 27 Substantive Consultants over the past 12 months. This included securing candidates in several key specialties such as Acute Medicine, Radiology, and Paediatrics, and reducing our consultant vacancy position notably by 75.9% since August 2024. Some specialties remain difficult to recruit to, reflecting the national workforce picture particularly Stroke, Geriatrics and Gastroenterology and these continue to be priority areas for targeted recruitment activity.

Leadership Development

We are committed to creating an inclusive, healthy, and high-performing workplace, where all staff have access to development and feel valued. In 2025/26, significant progress was made in developing our workforce, through targeted leadership, clinical and non-clinical training, wellbeing support, and equality initiatives. The refreshed leadership programmes are consistently attracting good feedback across all programmes.

Staff accessed a broad range of learning and personal developmental opportunities, including:

- The Expectations of Line Managers workshop, which was co-created by representatives from the People profession and aimed at building confidence and consistency in people management. The workshop has been attended by 920 people of which 401 are within our target audience of Band 6–8c line managers, resulting in 95% compliance. This will be developed for Clinical leads in the next financial year, with the first programme in Spring 2026.
- All internal leadership programmes have been comprehensively reviewed to maximise staff participation while minimising disruption to service delivery. In response, annual cohort capacity has increased by 80% while reducing time away from operational areas. Previously, we offered nine programmes per year with 250 places over 46 days. The new model delivers 12 programmes annually, offering 450 places over just 21 days, ensuring greater accessibility and efficiency. Since launching in September 2025, we have supported one cohort of 19 participants on Learning to Lead (Bands 3–4), 48 participants over two cohorts on Leading with Purpose (Bands 5–6), and one cohort with 23 participants on Leading with Intent (Bands 7–8a and new Consultants).
- Individuals have been able to access coaching and mentoring and have listened to other colleagues share their career pathway journeys through events and the recording of ‘Cake’, the BSW Hospital Group’s podcast.
- Masterclasses and special events provide a range of opportunities for staff to access training, alongside apprenticeships and work experience to enable a pipeline of future workforce.

The Academy continues to deliver Equality, Diversity & Inclusion (EDI) related training, including the Addressing Unprofessional Behaviours workshop which was designed by staff, Cultural Competence training and bespoke training for our EDI and Inclusion Recruitment Champions. Training is now open to staff from across the BSW Hospitals Group. Staff also complete mandatory EDI training every three years and we have achieved 93.7% compliance this year.

Health and wellbeing is central to our offer of holistic support. Our in-house Occupational Heath and Wellbeing Service also provides varied training to staff. Over past few years the Trust has trained 322 Mental Health First Aiders and 79 Health & Wellbeing Champions; and 177 staff have completed 'Mental Health Skills for Managers' and 120 staff have completed the 'Suicide First Aid Lite' workshop. We have also hosted Schwartz Rounds and staff can access a range of individual, group and online resources to support their wellbeing.

Education and Mandatory Training

The Clinical Education and Resuscitation Service Teams have transformed their training offer which has improved workforce capability throughout 2025, with a clear focus on improving compliance, safety, governance and organisational assurance. A systematic review of clinical skills, mandatory training, and resuscitation programmes enabled the implementation of a structured delivery model aligned to workforce demand, regulatory requirements, and service pressures. This has been supported by enhanced planning processes, including forward scheduling in alignment with roster periods and regular programme reviews to ensure responsiveness to operational need.

Education oversight has significantly strengthened through the introduction of an internal weekly RAG-rated review process covering clinical, resuscitation, and mandatory training scheduled over a rolling two-week period. This approach provides real-time visibility of training capacity, utilisation, and enabling early identification of underperformance. By focusing on utilisation and booking levels, the RAG system highlights scheduled training with poor uptake, enabling targeted interventions such as increased communication, prioritised engagement, and focused booking activity. In parallel, data quality improvements and comprehensive Training Needs Analyses across clinical education and resuscitation services have enhanced reporting accuracy, clarified competency expectations, and strengthened alignment between workforce planning and education delivery.

There is a continued organisational focus on strengthening compliance and engagement across resuscitation, mandatory and Maybo training, as these are essential to ensuring safe, effective, and high-quality clinical care, maintaining patient and staff safety, and meeting regulatory standards.

Maybo Training
Maybo training is a training programme designed to equip staff with the skills to prevent, reduce and safely manage challenging or aggressive behaviours. It focuses on communication, de-escalation skills, and keeping both staff and patients safe. This training has demonstrated measurable improvements in both workforce capability and safety outcomes. Maybo compliance increased substantially across adult services, alongside reductions in behavioural incidents and physical assaults. As a result, Trust-wide compliance across adult services has risen from 23% (Nov 2024) to 77.68% (Mar 2026).

Resuscitation Training
Resuscitation training equips staff to respond effectively to critically unwell patients and cardiac arrests, with training delivered according to role and responsibility.

In 2025, all defibrillators were replaced with new Mindray devices, improving reliability, preparedness, and audit capability. A comprehensive training programme was delivered ahead of rollout in July 2025, with over 50% of relevant staff trained within one month. The 85% compliance target was achieved prior to November 2025.

The new devices also enhance data capture during cardiac arrests, supporting improved learning, benchmarking, and patient care.

Mandatory Training Compliance
Mandatory training compliance remains above target at 91%, with medical and dental staff at 84%, slightly below the 85% target.

Reporting has been strengthened through monthly Academy Assurance Reports and improved data by staff group, enabling more targeted improvement work. Compliance is reinforced at induction and within appraisal processes using percentage-based recording.

Alignment with the national framework has reduced training requirements from 20 to 18.5 hours for clinical staff and from 8 to 7 hours for non-clinical staff.

Appraisals

In May 2025, the Trust fully transitioned away from paper-based appraisals, implementing Supervisor Self Service on the Electronic Staff Record (ESR) system to improve data quality and reporting capability. To date, 3,664 Agenda for Change staff have received an appraisal within the last 12 months (April 2025 to March 2026) representing an 80% compliance. Of those receiving an appraisal, 58% completed digitally via ESR (excluding Medical and Dental staff, who continue to use the SARD system). The appraisal process has also been enhanced to incorporate Our Behaviours self-assessment and manager feedback, alongside a specific prompt to confirm whether a Scope for Growth career conversation is required.

Apprenticeships

During 2025, the Trust supported an additional 31 staff to undertake apprenticeships across a range of standards, including Leadership and Management, Student Nursing Associate, and Health Care Support Worker. As a result, 3.48% of the Trust's workforce is now enrolled in an apprenticeship programme. The Trust has utilised 63.5% of its apprenticeship levy, both to invest in workforce development and to support local Health and Social Care providers through levy transfers.

Future workforce

The Trust has worked in partnership with local organisations to deliver a range of initiatives designed to support and strengthen the future workforce. These have included:

- The Project Search work experience programme for people with learning disabilities, which provides a 12-month supported pathway into employment; in 2025, three of the five interns from the previous cohort secured employment within the hospital.
- The Trust has also strengthened its approach to work experience by moving from ad hoc arrangements to a structured application process, allocating students to clearly defined placement periods.
- In addition, the Trust supported 75 T Level students through voluntary placements in year one and clinical placements in year two and delivered 'Dare to' events for 70 students across Nursing, Allied Health Professions, Midwifery and Healthcare Science pathways, promoting awareness of careers within the NHS.

Trust Health and Wellbeing

In 2025/26, the Trust's Occupational Health and Wellbeing Service continued to focus its development on prevention, early intervention, and accessible support. This is provided through a comprehensive, holistic package for staff, including multi-disciplinary clinical care, psychological and physiotherapy group-based support, staff training, and systemic interventions.

Key achievements include:

- Improved access to Employee Assistance Programme: 25% increase in staff accessing counselling support through Vivup, in addition to staff accessing their practical advice and salary sacrifice schemes.
- Enhanced Occupational Health support: Conducted 1,390 specialist assessments following management referrals, 1,907 pre-employment checks, 1,460 OH clinic nurse appointments, and a new development of tailored in-reach physiotherapy groups provided 86 contacts.
- Excellent flu vaccination programme: Achieved 64.2% uptake for frontline staff, ranking the Trust top in the Southwest for the 5th year running, and joint 4th nationally.
- Accessible counselling and psychological therapy: Delivered 696 in-house individual therapy sessions, with 87% demonstrating psychometric improvement on completing therapy. 812 staff contacts were also made through psychological wellbeing groups.

- Inclusive training in mental health skills: 188 staff have accessed training in Mental Health First Aid, Suicide First Aid, and Mental Health Skills for Line Managers.
- Preventative and restorative support through systemic interventions: Schwartz Rounds have been run to help facilitate a culture of compassionate care, and TRiM (trauma risk management) support has been provided following traumatic incidents.
- Self-care provisions: Regular tea trolley visits into departments, seasonal hampers, discounted food across winter, and Trust wide wellbeing events held throughout the year.
- Enhanced Financial support: A series of financial webinars have been run for staff and the app Stream was enhanced this year to include additional financial offers, which 17% of the workforce have engaged with.

Equality, Diversity & Inclusion (EDI)

The Trust published its new 4-Year Strategic Plan in 2025, the plan sets out how we will create a sense of belonging for all, by collectively building an environment where everyone, regardless of background, identity or difference, feels valued, respected and supported.

The plan sets out GWH's four strategic objectives:

The objectives mirror our previous strategic plan 2020-2024, this was determined through engagement with our staff, who were keen to maintain momentum and drive improvements in these areas. Taking a phased approach, we will focus on building inclusion capability and scaling innovation to enable sustainable change over the next four years. This report highlights how we have responded to year one of the Strategic Plan – our work has centred on delivering against the NHS EDI Improvement Plan (a national plan that sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce), engaging with our workforce and embedding allyship. This important work is overseen by the Inclusion & Health Inequalities Subcommittee, who provide governance.

Responding to the EDI Improvement Plan

"The NHS equality, diversity, and inclusion (EDI) improvement plan, published by NHS England in June 2023, sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce."
NHS England (NHSE)

In response to national drivers, the initiatives delivered across the year at GWH have been designed to align with the NHSE improvement plan and a few of these initiatives are highlighted in the table below:

High Impact Action	EDI Improvement Plan Action
1: Board commitments	• Board set commitments - engagement with staff, including site visits to understand their working life experience. • NED appointed who sponsors EDI at board level.
2: Recruitment and talent management	• Improve equalities information – including annual reminder to staff to update their demographic information. • Increase number of Inclusion Recruitment Champions – trained staff who sit on interview panels for senior roles. • Deliver programmes that support recruitment from groups that are economically or otherwise disadvantaged – Project Search, Dare 2 programmes, Carer's Charter initiatives.
3: Eliminate pay gaps	• Introduce ethnicity pay gap reporting and begin design and planning for disability pay gap reporting. • Promote and deliver a suite of leadership programmes for clinical and non-clinical staff. • Promote and support mentoring across the organisation.
4: Address workforce health inequalities	• Develop the Cultural Ambassadors programme ready for launch in 2026/27. • Monitor access to health and wellbeing and other programmes to ensure equitable access across protected characteristics and take action where necessary.
5: Induction, onboarding and development of international staff	• Deliver the SIFE programme, which supports internationally educated nurses to acquire their RCN Pin. • Promote and support access to leadership development and mentoring.
6: Eliminating discrimination, bullying and harassment	• Increase the number of EDI Champions, these are staff who are trained to address unprofessional behaviours in their area of work. • Deliver suite of EDI-related training to equip staff to address unprofessional behaviours and improve cultural competence. • Relaunch Never OK campaign in partnership with Wiltshire Police to highlight the personal impact of abuse and remind staff about the importance of reporting incidents. • Design and launch the guide to 'Addressing racist incidents' to help staff combat discrimination.

A more detailed update will be provided in the annualised reports that will be published on the EDI page of the Trust's website, in October 2026.

Meeting the Public Sector Equality Duty

The initiatives we deliver across the year demonstrates our commitment to have due regard to the Public Sector Equality Duty set out in the Equality Act 2010. This duty instructs the Trust to:

- Eliminate unlawful discrimination, victimisation, harassment and any other unlawful conduct
- Advance equality of opportunity for groups who are disadvantaged
- Foster positive relationships between different groups of people.

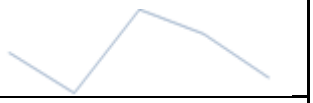
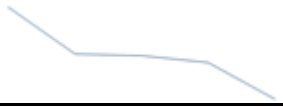
There have been notable legal milestones in recent years including The Equality Act 2010 (Amendment) Regulations 2023 which came into force in 2024 – the amendment included expanding the definition of disability; the 'For Women Scotland Ltd v The Scottish Ministers case which addressed the definition of 'woman' under the Equality Act 2010 and the Employment Rights Act 2025, which prioritises fairness, equality and wellbeing of staff. The Trust is currently revising its key policies including the EDI policy to align with these changes.

Measuring Impact

Discrimination

The Trust has focussed on addressing Discrimination in the workplace for the past two years, our ambition is to address discrimination for all staff and to reduce the disparity of experience between White staff and staff from

ethnic minority communities who, in 2024 were 2.8 times more likely to experience this behaviour. The data in the table below, highlights the impact of an organisation-wide effort, which has utilised the Trust's continuous improvement methodology, Improving Together. This has included training and deploying EDI Champions; developing and delivering bespoke EDI training (Addressing Unprofessional Behaviours); local action taken by EDI/Staff Survey Divisional Working Groups and involving staff in change management. This has resulted in an improvement of 5.2% fewer ethnic minority staff reporting discrimination; in addition, discrimination has improved by 1.9% for Disabled staff and has remained relatively the same for White staff (-0.26). Our Board and Executive team continue to play an active and vital role in driving the direction of this work.

Demographic	2021	2022	2023	2024	2025	5-Year Trend
White staff	6.58%	6.34%	6.84%	6.69%	6.43%	
All other ethnic groups	26.37%	19.78%	19.55%	18.57%	13.34%	

Equality Delivery System (EDS) 2025/26

EDS is a self-assessment framework used to measure equity. The assessment involves stakeholders evaluating a range of evidence including policy, practice and support in place to attain equitable access, experience and outcomes for staff and patients.

The EDS assessment for Domain 2 (Workforce Health & Wellbeing) and Domain 3 (Inclusive Leadership) took place in March 2026. The Trust maintained its rating of '**Achieving**', having improved from '**Developing**' (minimal activities taking place), to '**Achieving**' (required level of activity taking place) the year before. Stakeholders acknowledged the progress the Trust has made including the 'Never OK' campaign designed to deter bullying and harassment against staff and staff feel they have a voice; and the redesign of the Freedom to Speak Up Service has improved confidence in this process too. Staff shared in their feedback that they are keen for the Trust to continue to drive cultural change and address poor behaviours and that additional support should be given to departments who need help to interpret their data and drive local culture change.

The full EDS report (Domain 1-3) will be published in October 2026.

Pay Gap Reporting 2024/25

The Trust published our 2024/25 Pay Gap (GPG) reports in October 2025, based on a snapshot date of 31 March 2025. These reports outline the differences in the average earnings and bonus payments between men and women and White and Ethnic Minority staff.

GWH recorded a mean gender pay gap of £7.32 per hour (26.03%) in favour of men, with women earning £0.74 for every £1 earned by men. The median bonus pay gap in monetary terms was £3.04. When expressed as a percentage of overall bonus pay, the mean bonus gap was 30.76% and the median bonus gap was 62.44%.

The Trust published its Ethnicity Pay Gap for the first time in 2025. The mean ethnicity pay gap was £0.79 per hour (3.6%) in favour of White staff, while the median gap was -£0.28 (-1.45%) in favour of Ethnic Minority staff. White staff were over-represented in the upper quartile, whereas Ethnic Minority staff were more concentrated in the middle quartiles. Bonus disparities were also observed: the mean bonus gap was 8.24% in favour of White staff, while the median was -35.81%, reflecting the distribution and small number of awards to Ethnic Minority staff.

We recognise these structural inequalities and are committed to taking action, the training and development and recruitment sections of this report highlight some of the initiatives in place to increase women and minoritised groups in leadership roles.

The full pay gap report can be accessed via the Trust website.

Workforce Disability & Race Equality Standards (WRES/WDES) 2025-2026

The Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) are NHS mandated equalities frameworks which are designed to measure the working life experience of disabled staff and staff from ethnic minority backgrounds.

Interim data indicates that the Trust has made progress across several key indicators of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) in 2025/26, reflecting our commitment to building a more inclusive and equitable workplace – this includes bullying and harassment or abuse from colleagues which has significantly improved for Disabled staff (-4.39%) and discrimination, which has significantly improved for staff from ethnic minority backgrounds (-5.2%). We have also seen a small improvement in bullying and harassment from patients for these groups. However, both groups are less likely to feel they have equal opportunities for career progression or promotion.

We will continue to develop our approach to this work and staff will be invited to help shape the 2026/27 EDI actions during April and May 2026.

A detailed WDES and WRES report, will be published in October 2026.

Looking ahead

Our four-year Equality, Diversity & Inclusion (EDI) strategic plan captures our bold ambition to harness the ingenuity of our people and to adopt technology and best practice to improve equity and inclusion. To make change sustainable, our ambition is to equip staff to undertake equity and inclusion initiatives at every level of the organisation with shared accountability and responsibility across all levels of management and leadership, this bold approach will require us to build capability at individual and organisation level and requires a cultural shift towards a more collectivist approach – we acknowledge that cultural change takes years and we are committed to making this investment.

Our journey starts with ‘Building Capability’, the focus of our EDI and Health Inequalities Conference to be arranged in 2026. In addition to the conference, we will deliver high quality EDI training; create helpful self-service resources to enable staff to independently access support; target departments where their workforce data is significantly under-performing in comparison with the organisation-level data; and we will remodel the EDI service to increase capacity.

From April 2026, the EDI service will be delivered at BSW Group level, the EDI staff from all three care organisations will work as one team. A group approach will help us to offer a standardised service across the three organisation – GWH, RUH Bath and Salisbury NHS Foundation Trusts and reduce duplication (staffing and resourcing) which will also enable us to deliver a more cost-effective service.

7 CODE OF GOVERNANCE FOR NHS PROVIDER TRUSTS

Corporate governance is the means by which a Board of Directors leads and directs their organisation so that decision-making is effective, and the right outcomes are delivered. In the NHS this means delivering safe, effective services in a caring and compassionate environment in a way that is responsive to the changing needs of patients and service users. The code of governance for NHS provider Trusts came into effect from 1 April 2023 and replaced the 2014 NHS Foundation Trust code of governance. The code of governance for NHS provider Trusts sets out best practice principles and processes to assist NHS Foundation Trusts to achieve this goal. The main areas are:

Leadership

Every NHS Foundation Trust should be headed by an effective Board of Directors. The Board is collectively responsible for the performance of the NHS Foundation Trust. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.

Effectiveness

The Board of Directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS Foundation Trust to enable them to discharge their respective duties and responsibilities effectively.

Accountability

The Board of Directors should present a fair, balanced and understandable assessment of the NHS Foundation Trust's position and prospects. The Board of Directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The Board should maintain sound risk management systems.

Relations with stakeholders

The Board of Directors should appropriately consult and involve members, patients and the local community and the Council of Governors must represent the interests of Trust members and the public.

Details regarding how the Trust has applied the code principles and complied with its provisions are set out throughout the annual report. A summary table is provided below.

Statement of Compliance

Great Western Hospitals NHS Foundation Trust has applied all the principles of the Code of Governance for NHS Provider Trusts and fully complied with all provisions of the Code during 2025/26. There were no instances during the year where the Trust departed from the requirements of the Code, and therefore no explanations for non-compliance are required.

The Trust confirms that it was not subject to any formal regulatory interventions during the year.

Summary of Code of Governance disclosures contained in the Annual Report 2025/26

Code Reference	Summary of Requirement	Annual Report References/Response
A2.1	The trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships.	This information is available in the Annual Governance Statement of this Annual Report
A2.3	The board of directors should assess and monitor culture.	This information is available in the Staff Report of this Annual Report.
A2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered.	This information is available in the Performance Report of this Annual Report.
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent.	This information is available in the Directors' Report of this Annual Report.
B2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	This information is available in the Directors' Report and the Remuneration Report of this Annual Report.
B2.17	A clear statement detailing the roles and responsibilities of the council of governors.	This information is available in the Directors' Report.
C2.5	If an external consultancy is engaged for Board recruitment.	No external recruitment agency was used in 2025/26.
C2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors.	This information is available in the Directors' Report.
C4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience	This information is available in the Directors' Report.
C4.7	Description of any externally facilitated developmental reviews of their leadership and governance using the Well-led framework.	This information is available in the Directors' Report.
C4.13	Describe the work of the nominations committee(s),	This information is available in the Directors' Report.
C5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent and the annual report should contain a statement as to how this requirement has been undertaken and satisfied.	This information is available in the Directors' Report.
D2.4	Annual Audit Committee Report	This information is available in the Directors' Report.
D2.6	Directors state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for	This information is available in the Directors' Report.

Code Reference	Summary of Requirement	Annual Report References/Response
	stakeholders to assess the trust's performance, business model and strategy.	
D2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks.	This information is available in the Performance Report and the Annual Governance Statement of this Annual Report.
D2.8	The board of directors should monitor the trust's risk management and internal control systems, and, at least annually, review their effectiveness and report on that review in the annual report.	This information is available in the Annual Governance Statement of this Annual Report.
D2.9	The board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern.	This information is available in the Performance Overview of this Annual Report.
E2.3	Where a trust releases an executive director, for example, to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable for the reporting year.
Identify the members of the council of governors		This information is available in the Directors' Report of this Annual Report.
Contact procedures for members who wish to communicate with governors and/or directors.		This information is available in the Directors' Report of this Annual Report.
If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.		Not applicable for the reporting year.

8 NHS OVERSIGHT FRAMEWORK

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'. Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)

b) considering financial override which may limit a segment to be no better than 3

c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and

d) capability assessments which consider the organisation's leadership and governance.

Segmentation

Based on the most up-to-date information available at the time of preparing this Annual Report, the Trust was assessed by NHS England as Segment 4 under the NHS Oversight Framework as at 1 April 2026.

During the year, the Trust was subject to enhanced national oversight and improvement support from NHS England for specific priority areas through national Tier 1 performance arrangements. These arrangements provide structured engagement with NHS England national teams, alongside system partners, to support recovery, provide additional scrutiny, and monitor delivery against agreed performance trajectories.

The Trust continued to work closely with NHS England and system partners to address the areas identified for improvement. Further detail on the actions taken, arrangements for oversight and assurance, and assessment of leadership and governance capability is set out in the Annual Governance Statement.

This segmentation information is the Trust's position as at 1 April 2026. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentation and-league-tables/. The Trust is included on the acute Trust dashboard.

9 STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the chief executive's responsibilities as the accounting officer of Great Western Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Great Western Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Great Western Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care's Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in *the NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Cara Charles-Barks
Chief Executive Officer
Date: 25 June 2026

10 ANNUAL GOVERNANCE STATEMENT

SCOPE OF RESPONSIBILITY

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Great Western Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Trust Board

The Trust Board has approved a Risk Management Policy which sets out how risk is identified, assessed, managed and monitored across the organisation. The Board recognises that effective risk management is a core component of good governance and is integral to decision-making, assurance and delivery of the Trust's strategic objectives.

The Policy defines the Trust's risk appetite and the supporting systems and processes for managing risk. Principal strategic and corporate risks are overseen through the Board Assurance Framework (BAF). Each risk on the BAF is assigned to a named Executive Lead who is accountable for its management and mitigation.

The Board uses a single, integrated framework to bring together corporate, financial, workforce, clinical and operational risks. The BAF provides clarity on the principal risks that could impact delivery of the Trust's objectives, the key controls in place, sources of assurance and any material gaps in control or assurance.

Board Committees

Audit, Risk & Assurance Committee - the Audit, Risk and Assurance Committee has delegated responsibility on behalf of the Board for overseeing the effectiveness of the Trust's risk management framework and internal control arrangements. The Committee receives assurance from Internal Audit, including an annual opinion on the adequacy and effectiveness of the Trust's systems of governance, risk management and control, which supports the Board's assurance through the BAF.

Other Board Committees—including Quality and Safety, Finance, Infrastructure and Digital, Performance, Population and Place, and People and Culture— provide assurance to the Board on significant strategic and corporate risks within their respective remits. Where risks are assessed as being outside the Board's risk appetite,

Committees may commission additional assurance, including deep dives or targeted reviews, and escalate issues through established governance routes.

Executive Directors

Chief Executive - has overall accountability for risk management within the Trust. Day-to-day operational responsibility for the Trust's risk management framework is delegated to the Chief Nursing Officer, who leads the strategic development and implementation of organisational risk management systems and processes, including compliance with Care Quality Commission (CQC) registration requirements and other legal and regulatory standards. The Chief Nursing Officer is also accountable for patient safety and patient experience.

Chief Finance Officer - is responsible for the oversight and operation of the Trust's Standing Financial Instructions, including budgetary controls, procurement, income and expenditure processes, losses and special payments, and counter fraud arrangements. The Chief Finance Officer attends the Audit, Risk and Assurance Committee and works closely with Internal Audit, External Audit and Counter Fraud services, which deliver risk-based assurance programmes.

Managing Director - the Managing Director chairs the Trust Management Committee, which provides executive oversight of the management of key operational and corporate risks. Day-to-day management of risks is undertaken within clinical divisions and corporate directorates, where managers are responsible for proactive risk identification, assessment and mitigation within their areas of responsibility.

Clear escalation arrangements are in place through Executive Performance Reviews, governance committees and other forums where there are challenges in implementing agreed risk mitigations. Divisional Governance Committees, introduced to further strengthen the Trust's governance framework, are now embedded and provide structured oversight of divisional risk management and governance processes.

Training & Support

The Trust recognises that a positive risk culture is dependent on staff capability and understanding. To support this, a structured programme of risk management training and development is in place and has continued throughout the year, with delivery planned to continue during 2025/26.

Executive and Non-Executive Directors receive specific training on risk management and their leadership responsibilities in this area. Risk reports provided to the Board and Committees include prompts to support effective challenge and discussion.

Risk management awareness is introduced to staff at the point of employment, with training provided proportionate to role and responsibility. All staff have access to risk management training via the Electronic Staff Record (ESR). Staff with defined responsibilities for managing risks receive additional one-to-one training on the use of the electronic risk register prior to access being granted, with refresher sessions and group clinics available where required.

Divisions receive a monthly risk register report, including analysis of movement compared to the previous month. This supports consistent monitoring and assurance and forms part of the Trust's overarching risk management framework, ensuring a consistent approach to the identification and management of risk across the organisation.

The risk and control framework

The Trust has a Board-approved Risk Management Policy which sets out the arrangements for identifying, assessing, managing and monitoring risk across the organisation. Risk management is embedded within strategic planning, operational management and decision-making processes and supports the delivery of the Trust's objectives.

Risks are identified proactively through horizon scanning, business planning, performance monitoring, incident reporting, audit and assurance activity, and consideration of internal and external change. Identified risks are

recorded on the Trust's electronic risk management system to enable consistent assessment, escalation and monitoring.

Risks are evaluated using a standardised risk scoring matrix which assesses likelihood and consequence to determine the level of residual risk. Appropriate risk responses are applied, including treating, tolerating, transferring or terminating risk, supported by defined controls and, where required, time-limited action plans with named owners. Risks outside the Trust's risk appetite are escalated through established governance arrangements and subject to enhanced scrutiny and assurance.

The Trust's risk appetite is reviewed annually and approved by the Board through a formal Risk Appetite Statement. This sets out the level of risk the Trust is prepared to accept in pursuit of its strategic objectives, across defined themes including quality, workforce, finance, estates, digital and reputation. Risk tolerance thresholds are used to guide prioritisation and decision-making where risk exposure changes over time. The Risk Tolerance Statement is explained below.

The Board Assurance Framework provides oversight of the Trust's principal risks, key controls and sources of assurance, enabling the Board to understand whether risks are being managed within appetite and where further action or assurance is required.

Risk Assessment

All Trust employees are responsible for identifying and managing risk. The Trust uses the National Patient Safety Agency (NPSA) Risk Matrix for Risk Managers to ensure risks are collectively scored objectively against the likelihood and the consequence of the risk materialising.

In addition, a robust Patient Safety Incident Review Framework Policy is in place and at corporate induction employees are actively encouraged to utilise the web-based incident reporting system. Incident reporting levels are comparable with other Trusts providing assurance that employees feel able to report incidents and risks.

Risk Register (risk management tool)

The risk register is a risk management tool whereby identified risks are described, scored, controls identified, mitigating actions planned and a narrative review is recorded. Data in the risk register is extractable into report format to provide an overall picture of risks to the Trust as well as thematic overviews.

The Trust has agreed that the most significant risks to the Trust, being those that score 15 and above (15+) should be reviewed quarterly at the Trust Management Committee and relevant Board committees, with other risks reviewed through the Divisions. A register containing 15 plus risks is scrutinised and challenged by the Trust Management Committee (to ensure risks are being managed) and three times a year at the Audit, Risk and Assurance Committee (to ensure processes in place to manage risk are effective). This high-level register is informed both by those risks which score 15 and above in the Board Assurance Framework (top down) and risks identified from within the Divisions (bottom up).

There is a continual focus on maintaining effective management of risk with on-going actions to support this including: -

- Ad hoc individual training sessions provided as well as group sessions
- Access to risk training through ESR for all staff
- Guides refreshed and widely circulated
- Monthly reporting of Divisional Risks Registers to Divisional Managers
- Review and update of Divisional governance arrangements for risk management
- Divisional risk leads refreshed
- Electronic system reconfigured to continually remind handlers of risk actions
- Key performance indicators (KPIs) in place to monitor risk management, including refinement as required to provide good oversight

- Divisional and Corporate department presentations to the Audit, Risk and Assurance Committee
- A Risk Committee to enable deep dive into risks and scrutinise and challenge
- 15+ Risk Map produced monthly (aligned to the CQC key lines of enquiry),
- Risk management internal effectiveness reviews reported to both Audit, Risk and Assurance Committee and the Board
- A standardised approach to risk management and escalation through an agreed template for sharing at each governance meeting

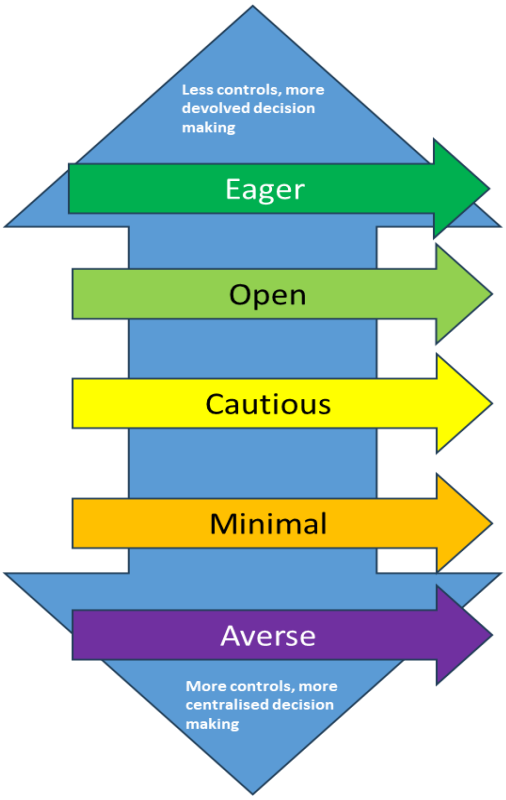
Risks are scrutinised locally at divisional and corporate department meetings and there is a strong emphasis from Executive Directors that managing all risks at Divisional and Corporate department level using the risk management system is essential.

Risk Appetite & Tolerance

The Board has a risk tolerance statement aimed at supporting managers in decision making. The statement sets out the Trust's appetite for risk and is refreshed annually. A framework was developed which the Board uses to inform its view of risk tolerance.

Risk Appetite Tolerance Statement 2025/26

The Trust has adapted definitions for Risk Appetite and Risk Tolerance from the '*Orange Book – Risk Appetite guidance note'*, Government Finance Function (October 2020) and to utilise the following Risk Appetite scales that broadly show the different appetites an organisation could have to meet its strategic objectives.



Willing to be innovative and take on a very high level of risk but only in the right circumstances

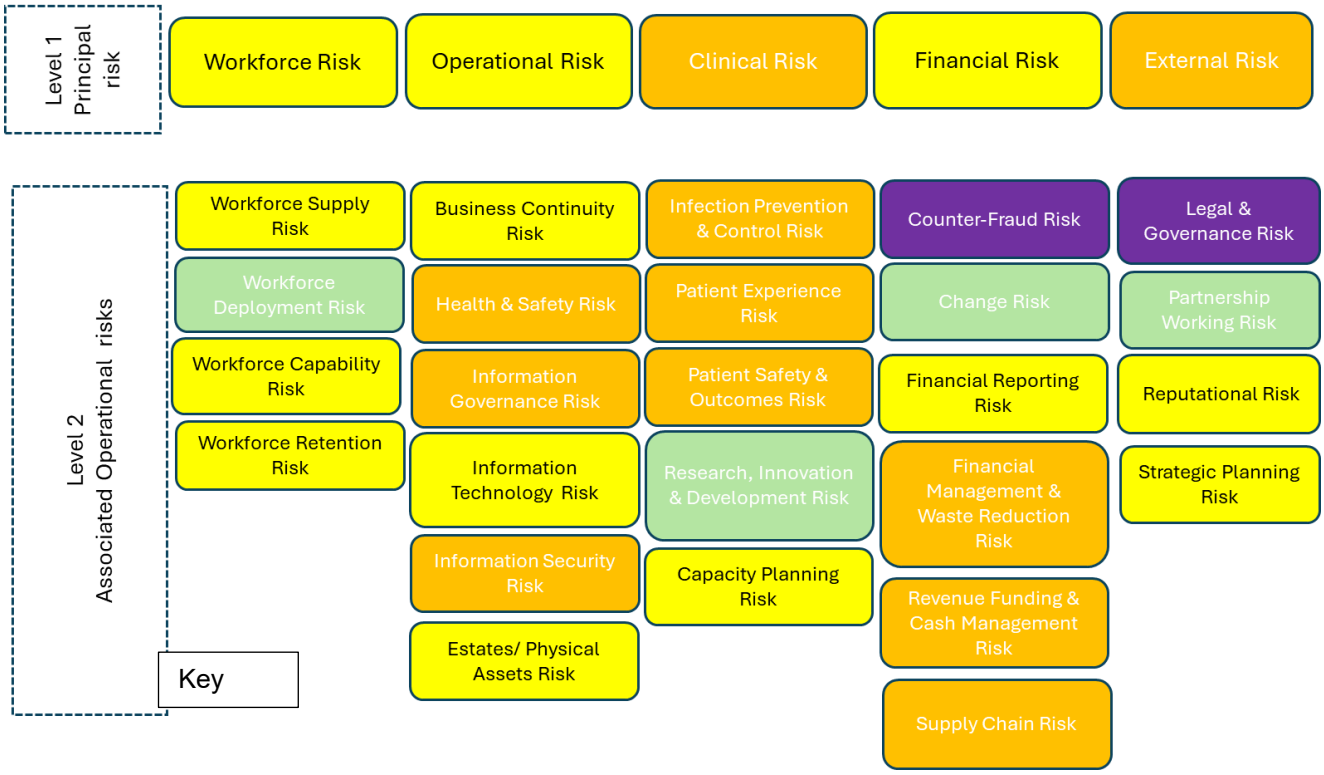
Willing to consider all options and choose one that is most likely to result in successful delivery; recognise that there could be a high-risk exposure

Preference for safe options though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls

Preference for safe options leading to only minimum risk exposure: low likelihood of occurrence of the risk after application of controls

Avoidance of risk and uncertainty is key objective

The Trust has developed risk categories which is a useful scheme of classification for organising risks and provide illustrative descriptions of underlying causes. Using this methodology the Trust Board developed its Risk Appetite & Tolerance statement as follows:-



Risk Appetite Levels:

Risk Appetite	Tolerance Range
Eager	16 – 25
Open	12 – 20
Cautious	9 – 15
Minimal	6 – 10
Averse	4 – 6

This risk appetite and tolerance statement for 2025/26 depicted in the chart above assists managers and staff in decisions which may involve or facilitate exposure to risk.

The Board Assurance Framework

The Board has established a robust Board Assurance Framework (BAF) which deals with statements of internal control and assurances. A BAF was in place during the reporting period and is part of the wider Risk Management Framework to ensure the Trust's performance across the range of its activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for service users. Risks to strategic objectives are aligned to Board Committees and are reviewed on a quarterly basis.

The BAF records that the Trust has been managing 10 significant risks during the year. The table below describes the risk and the risk scores throughout the year. The theme of the significant risks were around:-

SR1 : Quality of Care
SR2 : Culture & Inclusion
SR3 : Workforce Sustainability
SR4 : Operational Performance & Access
SR5 : Partnership Working & Population Health
SR6 : Financial Sustainability
SR7 : Estates & Infrastructure
SR8 : Digital Tranformation
SR9 : Cyber Security & Information Protection
SR10 : Electronic Patient Record (EPR) Programme

SUMMARY 25/26

BAF Ref	Risk Summary	Assurance				Change	Risk Score				Change	Risk Appetite	Tolerance Range	Target date
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				
SR1	If we do not meet internally and externally set standards of quality and safety then this may result in harm to patients and impact negatively on patient experience.	G	G	G	G	⇹	16	16	20	20	↑	Minimal	6-10	Q1 26/27
SR2	If we are unable to develop and sustain an inclusive, diverse and accountable workplace culture, then this may result in poor behaviours, low employee engagement, poor learning environment and increased turnover which will have a negative impact on the quality of patient care, safety and organisational performance	G	G	G	G	⇹	9	9	9	9	⇹	Cautious	9-15	Within tolerance
SR3	If we do not have effective workforce planning, we will have poor recruitment, retention and representation, then this may result in high agency usage and compromised patient safety and suboptimal service delivery.	P	P	P	P	⇹	16	16	16	16	⇹	Cautious	9-15	Q1 26/27
SR4	If we do not work across the Trust, the Integrated Care System & Group to recover services then patient care may be delayed that could result in both physical and psychological harm.	G	G	G	G	⇹	16	16	16	16	⇹	Cautious	9-15	Q1 26/27
SR5	If we do not develop and maintain collaborative relationships with partner organisations across health & social care based on shared aims, objectives, and timescales then we may not be able to improve healthcare outcomes and address health inequalities.	G	G	G	G	⇹	16	16	16	16	⇹	Open	12-20	Within tolerance
SR6	If we do not adequately control, report and manage the Trust's financial position then this may hinder the achievement of longer-term financial sustainability of the Trust and the wider system	G	P	P	P	⇹	16	20	20	16	⇹	Cautious	9-15	Q1 26/27
SR7	If we do not provide an estate that is fit and resilient for the future this may lead to unsafe environment for both our patients and our workforce.	G	G	G	G	⇹	12	12	12	12	⇹	Cautious	9-15	Within tolerance
SR8	If we do not deliver an appropriate digital environment that is stable, resilient and responsive then delivery of safe and effective services, our ability to beneficially impact population health, patient care and colleague experience may be adversely compromised.	G	P	G	G	↑	12	16	16	16	⇹	Cautious	9-15	Q1 26/27
SR9	If we do not prevent a cyber-attack or data breach this may have a detrimental impact on the organisation's ability to delivery operational services and maintain patient safety.	G	G	G	G	⇹	20	20	20	20	⇹	Minimal	6-10	Q1 26/27
SR10	Delayed or suboptimal deployment of the joint Electronic Patient Record would result in clinical, strategic, and financial benefits not being realised and impact the delivery of the Trust future operating model.	-	-	P	P	New risk	-	-	16	16	-	Cautious	9-15	Q1 26/27

The Board Assurance Framework was reported to the Board on a quarterly basis in 2025/26 and also reported to its aligned assurance Committees, which have the authority to commission additional assurance measures where these are felt necessary in improving the effectiveness of the Trust's overall control environment. Chairs of Committees formally report at each meeting of the Board from a risk escalation and assurance perspective, via a Chair's Board Assurance Report.

Major risks 2026/27

As we enter 2026/27, the Trust remains focussed on enacting recovery plans whilst dealing with significant operational and financial challenges in the context of significant changes within the health sector. The focus will be on

(i) Financial sustainability remains a significant and clear strategic priority for 2026/27. The Trust continues to operate in a challenging financial environment, with ongoing cost pressures, increasing demand for services, workforce constraints, and limited growth in funding. Delivery of a balanced financial position will require sustained focus on efficiency, productivity, and cost improvement programmes, alongside tight financial control. There is a risk that failure to deliver planned savings or respond effectively to system pressures could impact the Trust's financial resilience and its ability to invest in service quality and transformation. Robust financial governance, strengthened grip on expenditure, and delivery of credible, recurrent savings plans will be essential to mitigate this risk, supported by continued collaboration across the group to optimise resources and drive shared efficiencies.

(ii) the delivery of NHS England Operational and strategic priorities 2027/28:-

- From hospital to community : Shift demand from acute settings by improving patient flow, reducing avoidable admissions, and strengthening mental health crisis and community-based pathways, including for children and young people;
- From analogue to digital : Use digital and data-enabled pathways to support elective recovery, urgent care access and improved system flow, including digital triage, scheduling and productivity improvements

- From treatment to prevention : Reduce long waits and improve outcomes by prioritising timely access to elective, urgent and mental health services, focusing on earlier intervention and preventing deterioration and avoidable escalation

(iii) moving to a group model and its strategic initiatives:-

- becoming an effective group
- delivering digital maturity
- increasing sustainability
- transforming model of care.

Other key risks include:

- Dependence on effective system-wide change to deliver Group objectives. *Mitigation:* Strengthen Group-wide engagement through a coordinated communications and change programme, ensuring consistent messaging, regular feedback loops and clear accountability across all partner organisations. *Outcome assessed through:* Delivery against agreed Group change milestones, staff engagement feedback, and evidence of consistent implementation across Group entities.
- Financial constraints limiting the Group's ability to deliver transformational change at scale. *Mitigation:* Operate a robust Group governance and prioritisation framework to align resources to shared strategic priorities, support system productivity, and target investment towards reducing health inequalities across the Group footprint. *Outcome assessed through:* Group financial balance and forecast position, delivery of agreed productivity plans, and monitoring of investment impact on priority population outcomes.
- Short-term operational pressures creating misalignment with the Group's long-term strategic direction. *Mitigation:* Maintain clear line-of-sight between operational plans and the Group's agreed strategic priorities through regular assurance reviews, with formal checkpoints to test alignment and resolve divergence. *Outcome assessed through:* Evidence of alignment between operational performance reports and strategic objectives, and reduced instances of exception reporting or corrective intervention.
- Inconsistent or poor-quality data across the Group undermining effective decision-making. *Mitigation:* Implement a Group-wide data and information framework, including shared data standards, routine quality assurance, and targeted capability development to support consistent, evidence-based decision-making. *Outcome assessed through:* Improvements in data quality metrics, reduced reconciliation issues between organisations, and increased use of shared data in Group decision-making and assurance reporting.

Our underlying financial position remains a significant challenge. The financial context for the NHS as a whole in 2026/27 is as challenging as has been seen in recent years.

Quality Governance

The Trust maintains effective quality governance through a comprehensive framework of structures and processes operating at Board, committee and operational levels. This framework enables leadership and oversight of Trust-wide quality performance, including:

- ensuring compliance with required quality and safety standards
- identifying, investigating and learning from sub-standard care
- planning, delivering and sustaining continuous improvement
- sharing and embedding best practice; and
- identifying, managing and escalating risks to the quality of care.

The Chief Executive is the Trust's Accountable Officer for quality governance. Executive accountability is supported through clearly defined leadership roles, with the Chief Medical Officer responsible for clinical

effectiveness and the Chief Nursing Officer responsible for patient safety and patient experience. Each Executive Director leads on specific Board objectives, providing collective accountability for quality outcomes.

Continuous Improvement

Improving Together is the Trust's approach to continuous improvement and underpins the delivery of high-quality care. It aligns with the five components of NHS Impact and brings together improvement tools, management routines and behaviours that support a culture of continuous improvement. The approach is founded on coaching leadership and empowers staff at all levels to improve services and contribute to the delivery of the Trust's strategy.

Evidence demonstrates that organisations with a strong continuous improvement culture deliver better patient outcomes and higher levels of staff engagement and satisfaction. At its heart, *Improving Together* focuses on improving the quality of care by directing effort and resources to where they have the greatest impact. The approach is built around five core principles:

- **Alignment of priorities** – using a clear planning framework from Board to ward so that priorities are shared and connected.
- **Empowerment** – enabling colleagues to make improvements within their teams, supported by the skills and tools to change practice.
- **Culture development** – giving every member of staff a voice and supporting compassionate, inclusive and enabling leadership.
- **Continuous quality improvement** – applying evidence-based improvement methods to understand, improve and sustain high-quality services.
- **Value focus** – stopping activities that do not add value for patients, staff, populations or partners.

Integrated Governance and Assurance

Throughout the year, the Trust has continued to strengthen integrated governance arrangements to ensure that clinical governance, performance management and risk management operate seamlessly. These arrangements provide clear visibility of risks, concerns, learning and improvement from ward and team level through to the Board, while also enabling the sharing and recognition of good practice.

The Trust has a robust approach to assessing the potential impact of cost improvement programmes on quality. A structured Quality Impact Assessment (QIA) process is applied using a standardised template and requires Divisional Management Team sign-off. The Chief Medical Officer and Chief Nursing Officer provide assurance to the Board that cost improvement activity does not have an adverse impact on the quality or safety of care.

The Quality & Safety Committee provides oversight of the effectiveness of the Trust's quality governance arrangements. It receives planned assurance reports and undertakes a programme of quality deep dives across services and clinical networks. This is supported by the Trust's Performance & Accountability Framework, which clearly defines roles, responsibilities and escalation routes and ensures alignment between performance, quality and risk. Executive performance reviews with Divisions are undertaken on a monthly basis.

Delivery of the Trust's strategic quality objectives is supported by the Annual Quality Account, which reports progress against quality priorities for 2025/26 and sets out priorities for 2026/27. Delivery and impact are monitored through the Patient Quality Sub-Committee and the Quality & Safety Committee using a comprehensive suite of quality metrics. The Quality Accounts can be found on the Trust's website.

Patient Safety and Patient Voice

The Trust implemented the National Patient Safety Incident Response Framework (PSIRF) in early 2024 and has continued to embed it across the organisation. This has included the appointment of a dedicated Lead Incident Investigation and Patient and Family Engagement Manager and the delivery of mandatory Level 1 and Level 2

PSIRF training for staff, supporting a consistent and compassionate approach to learning from patient safety incidents.

Patient stories remain central to quality governance, providing valuable insight and challenge and ensuring patient and service user experiences inform learning, assurance and improvement. The Trust's response to national patient safety alerts and related governance actions is overseen by the Quality & Safety Committee and reported to the Board.

The Trust promotes an open and supportive culture that encourages both patients and staff to raise concerns. Patient feedback, complaints, staff survey results and the Friends and Family Test are routinely reviewed to support learning and improvement. The Trust's Freedom to Speak Up arrangements include Guardians, supported by a strengthened Lead Guardian role, and a secure system for recording and triangulating concerns with wider quality and safety intelligence.

Incident reporting is embedded through the Incident Management Policy, requiring the reporting of incidents and near misses to support organisational learning. Quality and equality impact assessments are applied to Trust-wide policies and decisions, ensuring that quality, safety and fairness remain central to governance and improvement activity.

CQC Registration

Compliance with CQC registration is on a rolling program of review. This work is on-going with updates to registration made as required. Processes are in place to ensure on-going monitoring of registration requirements.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

CQC Inspections 2025/26:
During 2025/26, three Care Quality Commission (CQC) inspections were undertaken across key services at Great Western Hospital. These inspections provide important insight into the culture of openness, safety, and responsiveness within the organisation.

Surgical Services (March 2025) : The CQC found that surgical services deliver safe, effective and compassionate care, supported by strong leadership and a culture of continuous improvement. However, areas for improvement were identified, including:

- Timeliness of access to surgical care
- Consistency of airway monitoring in the Post Anaesthetic Care Unit
- Completion of patient metrics (height and weight)
- NEWS2 compliance on admission

In response, the Trust has progressed targeted actions, including completion of work on swab count processes and single-use items, alongside a wider Trust-wide programme to improve integration of electronic and paper systems.
The CQC rated this service as good.

Urgent and Emergency Care (April 2025) : The inspection recognised a dedicated and compassionate workforce operating under significant pressure, supported by improved facilities and positive initiatives in safeguarding and inclusion. However, significant concerns were identified, including:

- Delays in treatment and ambulance handovers
- Use of corridor care impacting patient dignity
- Inconsistencies in incident reporting
- Gaps in governance and oversight

The Trust received a first-level regulatory breach, which required submission of an action plan. This has been subject to ongoing monitoring, with a CQC reassessment expected shortly.

A comprehensive improvement plan has been implemented, focused on:

- Strengthening incident reporting and organisational learning
- Addressing workforce gaps
- Eliminating corridor care and improving patient dignity
- Enhancing oversight and ensuring clinical areas are fit for purpose

This work is being actively monitored through Divisional governance structures.
The CQC rated this service as requires improvement.

Maternity Services (January 2026) : The inspection identified several areas of good practice, including:

- Strong multidisciplinary team working
- Visible and engaged leadership
- Effective escalation processes

The Trust has submitted its factual accuracy response and is awaiting formal feedback from the CQC.

The overall CQC rating is as follows:-

CQC ratings 2024/25

Overall rating	Safe	Effective	Caring	Responsive	Well-led
Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

CQC ratings 2025/26

Overall rating	Safe	Effective	Caring	Responsive	Well-led
Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Good

Workforce Plan

The Trust has a comprehensive Workforce Plan which is reviewed and updated annually and formally approved by the Board of Directors. Workforce planning arrangements are aligned to national developing workforce safeguards and are designed to ensure that the Trust has the capacity, capability and skills required to deliver safe and effective care.
The workforce planning process includes:

- undertaking a baseline assessment to maintain up-to-date workforce intelligence
- aligning workforce planning with the annual planning round to ensure integration with service and financial planning
- analysing workforce data to identify availability, gaps and key workforce risks
- developing short- and medium-term workforce strategies to address identified challenges; and
- monitoring delivery and impact through the People & Culture Committee.

Establishment information is reported within the monthly Workforce Report, enabling changes to workforce capacity and composition to be monitored throughout the year. In addition, a formal six-monthly review is undertaken to assess any changes in service demand and workforce requirements. The workforce planning cycle is led jointly by clinical and operational leaders and is informed by available data, evidence and professional judgement to ensure that workforce capacity and demand remain aligned.

On behalf of the Board of Directors, the Quality & Safety Committee receives and approves a monthly Safer Staffing Nursing Report, providing assurance on nursing staffing levels and associated risks. The Board also receives a detailed safer staffing report on a six-monthly basis, which is published in the public Board papers on the Trust's website. These reporting arrangements meet the expectations and recommendations set out within the developing workforce safeguards.

External Well Led Development Review

NHS England strongly encourage all providers to carry out externally facilitated development reviews of their leadership and governance using the Well Led framework (re-issued by NHSE in June 2017) every three to five years, according to their circumstances. The framework retains a strong focus on integrated quality, operational and financial performance and is now aligned to the CQC well-led assessment.

The most recent Well-Led developmental review was commissioned jointly with the BSW acute trusts in Quarter 4 of 2022/23, with Aqua appointed as the provider. The Trust's review took place between August and October 2023, and the final report was considered by the Board in December 2023.

Looking ahead, the Trust intends to commission a further well-led review during 2026/27, with a specific focus on the effectiveness and maturity of Group governance arrangements. This will provide external assurance to the Board on the operation of the developing Group model and help identify any further areas for improvement.

Register of Interest

In accordance with the 'Managing Conflicts of Interest in the NHS policy' and NHS England's guidance decision making staff are required to declare any interests which are relevant and material to the business of the Trust, this includes financial interest, outside employment, shareholdings, family interests, gifts and hospitality interests of which the staff member is aware, irrespective of whether the interests are actual and potential, direct or indirect.

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance. Copies of the declaration of interest register can be found on the following website link Lists and registers | Great Western Hospital (gwh.nhs.uk).

Employer Obligations – Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Sustainability – Green Plan

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied.

Equality, diversity and inclusion

Control measures are in place to ensure that all obligations under equality, diversity and human rights legislation are complied with in line with the requirements of the Public Sector Equality Duties under the Equality Act 2010. We recognise that we need to do more to address equality, diversity and inclusion issues and we have agreed an extensive work plan. All relevant Trust policies are subject to an equality impact assessment. The Trust publishes

data from the Workforce Race Equality Standard (WRES) annually and analysis is undertaken to inform local and Trust wide improvement plans in collaboration with our BAME staff network and staff side colleagues. The Trust uses disclosures on protected characteristics to improve staff engagement and experience, while ensuring opportunities are equitable, including in relation to gender pay. The Inclusion & Health Equalities Sub-Committee ensures that the Trust is meeting the information and physical accessibility needs of patients and carers who are vulnerable or have physical and sensory disabilities, and that we are compliant with the Accessible Information Standard. Equality impact assessments are an integral part of the Trust's patient and public engagement toolkit and inform the engagement strategy during any transformation or service change. They are required for all new Trust business cases and during all policy development, including those related to employment.

Compliance with NHS Foundation Trust Provider Licence

The Trust has assessed compliance with the NHS provider licence. The Board has not identified any principal risks to compliance with its provider licence.

The conditions cover the effectiveness of governance structures, the responsibilities of directors and committees, the reporting lines and accountabilities between the board, its committees and the executive team. The board is satisfied with the timeliness and accuracy of information to assess risks to compliance with the foundation trust's licence and the degree of rigour of oversight it has over performance.

The Trust has processes in place to record and monitor compliance with NHSE's Provider Licence conditions and for 2025/26 was compliant in all areas.

The Board has complied with the relevant aspects of the HM Treasury/Cabinet Office Corporate Governance Code. The Trust is not required to comply with the UK Code of Corporate Governance. With reference to the requirements of the Trust's Standing Orders and Standing Financial Instructions, the Chief Financial Officer and the Company Secretary retain oversight of the arrangements for the discharge of statutory functions and no gaps in legal compliance have been identified.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has established robust arrangements to ensure the economic, efficient and effective use of resources and to maintain an effective system of internal control. These arrangements support the delivery of safe, high-quality and sustainable services and provide clear accountability and assurance to the Board.

The Board receives regular reporting on financial, operational, quality, safety and workforce performance. This is supported by structured scrutiny through Board Committees and executive management arrangements, enabling effective challenge, timely escalation and informed decision-making.

The Board approves an annual internal audit plan through delegated authority to the Audit, Risk & Assurance Committee (ARAC). Internal audit provides assurance on the effectiveness of governance, risk management and internal control, including financial management and value for money. Where internal audit reviews provide limited assurance, management action plans are agreed, progress is monitored by ARAC and significant issues are escalated to the Board as required. Although there were no limited rated audit reports during 2025/26, there were high priority recommendations as follows:-

- Management of IT Applications – 3 priority recommendations. At year-end, two high priority management actions had been implemented. An extension was approved for one action
- Data quality (NCTR) – 2 high priority recommendations carried forward form 2024/25. Each of the two actions has been extended.

The value-for-money element of the internal audit programme provides assurance against strategic financial risks, and no significant issues were identified during the year.

Oversight of value for money, financial sustainability and resource utilisation is delegated to Audit, Risk & Assurance Committee and the Finance, Infrastructure & Digital Committee. Divisions and corporate teams are accountable for delivering agreed financial and operational targets through a clearly defined performance management framework, including executive performance reviews, compliance with the Financial Accountability Framework, and delivery of cost improvement, productivity and recovery programmes. Financial governance arrangements are subject to both internal and external audit.

The Board Assurance Framework supports the identification of principal risks to financial sustainability and delivery of agreed plans, informing the Board's focus on economy, efficiency and effectiveness.

Information Governance

Both our data security and data protection are informed through both internal and external reviews and advice. They are managed through compliance with the data security and protection toolkit which is mandated by NHS Digital. Data security and information governance incidents are managed in accordance with internal procedures and notified to the ICO in the data security incident reporting tool where required

During 2025/26 there were a total of 63 such incidents, which were classified as follows:

Summary of data security and protection incidents in 2025/26		
	Breach type	
A	Confidentiality	51
B	Availability	8
C	Integrity	4
	Total	**63**

Notifiable breaches are those that are likely to result in a high risk to the rights and freedoms of the individual (data subject). During 2025/26 the Trust reported three high risk incidents via the Data Security and Protection Toolkit incident reporting tool which required notification to the Information Commissioner's Office (ICO).

- June 2025: An upgrade to the Trust's laboratory information management system (LIMS) caused the unavailability of some information to GP surgeries. The results are sent by electronic transfer but if there is no location selected, then the result is not sent. A backlog was identified and the results reviewed to determine if any action was needed to support patient care. No action was taken by the ICO.
- July 2025: Complaint received from a member of the public stating that they believe their medical record may have been accessed by a member of staff inappropriately. An audit report was run which confirmed that there had been access. No action was taken by the ICO.
- August 2025: Complaint received from two patients stating that they believed their medical records may have been accessed by a member of staff inappropriately. An audit report was run which confirmed that there had been access. No action was taken by the ICO.

In quarter 4 of 2025/26 and into quarter 1 of 2026/27, the Trust is subject to an Internal Audit of our current DSPT compliance. The Trust will be given a confidence level and recommendations that will need to be implemented ahead of the final DSPT submission, which is in June 2026.

The Trust's risk register is updated with currently identified information risk around cyber security which is reviewed by the Finance, Infrastructure & Digital Committee. We are compliant with GDPR legislation which came into effect on 25 May 2018. Compliance is monitored through our risk management systems and the data security and protection toolkit submissions and annual external assurance review. In addition, independent assurance is

provided as part of the NHS England coding and costing assurance audit process. The Trust's latest submission in June 2025 against the data security and protection toolkit was 'standards met'.

Data Quality and governance

The Trust has appropriate arrangements in place to manage risks relating to information governance, data security and data quality as part of its overall system of internal control. Responsibility for information risk is clearly defined, with an Executive Director appointed as the Senior Information Risk Owner (SIRO), accountable to the Board for the management of information risk.

Oversight of information governance is exercised through the Information Governance Steering Group, with assurance reported to the Board via the Finance, Infrastructure & Digital Committee. Cyber security and wider digital risks are overseen through the same Committee. Information risks are managed in line with the Trust's Risk Management Strategy, supported by an Information Asset Risk Management Policy and a maintained Information Asset Register.

Assurance is provided through annual completion of the NHS Data Security and Protection Toolkit (DSPT), internal audit and other independent reviews, alongside incident reporting and escalation arrangements. Material information governance, data security or data quality risks are escalated through the Trust's risk management framework where appropriate.

These arrangements provide the Board with assurance that information governance, data security and data quality risks are being effectively identified, managed and controlled.

The Trust has established clear arrangements to assure the quality and accuracy of elective waiting time data. Waiting list data is derived from core patient administration systems and is subject to routine validation and monitoring by dedicated operational and data quality teams. Regular reconciliation and validation reviews are undertaken to identify errors, duplicates or inappropriate clock adjustments, with corrective action taken where required.

Oversight of elective waiting time performance and data quality is provided through established operational governance arrangements, including regular executive and Board-level reporting. Key risks to the accuracy of elective waiting time data, including data completeness, coding accuracy and system dependency, are identified, assessed and managed through the Trust's risk management framework. Executive sign-off is required for external elective performance returns, providing assurance that reported data is accurate and reliable.

These arrangements provide the Board with assurance that elective waiting time data is appropriately governed and supports effective performance oversight and decision-making.

Review of effectiveness

As Accountable Officer, I have reviewed the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, and the board assurance committees, and a plan to address weaknesses and ensure continuous improvement of the system is in place. The BAF provides me with evidence that the effectiveness of controls to manage risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- assessment of financial reports submitted to NHS England, the independent regulator of NHS Foundation Trusts
- opinions and reports made by external auditors
- opinions and reports made by internal auditors
- NHS Litigation Authority claims profile and other external inspections, accreditations and reviews.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been reviewed by:

- the Board: through consideration of key objectives and the management of principal risks to those objectives within the BAF, which is presented at board meetings
- the audit, risk & assurance committee: by reviewing and monitoring the opinions and reports provided by both internal and external audit, and reviewing the risk management arrangements
- the quality & safety committee: by reviewing and monitoring the opinions and reports provided by both internal and external audit, and reviewing clinical governance and clinical risks
- the finance, infrastructure & digital committee : by reviewing and monitoring the opinions and reports provided by both internal and external audit and reviewing finance, estates, and digital risks
- the people & culture committee: by reviewing and monitoring the opinions and reports provided by both internal and external audit and reviewing workforce risks
- the performance, population & place committee : by reviewing and monitoring the opinions and reports provided by both internal and external audit and reviewing performance and partnership risks
- external assessments of services

KPMG delivered the 2025/26 Internal Audit Plan of nine reviews, alongside the 2024/25 DSP Toolkit carried forward from the prior year. Six audits received *Significant assurance with minor improvement opportunities* with a further four (financial controls was split between general ledger and staff lottery; staff lottery was partial assurance) *partial assurance with improvement* required. These reviews generated 71 management actions in the course of the nine reviews with three high priority actions from the review of Management of IT Applications. At year-end, two high priority management actions had been implemented. An extension was approved for one action from the Management of IT Applications review. There are two high priority actions carried forward from 2024/25, from our review of Data Quality (NCTR). Each of the two actions has been extended.

KPMG provided an annual conclusion over four components aligned to the Global Internal Audit Standards (GIAS): governance; risk management and control; financial reporting and management; and data captured and used by the organisation with the following conclusions:

Rating	Component	Overall Finding
Amber Green	Governance	Overall findings on design show some controls to be effectively designed with some exceptions. Testing showed some controls to be operating effectively and others could be more consistently applied.
Amber Green	Risk management and control	
Amber Green	Financial reporting and management	
Amber Red	Data captured and used by the organisation	Overall findings on design show some controls to be effectively designed with some exceptions. Testing showed the need to improve the operating effectiveness of controls

Conclusion

Based on the review of the effectiveness of the system of internal control, and taking into account the findings of internal and external audit, it is my opinion that, while the Trust has in place an appropriate framework of governance, risk management and internal control, significant internal control issues have been identified in relation to the Trust's financial sustainability.

This weakness reflects the scale of the financial challenge facing the Trust, including current deficit position, cost pressures, and delivery risks associated with the financial plan. The Board recognises that this represents a material risk to the long-term viability of the organisation and to the delivery of its strategic objectives if not effectively addressed.

The Trust has established, and continues to strengthen, a comprehensive programme of actions to address this position. This includes the development of a robust financial recovery plan, enhanced oversight of cost improvement programmes, strengthened financial governance and controls, and continued engagement with system partners and NHS England to secure sustainable solutions. Progress against these actions is subject to regular review by the Board and its Committees.

The Board is committed to improving financial sustainability while maintaining the quality and safety of services. Whilst further work is required to fully mitigate this weakness, I am assured that appropriate plans are in place and are being actively monitored, and that the Trust is taking all reasonable steps to address the underlying causes.

Cara Charles-Barks
Chief Executive Officer
Date: 25 June 2026

Voluntary Disclosures

Modern Slavery Act 2025/26 Statement

At the Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. We are fully aware of the responsibilities we hold towards our service users, employees and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies that we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking.

Policies

The Trust has a number of policies relevant to exploitation and human trafficking and exploitation and has joint guidance for services run in partnership with other providers, such as Swindon Community Services. Our Safeguarding Adults at Risk and Child Protection policy have sections and guidance on trafficking and our HR processes mandate recruitment checks to ensure pre-employment suitability and Disclosure and Barring compliance where appropriate.

The majority of our healthcare provision is through direct contact with clinical staff. Our HR processes and professional registration requirements provide the checks to ensure that our workforce is compliant. Areas of greater risk would include supply chains of certain products and equipment. When procuring suppliers the Trust procurement process requires evidence of measures taken in line with the prohibition of human trafficking and exploitation.

Training

All clinical staff receive safeguarding training appropriate to their role, which includes training about human trafficking and exploitation and complies with the Adult Safeguarding competency requirements as outlined by the Nursing and Midwifery Council. Our safeguarding team receive specialist training and act as a resource to the workforce on any human trafficking and exploitation concerns.

The effectiveness of approach

The Trust monitor each clinical area against the requirement to train staff in all aspects of safeguarding training appropriate to the clinical environment, and compliance is monitored through Divisional Boards.

11 AUDITOR'S REPORT

Independent auditor's report to the board of governors and board of directors of Great Western Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

In our opinion the financial statements of Great Western Hospitals NHS Foundation Trust (the 'foundation trust' and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2026 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the group and foundation trust statements of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in taxpayers' equity;
- the group and foundation trust statements of cash flows; and
- the related notes 1 to 34.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the foundation trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

We considered the nature of the group and its control environment, and reviewed the group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit, local counter fraud and those charged with governance about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

We obtained an understanding of the legal and regulatory framework that the group operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations and IT specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address it are described below:

- determination of whether an expenditure is capital in nature, and for major projects the value of work completed at 31 March 2026, is subjective: we tested a sample of expenditure to assess whether they meet the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure is recognised in the correcting accounting period.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion, except for the matters described in the 'Basis for Qualified Opinion' section of our report:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006 in all material respects; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Basis for Qualified Opinions on other matters prescribed by the National Health Service Act 2006

The Trust was unable to provide sufficient supporting information in respect of the pension benefits disclosure information disclosed for one director within the Remuneration Report on page x for the year ended 31 March 2026. The pension information relates to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme. The Trust was unable to obtain the information from the NHS Business Services Authority in time. The Trust was also unable to obtain the information from other sources. As a result, we were unable to obtain sufficient appropriate audit evidence to determine whether the pension benefits disclosures relating to that director were complete and accurate.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

On 17 June 2026 we reported to the foundation trust a significant weakness in the foundation trust's arrangements to secure financial sustainability .

The significant weakness reported was:

- in respect of the foundation trust's arrangements to secure financial sustainability, given the deteriorating financial position, where the Trust achieved a significant adjusted deficit at year-end and had increased reliance on non-recurrent efficiencies to achieve total savings.
- Our recommendations for improvement included that the Trust strengthens its arrangements for identifying, developing and delivering recurrent savings opportunities. This should include

realistic planning assumptions, early identification of savings schemes, robust delivery plans and enhanced monitoring arrangements to improve long-term financial sustainability.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of

the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

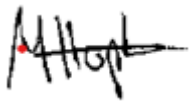
Delay in certification of completion of the audit

As at the date of this audit report, we have not yet completed our work in respect of the Trust's consolidation returns for the year ended 31 March 2026 and have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Great Western Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Michelle Hopton
For and on behalf of Deloitte LLP
Appointed Auditor
Bristol, United Kingdom
26 June 2026

12 ANNUAL ACCOUNTS 2025/26

Foreword to the accounts

Great Western Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Great Western Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Cara Charles-Barks
Chief Executive Officer
Date: 25 June 2026

Consolidated Statement of Comprehensive Income

		Group	
		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	523,463	530,705
Other operating income	4	41,289	34,292
Operating expenses	6,8	(578,591)	(561,673)
Operating (deficit)/surplus from continuing operations		**(13,839)**	**3,324**
Finance income	10	2,736	3,204
Finance expenses	11	(12,510)	(15,445)
PDC dividends payable		(4,460)	(4,643)
Net finance costs		**(14,234)**	**(16,884)**
Other (losses)	12	(260)	(421)
(Deficit) for the year		**(28,333)**	**(13,981)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments of assets	7	(7,237)	(614)
Revaluations of property, plant and equipment	14.1	5,157	224
Other reserve movements		(130)	(1)
Total comprehensive (expense) for the year		**(30,543)**	**(14,372)**

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	13	13,917	8,688	13,917	8,688
Property, plant and equipment	14	258,528	268,907	258,528	268,907
Right of use assets	17	6,894	10,387	6,894	10,387
Investment property	18	8,503	8,831	8,503	8,831
Investments in associates and joint ventures	19	-	163	-	163
Receivables	22	444	474	444	474
Total non-current assets		**288,286**	**297,450**	**288,286**	**297,450**
Current assets					
Inventories	21	5,747	5,529	5,747	5,529
Receivables	22	34,699	28,308	34,669	28,307
Cash and cash equivalents	23	21,022	43,561	20,133	42,493
Total current assets		**61,468**	**77,398**	**60,549**	**76,329**
Current liabilities					
Trade and other payables	24	(57,128)	(50,923)	(57,068)	(50,809)
Borrowings	26	(20,845)	(14,930)	(20,845)	(14,930)
Provisions	27	(219)	(173)	(219)	(173)
Other liabilities	25	(4,810)	(3,902)	(4,810)	(3,902)
Total current liabilities		**(83,002)**	**(69,928)**	**(82,942)**	**(69,814)**
Total assets less current liabilities		**266,752**	**304,920**	**265,893**	**303,965**
Non-current liabilities					
Borrowings	26	(79,167)	(101,896)	(79,167)	(101,896)
Provisions	27	(2,911)	(3,239)	(2,911)	(3,239)
Other liabilities	25	(334)	(448)	(334)	(448)
Total non-current liabilities		**(82,412)**	**(105,583)**	**(82,412)**	**(105,583)**
Total assets employed		**184,340**	**199,337**	**183,481**	**198,382**
Financed by					
Public dividend capital		252,033	236,486	252,033	236,486
Revaluation reserve		65,994	68,074	65,994	68,074
Income and expenditure reserve		(134,546)	(106,178)	(134,546)	(106,178)
Charitable fund reserves	20	859	955	0	0
Total taxpayers' equity		**184,340**	**199,337**	**183,481**	**198,382**

The notes on pages 138-175 form part of these accounts.

Cara Charles-Banks
Chief Executive Officer
Date: 25 June 2026

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**236,486**	**68,074**	**(106,178)**	**955**	**199,337**
Surplus/(deficit) for the year	-	-	(28,242)	(92)	**(28,334)**
Impairments	-	(7,237)	-	-	**(7,237)**
Revaluations	-	5,157	-	-	**5,157**
Public dividend capital received	15,546	-	-	-	**15,546**
Other reserve movements	-	-	(126)	(4)	**(130)**
Taxpayers' and others' equity at 31 March 2026	**252,032**	**65,994**	**(134,546)**	**859**	**184,340**

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**206,369**	**68,464**	**(92,331)**	**1,089**	**183,591**
Surplus/(deficit) for the year	-	-	(13,847)	(134)	**(13,981)**
Impairments	-	(614)	-	-	**(614)**
Revaluations	-	224	-	-	**224**
Public dividend capital received	30,118	-	-	-	**30,118**
Other reserve movements	(1)	-	-	-	**(1)**
Taxpayers' and others' equity at 31 March 2025	**236,486**	**68,074**	**(106,178)**	**955**	**199,337**

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**236,486**	**68,074**	**(106,178)**	**198,382**
Surplus/(deficit) for the year	-	-	(28,242)	**(28,242)**
Impairments	-	(7,237)	-	**(7,237)**
Revaluations	-	5,157	-	**5,157**
Public dividend capital received	15,546	-	-	**15,546**
Other reserve movements	-	-	(126)	**(126)**
Taxpayers' and others' equity at 31 March 2026	**252,033**	**65,994**	**(134,546)**	**183,481**

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**206,369**	**68,464**	**(92,331)**	**182,502**
Surplus/(deficit) for the year	-	-	(13,847)	**(13,847)**
Impairments	-	(614)	-	**(614)**
Revaluations	-	224	-	**224**
Public dividend capital received	30,118	-	-	**30,118**
Other reserve movements	(1)	-	-	**(1)**
Taxpayers' and others' equity at 31 March 2025	**236,486**	**68,074**	**(106,178)**	**198,382**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 20.

Statements of Cash Flows

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		(13,839)	3,324	(13,709)	3,528
Non-cash income and expense:					
Depreciation and amortisation	6.1	17,917	17,626	17,917	17,626
Net impairments	7	21,683	18,627	21,683	18,627
Income recognised in respect of capital donations	4	(158)	(7)	(158)	(7)
(Increase) / decrease in receivables and other assets		(2,306)	349	(2,245)	349
(Increase) / decrease in inventories		(218)	(55)	(218)	(55)
Increase / (decrease) in payables and other liabilities		5,209	(628)	5,147	(628)
Increase / (decrease) in provisions		(355)	(547)	(355)	(547)
Movements in charitable fund working capital		(83)	(16)	-	-
Other movements in operating cash flows		(4)	-	-	-
Net cash flows from / (used in) operating activities		**27,846**	**38,673**	**28,062**	**38,893**
Cash flows from investing activities					
Interest received		2,697	3,134	2,697	3,134
Purchase of intangible assets		(6,844)	(3,339)	(6,844)	(3,339)
Purchase of PPE		(28,887)	(35,179)	(28,885)	(35,179)
Sales of PPE		83	34	83	34
Receipt of cash donations to purchase assets		158	7	158	7
Net cash flows from charitable fund investing activities		39	70	-	-
Net cash flows from / (used in) investing activities		**-32,754**	**(35,273)**	**(32,791)**	**(35,343)**
Cash flows from financing activities					
Public dividend capital received		15,546	30,118	15,546	30,118
Movement on loans from DHSC		(55)	(110)	(55)	(110)
Movement on other loans		-	(4,311)	-	(4,311)
Capital element of lease liability repayments		(1,908)	(1,945)	(1,908)	(1,945)
Capital element of PFI, LIFT and other service concession payments		(16,651)	(14,178)	(16,651)	(14,178)
Interest on loans		-	(1)	-	(1)
Other interest		(41)	-	(41)	-
Interest paid on lease liability repayments		(342)	(388)	(343)	(388)
Interest paid on PFI, LIFT and other service concession obligations		(8,311)	(9,436)	(8,311)	(9,436)
PDC dividend (paid) / refunded		(5,869)	(2,789)	(5,869)	(2,789)
Net cash flows from / (used in) financing activities		**(17,631)**	**(3,040)**	**(17,632)**	**(3,040)**
Increase / (decrease) in cash and cash equivalents		**(22,539)**	**360**	**(22,361)**	**510**
Cash and cash equivalents at 1 April - brought forward		**43,561**	**43,201**	**42,493**	**41,983**
Prior period adjustments		0	-	-	-
Cash and cash equivalents at 31 March	23	**21,022**	**43,561**	**20,133**	**42,493**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

NHS Charitable Funds

The trust is the corporate trustee to Great Western Hospitals NHS Foundation Trust charitable fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

The key accounting policy for the Charity is in relation to investments. The corporate trustee has determined the investment policy to, in so far is reasonable, avoid undue risk to the real value of the capital and income of the portfolio, after allowing for inflation, so the investments are held at fair value. The investment policy also requires that all monies not required to fund working capital should be invested to maximise income and growth.

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's (deficit) for the period was £28.2 m (2024/25 13.8 m deficit). The trust's total comprehensive income for the period was £564 m (2024/25 £564m).

Joint ventures

In July 2016, Wiltshire Health and Care (a limited liability partnership (LLP) and joint venture created between Great Western Hospitals Foundation Trust, Salisbury Foundation Trust and the RUH) commenced its £40 million a year contract to deliver seamless and improved community services across Wiltshire. The RUH, along with Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust, are working with local third sector, end of life, primary care, community services and mental health services to consider how we can work together to support transformation of community services in future. The Wiltshire Health and Care contract was moved and ceased trading on the 1st April 2025.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The Trust recognises income earned for patient care delivered during the financial year 2024/25 following the NHS contract and NHS Payment system rules. Payment is expected to be made in line with standard NHS payment terms for patient care delivered in the period covered

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

National Employment Savings Trust (NEST)
As part of the Government's pension reform the Foundation Trust commenced auto-enrolment in July 2013. Staff not eligible to join the NHS pension scheme are automatically enrolled into NEST, a defined contribution workplace pension scheme

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Lifecycle replacement Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and measured initially at cost.

The element of the annual unitary payment allocated to the lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised.

The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	14	71
Dwellings	34	34
Plant & machinery	5	15
Information technology	5	8
Furniture & fittings	5	5

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	3	8
Licences & trademarks	5	8

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy stocks are valued at average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

Note 1.11 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust has identified three main classes of receivables: Overseas, Non-NHS and NHS. The Trust has recognised an impairment allowance for overseas and Non-NHS receivables based on past experience of what is likely to be collectable. There are no credit losses expected in relation to NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 27.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

The Trust does not have a corporation tax liability for the year 2025/26 (2024/25 £nil).

Tax may be payable on activities as described below:
• the activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private healthcare falls under this legislation and is therefore not taxable.
• the activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.
• the activity must have annual profits of over £50,000.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016 and is not applicable to DHSC group bodies.

IFRS 18 Presentation and Disclosure in Financial Statements. The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made several changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5-year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:
• Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
• Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.
These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:
• A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
• Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £265m as at 31 March 2026.

The Trust property valuation did not use an alternative site basis in the year to 31 March 2026.

Note 1.26 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

In the application of Foundation Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of the evaluation is to consider whether there may be a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements.

Valuation basis
Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued based on depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore, the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend to replace the current assets.
An optimised notional Modern Equivalent Asset approach has been adopted, as developed by the Trust's Estates Department, taking advice from an independent Consultant. It is understood that the process and rationale to this approach has been approved and agreed by the Trust as representing its actual service delivery from the actual physical estate.

Note 1.27 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Valuation of property When arriving at the valuation for property, Trust management engages a qualified surveyor to assist them in forming estimates. Estimates include the remaining life of each asset, and BCIS estimates published in March 2026 for Tender Price Index and Location Factors which are subject to change. This year an optimised notional Modern Equivalent Asset approach has been adopted, as developed by the Trust's Estates Department, taking advice from an independent Consultant.

PFI Lifecycle Prepayment. The PFI Lifecycle Prepayment is £18.4m (24/25 £15.9m). The Foundation Trust has reviewed the appropriateness of this treatment and, following a review of the large value lifecycle works in the original contract, the undertaking of a condition survey to inform investment required over the coming years and actions to provide decant space in the new year to facilitate the completion of major maintenance and replacement works, the management team is of the view that the treatment of lifecycle payments not yet expended by The Hospital Company (THC) as a prepayment is appropriate.

Note 2 Operating Segments

For 2025/26 the Trust's Board has determined that the Foundation Trust operates as the Trust, and the NHS Charity.

The Chief Operating Decision Maker for these operating segments is the Trust Board

2025/26	**GWH**	**Charity**	**Total**
	£000	**£'000**	**£'000**
Operating Income	523,463	-	523,463
Other operating income	40,849	440	41,289
Total Income	**564,312**	**440**	**564,752**
Pay	(352,511)	-	(352,511)
Other Operating Expenditure	(225,510)	(571)	(226,081)
Total Operating Expenditure	**(578,020)**	**(571)**	**(578,591)**
EBITDA	**(13,709)**	**(131)**	**(13,840)**
Non-Operating Expenditure	(14,533)	39	(14,494)
(Deficit)	**(28,242)**	**(92)**	**(28,334)**

The Trust's Statement of Financial Position is not reported at segmental level.

2024/25	**GWH**	**Charity**	**Total**
	£000	**£'000**	**£'000**
Operating Income	530,705	-	530,705
Other operating income	33,635	657	34,292
Total Income	**564,340**	**657**	**564,997**
Pay	(346,392)	-	(346,392)
Other Operating Expenditure	(214,420)	(861)	(215,281)
Total Operating Expenditure	**(560,812)**	**(861)**	**(561,673)**
EBITDA	**3,528**	**(204)**	**3,324**
Non-Operating Expenditure	(17,375)	70	(17,305)
(Deficit)	**(13,847)**	**(134)**	**(13,981)**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	118,644	118,131
Income from commissioners under API contracts - fixed element*	290,633	273,648
High cost drugs income from commissioners	43,474	39,261
Other NHS clinical income	30,794	23,682
Community services		
Income from commissioners under API contracts*	5,103	33,450
Income from other sources (e.g. local authorities)	77	4,161
All services		
Private patient income	2,606	3,092
National pay award central funding***	-	1,072
Additional pension contribution central funding**	20,142	20,349
Other clinical income****	11,990	13,859
Total income from activities	**523,463**	**530,705**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

****Other Clinical Income includes £7.2m deficit funding (2024/25 £10.2m)

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2025/26 £000	2024/25 £000
NHS England	56,467	84,377
Integrated care boards	459,081	437,678
Other NHS providers	427	311
NHS other	27	60
Local authorities	2,887	4,270
Non-NHS: private patients	2,606	3,092
Non-NHS: overseas patients (chargeable to patient)	881	311
Injury cost recovery scheme	610	416
Non NHS: other	477	190
Total income from activities	**523,463**	**530,705**
Of which:		
Related to continuing operations	523,463	530,705

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	881	311
Cash payments received in-year	238	250
Amounts added to provision for impairment of receivables	651	272
Amounts written off in-year	48	90

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,040	-	**1,040**	929	-	**929**
Education and training	19,417	701	**20,118**	18,979	614	**19,593**
Non-patient care services to other bodies	9,710		**9,710**	4,060		**4,060**
Receipt of capital grants and donations and peppercorn leases		158	**158**		7	**7**
Charitable and other contributions to expenditure		-	**-**		1	**1**
Charitable fund incoming resources		440	**440**		657	**657**
Other income	9,823	-	**9,823**	9,045	-	**9,045**
Total other operating income	**39,990**	**1,299**	**41,289**	**33,013**	**1,279**	**34,292**
Of which:						
Related to continuing operations			41,289			34,292

Other Income further breakdown: -

Car parking income	2061	1,902
Catering	80	69
Pharmacy sales	60	46
Staff accommodation rental	673	657
* Other income not already covered (recognised under IFRS 15)	6949	6,371
	9,823	**9,045**

* Other income includes Electronic Patient Record income, PCN income, Income from domestic services provided, Bowel Screening income, funding from Thames Valley Cancer Alliance, Mortuary service income as well as various smaller provider to provider and other agreements

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	978	1,983
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2026 £000	31 March 2025 £000
within one year	4,810	3,902
after one year, not later than five years	334	448
after five years	-	-
Total revenue allocated to remaining performance obligations	**5,144**	**4,350**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	520,780	523,452
Income from services not designated as commissioner requested services	2,683	7,253
Total	**523,463**	**530,705**

Note 6.1 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,166	5,357
Purchase of healthcare from non-NHS and non-DHSC bodies	2,442	1,712
Staff and executive directors costs	352,511	346,381
Remuneration of non-executive directors	203	169
Supplies and services - clinical (excluding drugs costs)	46,450	46,298
Supplies and services - general	3,457	2,807
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	52,713	51,570
Consultancy costs	951	76
Establishment	25,593	20,455
Premises	10,127	10,723
Transport (including patient travel)	1,355	1,672
Depreciation on property, plant and equipment	16,301	15,929
Amortisation on intangible assets	1,616	1,697
Net impairments	21,683	18,627
Movement in credit loss allowance: contract receivables / contract assets	877	266
Change in provisions discount rate(s)	(246)	-
Fees payable to the external auditor		
audit services- statutory audit	340	338
Internal audit costs	111	111
Clinical negligence	13,338	14,564
Legal fees	423	440
Insurance (as a policy holder)	169	216
Education and training	3,532	3,459
Expenditure on short term leases	183	137
Redundancy	-	11
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	17,965	17,286
Losses, ex gratia & special payments	311	20
Other NHS charitable fund resources expended	564	854
Other	456	498
Total	**578,591**	**561,673**
Of which:		
Related to continuing operations	578,591	561,673

Note 6.2 Other auditor remuneration (Group)

External auditors have not carried out any non-audit services in the period 2025/26 or 2024/25, hence no non-audit fee is paid to external auditors in 2025/26 or 2024/25.

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 7 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	21,683	18,627
Total net impairments charged to operating surplus / deficit	**21,683**	**18,627**
Impairments charged to the revaluation reserve	7,237	614
Total net impairments	**28,919**	**19,241**

Note 8 Employee benefits (Group)

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	265,522	263,262
Social security costs	32,195	26,292
Apprenticeship levy	1,281	1,295
Employer's contributions to NHS pensions	50,851	51,586
Pension cost - other	17	64
Temporary staff (including agency)	5,123	5,599
Total staff costs	**354,989**	**348,098**
Of which		
Costs capitalised as part of assets	2,478	1,706

Note 8.1 Retirements due to ill-health (Group)

During 2025/26 there were 10 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £318k (£214k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2023, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

As set out in the accounting policy 1.6, the Trust also has employees who are members of the National Employment Savings Trust (NEST). Membership of this scheme is not material to the Foundation Trust's accounts.

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	2,697	3,134
NHS charitable fund investment income	39	70
Total finance income	**2,736**	**3,204**

Note 11.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	-	1
Interest on lease obligations	343	388
Interest on late payment of commercial debt	42	-
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	8,311	9,436
Remeasurement of the liability resulting from change in index or rate	3,743	5,581
Total interest expense	**12,438**	**15,406**
Unwinding of discount on provisions	72	39
Total finance costs	**12,510**	**15,445**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	42	-
Amounts included within interest payable arising from claims made under this legislation	42	-

Note 12 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	100	-
Losses on disposal of assets	(32)	(93)
Total gains / (losses) on disposal of assets	**68**	**(93)**
Fair value gains / (losses) on investment properties	(328)	(328)
Total other gains / (losses)	**(260)**	**(421)**

Note 13.1 Intangible assets - 2025/26

Group and Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**10,119**	**1,268**	**5,410**	**16,797**
Additions	13	-	6,831	**6,844**
Reclassifications	125	-	(125)	**0**
Cost at 31 March 2026	**10,258**	**1,268**	**12,116**	**23,642**
Amortisation at 1 April 2025 - brought forward	**7,032**	**1,078**	**-**	**8,110**
Provided during the year	1,482	134	-	**1,616**
Amortisation at 31 March 2026	**8,514**	**1,212**	**-**	**9,726**
Net book value at 31 March 2026	**1,744**	**56**	**12,116**	**13,916**
Net book value at 1 April 2025	**3,088**	**190**	**5,410**	**8,687**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 13.2 Intangible assets - 2024/25

Group and Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**9,839**	**1,227**	**2,392**	**13,458**
Additions	120	-	3,219	**3,339**
Reclassifications	160	41	(201)	**-**
Valuation / gross cost at 31 March 2025	**10,119**	**1,268**	**5,410**	**16,797**
Amortisation at 1 April 2024 - brought forward	**5,473**	**940**	**-**	**6,413**
Provided during the year	1,559	138	-	**1,697**
Amortisation at 31 March 2025	**7,032**	**1,078**	**-**	**8,110**
Net book value at 31 March 2025	**3,087**	**190**	**5,410**	**8,687**
Net book value at 1 April 2024	**4,366**	**287**	**2,392**	**7,045**

Note 14.1 Property, plant and equipment - 2025/26

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**23,950**	**185,388**	**4,450**	**24,819**	**40,394**	**28,505**	**2,470**	**309,976**
Additions	-	178	-	23,700	3,466	701	105	28,150
Impairments	(14,375)	(22,736)	-	-	-	-	-	(37,111)
Reversals of impairments	-	3,159	-	-	-	-	-	3,159
Revaluations	-	4,505	35	-	-	-	-	4,540
Reclassifications	-	10,043	-	(16,351)	6,149	70	89	(0)
Disposals / derecognition	-	-	-	-	(229)	-	-	(229)
Valuation/gross cost at 31 March 2026	**9,575**	**180,536**	**4,485**	**32,168**	**49,780**	**29,276**	**2,664**	**308,484**
Accumulated depreciation at 1 April 2025 - brought forward	-	338	0	-	20,078	19,603	1,051	41,070
Provided during the year	-	6,070	129	-	4,140	3,885	461	14,685
Impairments	-	(4,741)	-	-	-	-	-	(4,741)
Reversals of impairments	-	(292)	-	-	-	-	-	(292)
Revaluations	-	(488)	(129)	-	-	-	-	(617)
Disposals / derecognition	-	-	-	-	(148)	-	-	(148)
Accumulated depreciation at 31 March 2026	**0**	**887**	**0**	**0**	**24,070**	**23,488**	**1,512**	**49,957**
Net book value at 31 March 2026	**9,575**	**179,649**	**4,485**	**32,168**	**25,710**	**5,788**	**1,152**	**258,527**
Net book value at 1 April 2025	**23,950**	**185,050**	**4,450**	**24,819**	**20,316**	**8,902**	**1,419**	**268,906**

Note 14.2 Property, plant and equipment - 2024/25

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**23,950**	**172,071**	**4,350**	**41,256**	**34,184**	**27,177**	**2,005**	**304,993**
Additions	-	9,622	-	16,824	3,149	799	253	**30,647**
Impairments	-	(26,001)	-	-	-	-	-	**(26,001)**
Reversals of impairments	-	936	-	-	-	-	-	**936**
Revaluations	-	-	100	-	-	-	-	**100**
Reclassifications	-	28,760	(0)	(33,261)	3,760	529	212	**0**
Disposals / derecognition	-	-	(0)	-	(699)	-	-	**(699)**
Valuation/gross cost at 31 March 2025	**23,950**	**185,388**	**4,450**	**24,819**	**40,394**	**28,505**	**2,470**	**309,976**
Accumulated depreciation at 1 April 2024 - brought forward	-	202	0	-	17,079	15,615	572	33,468
Provided during the year	-	5,960	124	-	3,571	3,988	479	14,122
Impairments	-	(5,623)	-	-	-	-	-	(5,623)
Reversals of impairments	-	(201)	-	-	-	-	-	(201)
Revaluations	-	-	(124)	-	-	-	-	(124)
Disposals / derecognition	-	-	-	-	(572)	-	-	(572)
Accumulated depreciation at 31 March 2025	**0**	**338**	**0**	**0**	**20,078**	**19,603**	**1,051**	**41,070**
Net book value at 31 March 2025	**23,950**	**185,050**	**4,450**	**24,819**	**20,316**	**8,902**	**1,419**	**268,906**
Net book value at 1 April 2024	**23,950**	**171,869**	**4,350**	**41,256**	**17,105**	**11,562**	**1,433**	**271,525**

Note 14.3 Property, plant and equipment financing - 31 March 2026

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under constructio n	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	9,575	33,043	0	32,167	24,825	-	5,630	1,153	-	106,393
On-SoFP PFI contracts and other service concession arrangements	-	146,566	4,485	-	-	-	-	-	-	151,051
Owned - donated/granted	-	40	-	-	885	-	158	-	-	1,083
NBV total at 31 March 2026	9,575	179,649	4,485	32,167	25,710	-	5,788	1,153	-	258,527

Note 14.4 Property, plant and equipment financing - 31 March 2025

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under constructio n	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	23,950	30,746	(0)	24,492	19,430	-	8,902	1,419	-	**108,939**
On-SoFP PFI contracts and other service concession arrangements	-	154,304	4,450	-	-	-	-	-	-	**158,754**
Owned - donated/granted	-	-	-	327	887	-	-	-	-	**1,214**
NBV total at 31 March 2025	**23,950**	**185,050**	**4,450**	**24,819**	**20,317**	**-**	**8,902**	**1,419**	**-**	**268,907**

Note 15 Donations of property, plant and equipment

The Foundation Trust has received donated assets during the year. The value of these items 2025/26 £0.3m (2024/25 £0.2m) has been provided by Bath, North East Somerset, Swindon and Wiltshare Integrated Care Board , Uni Hosp Bristol & Weston NHS FT , GWH Charity and are included within the accounts

Note 16 Revaluations of property, plant and equipment

The District Valuer, who is a member of the RICS and is independent of the Trust, undertook a valuation of the Trust's land and buildings as at 31 March 2026. Indices were applied of BCIS 410 and Location Factor 100%. This recognised £2,080k as an downwards revaluation against the revaluation reserve and £21,683k as an impairment against the operating deficit. For the comparison based on the prior period adjustment for 2024/25, £389k was recognised as an downwards revaluation against the revaluation reserve and £18,627k as an impairment against the operating deficit.

For each asset occupied and used by GWH in the delivery of services for which we have a responsibility, the basis of valuation required since 1st April 2015 is Current Value in existing use, as defined in DHSC GAM and reflecting the adaptation approved by FRAB to IAS 16. Current Value has regard to the service potential that an asset provides in support of the entity’s service delivery. The measurement approaches used to arrive at the Current Value of in use assets are for non-specialised operational assets Existing Use Value (EUV) as defined at UK VPGA 6, and for specialised operational assets Depreciated Replacement Cost (DRC) in accordance with UK VPGA 1.5 and the RICS UK GN on DRC (2018).

Note 17 Leases - Great Western Hospitals NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust leases property (not including the main hospital site) from NHS Property Services, which is predominantly for space or buildings. The Trust also leases plant and equipment which comprises predominantly of medical equipment, office equipment or motor vehicles through leasing commercial arrangements.

The Trust has applied IFRS16 to account for lease arrangements from 1 April 2022.

Note 17.1 Right of use assets - 2025/26

Group and Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**10,483**	**5,182**	**263**	**15,928**	**10,483**
Additions	70	287	220	**577**	70
Remeasurements of the lease liability	-	165	-	**165**	-
Disposals / derecognition	(3,007)	-	(95)	**(3,102)**	(3,007)
Valuation/gross cost at 31 March 2026	**7,546**	**5,634**	**388**	**13,568**	**7,546**
Accumulated depreciation at 1 April 2025 - brought forward	**2,912**	**2,433**	**196**	**5,541**	**2,912**
Provided during the year	744	824	48	**1,616**	744
Disposals / derecognition	(451)	-	(32)	**(483)**	(451)
Accumulated depreciation at 31 March 2026	**3,205**	**3,257**	**212**	**6,674**	**3,205**
Net book value at 31 March 2026	**4,341**	**2,377**	**176**	**6,894**	**4,341**
Net book value at 1 April 2025	**7,571**	**2,749**	**67**	**10,387**	**7,571**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	4,341

Note 17.2 Right of use assets - 2024/25

Group and Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**10,483**	**3,146**	**236**	**13,865**	**10,483**
Additions	-	1,882	30	**1,912**	-
Remeasurements of the lease liability	-	223	-	**223**	-
Disposals / derecognition	-	(69)	(3)	**(72)**	-
Valuation/gross cost at 31 March 2025	**10,483**	**5,182**	**263**	**15,928**	**10,483**
Accumulated depreciation at 1 April 2024 - brought forward	**1,871**	**1,754**	**109**	**3,734**	**1,871**
Provided during the year	1,041	679	87	**1,807**	1,041
Accumulated depreciation at 31 March 2025	**2,912**	**2,433**	**196**	**5,541**	**2,912**
Net book value at 31 March 2025	**7,571**	**2,749**	**67**	**10,387**	**7,571**
Net book value at 1 April 2024	**8,612**	**1,392**	**127**	**10,131**	**8,612**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	7,571

Note 17.3 Revaluations of right of use assets

The RoU assets were reviewed to identify any revaluations, lease liability remeasurements or impairments such as change in lease contract and agreements. As a result of this there is £15,669k lease liability remeasurement.

Note 17.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 26.

	Group and Trust	
	2025/26	**2024/25**
	£000	**£000**
Carrying value at 1 April	**19,519**	**19,401**
Lease additions	577	1,912
Lease liability remeasurements	165	223
Interest charge arising in year	343	388
Early terminations	(2,684)	(72)
Lease payments (cash outflows)	(2,251)	(2,333)
Carrying value at 31 March	**15,669**	**19,519**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

No income generated from subleasing right of use assets was recognised in revenue from operating leases.

Note 17.5 Maturity analysis of future lease payments at 31 March 2026

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2026	**31 March 2026**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	2,028	839
- later than one year and not later than five years;	6,497	2,895
- later than five years.	8,904	1,234
Total gross future lease payments	**17,429**	**4,968**
Finance charges allocated to future periods	(1,760)	(440)
Net lease liabilities at 31 March 2026	**15,669**	**4,528**
Of which:		
Leased from other NHS providers		-
Leased from other DHSC group bodies	4,528	4,528

Note 17.6 Maturity analysis of future lease payments at 31 March 2025

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	2,416	1,183
- later than one year and not later than five years;	8,086	4,551
- later than five years.	11,469	3,082
Total gross future lease payments	**21,971**	**8,816**
Finance charges allocated to future periods	(2,452)	(973)
Net finance lease liabilities at 31 March 2025	**19,519**	**7,843**
Of which:		
Leased from other NHS providers		-
Leased from other DHSC group bodies	**7,843**	7,843

Note 18 Investment Property

The Investment Property comprises of IFRS16 leases which relate to buildings for primary care network. The Trust no longer provides this service for primary care network and are now recovering the IFRS16 lease cost from the relevant GP Practice.

	Group and Trust	
	2025/26	2024/25
	£000	£000
Carrying value at 1 April - brought forward	**8,831**	**9,159**
Movement in fair value	(328)	(328)
Carrying value at 31 March	**8,503**	**8,831**

Note 18.1 Investment property income and expenses (Group)

	2025/26	2024/25
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	418	418
Direct operating expense arising from investment property which did not generate rental income in the period		
Total investment property expenses	**418**	**418**
Investment property income	418	418

Note 19 Investments in associates and joint ventures

In July 2016, Wiltshire Health and Care (a limited liability partnership (LLP) and joint venture created between Great Western Hospitals Foundation Trust, Salisbury Foundation Trust and the Royal United Hospital) commenced its £40 million a year contract to deliver seamless and improved community services across Wiltshire.
The Royal United Hospital, along with Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust, are working with local third sector, end of life, primary care, community services and mental health services to consider how we can work together to support transformation of community services in future.
The Wiltshire Health and Care contract was moved and the Wiltshire Health and Care LLP ceased trading on the 1st April 2025.

Wiltshire Health and Care was focused solely on delivering improved community services in Wiltshire, which GWH had previously been contracted to deliver, and enabling people to live independent and fulfilling lives for as long as possible.

GWH has not invested any capital sum in this joint venture.

In 2025/26, Wiltshire Health and Care LLP did not trade (2024/25 breakeven).

	Group	
	2025/26	**2024/25**
	£000	**£000**
Carrying value at 1 April - brought forward	**163**	**163**
Disposals	(163)	-
Carrying value at 31 March	**-**	**163**

Note 20 Analysis of charitable fund reserves

The GWH Trust Charitable Funds have been consolidated within this set of accounts

	31 March 2026	31 March 2025
	£000	**£000**
Unrestricted funds:		
Unrestricted income funds	360	232
Restricted funds:		
Other restricted income funds	499	723
	859	**955**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 21 Inventories

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Drugs	2,079	1,752
Consumables	3,489	3,616
Energy	179	161
Total inventories	**5,747**	**5,529**

Inventories recognised in expenses for the year were £101,767k (2024/25: £56,276k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 22.1 Receivables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Contract receivables	10,863	10,422	10,863	10,422
Allowance for impaired contract receivables / assets	(2,556)	(1,716)	(2,556)	(1,716)
Deposits and advances	(6)	-	(6)	-
Prepayments (non-PFI)	4,625	2,231	4,625	2,231
PFI lifecycle prepayments	18,483	15,901	18,483	15,901
PDC dividend receivable	1,487	78	1,487	78
VAT receivable	1,669	1,106	1,669	1,106
Other receivables	104	285	104	285
NHS charitable funds receivables	30	1	-	-
Total current receivables	**34,699**	**28,308**	**34,669**	**28,307**
Non-current				
Other receivables	444	474	444	474
Total non-current receivables	**444**	**474**	444	**474**
Of which receivable from NHS and DHSC group bodies:				
Current	6,469	6,902	6,469	6,902
Non-current	444	474	444	474

Note 22.2 Allowances for credit losses - 2025/26

	Group Contract receivables and contract assets
	£000
Allowances as at 1 Apr 2025 - brought forward	**1,716**
New allowances arising	877
Utilisation of allowances (write offs)	(37)
Allowances as at 31 Mar 2026	**2,556**

Note 22.3 Allowances for credit losses - 2024/25

	Group Contract receivables and contract assets
	£000
Allowances as at 1 Apr 2024 - brought forward	**1,603**
New allowances arising	266
Utilisation of allowances (write offs)	(153)
Allowances as at 31 Mar 2025	**1,716**

Note 23 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**43,561**	**43,201**	**42,493**	**41,983**
Net change in year	(22,539)	360	(22,360)	510
At 31 March	**21,022**	**43,561**	**20,133**	**42,493**
Broken down into:				
Cash at commercial banks and in hand	907	1,083	18	15
Cash with the Government Banking Service	20,115	42,478	20,115	42,478
Total cash and cash equivalents as in SoFP	**21,022**	**43,561**	**20,133**	**42,493**

Note 24 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	12,314	11,588	12,314	11,588
Capital payables	9,347	7,502	9,347	7,502
Accruals	23,426	19,953	23,426	19,953
Social security costs	7,544	7,107	7,544	7,107
Pension contributions payable	4,437	4,659	4,437	4,659
NHS charitable funds: trade and other payables	60	114	-	
Total current trade and other payables	**57,128**	**50,923**	**57,068**	**50,809**
Of which payables from NHS and DHSC group bodies:				
Current	3,475	4,116		

Note 25 Other liabilities

	Group	
	31 March 2026	31 March 2025
	£000	£000
Current		
Deferred income: contract liabilities	4,810	3,902
Total other current liabilities	**4,810**	**3,902**
Non-current		
Deferred income: contract liabilities	334	448
Total other non-current liabilities	**334**	**448**

Note 26 Borrowings

	Group	
	31 March 2026	31 March 2025
	£000	£000
Current		
Loans from DHSC	-	56
Lease liabilities	727	2,416
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	20,118	12,458
Total current borrowings	**20,845**	**14,930**
Non-current		
Lease liabilities	14,942	17,103
Obligations under PFI, LIFT or other service concession contracts	64,225	84,793
Total non-current borrowings	**79,167**	**101,896**

Note 26.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**56**	**-**	**19,519**	**97,251**	**116,826**
Cash movements:					
Financing cash flows - payments and receipts of principal	(55)	-	(1,908)	(16,651)	**(18,614)**
Financing cash flows - payments of interest	-	-	(343)	(8,311)	**(8,654)**
Non-cash movements:					
Additions	-	-	577	-	**577**
Lease liability remeasurements	-	-	165	-	**165**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				3,743	**3,743**
Application of effective interest rate	(1)	-	343	8,311	**8,653**
Early terminations	-	-	(2,684)	-	**(2,684)**
Carrying value at 31 March 2026	**0**	**-**	**15,669**	**84,343**	**100,012**

Group - 2024/25	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**166**	**4,311**	**19,401**	**105,848**	**129,726**
Prior period adjustment	-	-	-	-	**-**
Carrying value at 1 April 2024 - restated	**166**	**4,311**	**19,401**	**105,848**	**129,726**
Cash movements:					
Financing cash flows - payments and receipts of principal	(110)	(4,311)	(1,945)	(14,178)	**(20,544)**
Financing cash flows - payments of interest	(1)	-	(388)	(9,436)	**(9,825)**
Non-cash movements:					
Additions	-	-	1,912	-	**1,912**
Lease liability remeasurements	-	-	223	-	**223**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				5,581	**5,581**
Application of effective interest rate	1	-	388	9,436	**9,825**
Early terminations	-	-	(72)	-	**(72)**
Carrying value at 31 March 2025	**56**	**-**	**19,519**	**97,251**	**116,826**

Note 27 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**660**	**469**	**380**	**1,903**	**3,413**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	(206)	-	-	(40)	**(246)**
Arising during the year	-	6	-	204	**210**
Utilised during the year	(119)	(43)	(120)	(37)	**(319)**
Unwinding of discount	16	16	-	40	**72**
At 31 March 2026	**351**	**448**	**260**	**2,070**	**3,130**
Expected timing of cash flows:					
- not later than one year;	120	43	-	56	**219**
- later than one year and not later than five years;	175	142	260	2,014	**2,591**
- later than five years.	56	264	(0)	(0)	**320**
Total	**351**	**449**	**260**	**2,070**	**3,130**

Pension provisions arise from early retirements which do not result from ill health. These liabilities are not funded by the NHS Pension Scheme.

Legal claims relate to the Trust's provision for personal injury and employee claims. These are based on valuation reports provided by the Trust's legal advisers.

Other includes provisions for Clinicians Pensions Tax Reimbursement Scheme (£455k), VAT Review risk £1.2m) and additional pension provision not relating to early departure or injury benefits.

Note 27.1 Clinical negligence liabilities

At 31 March 2026, £207,234k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Great Western Hospitals NHS Foundation Trust (31 March 2025: £208,827k).

Note 28 Private Finance Initiative Contracts

Group and Trust

PFI schemes on-Statement of Financial Position

The Trust has 1 PFI scheme which is deemed to be on-Statement of Financial Position at the period end. This is for the Main Hospital and Brunel Treatment Centre and Downsview Residences (treated as one agreement).

Great Western Hospital

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Great Western Hospital, which was completed in November 2002, for subsequent occupation and use by the Trust. The Trust pays the operator company a quarterly availability fee for the occupation of the hospital and a quarterly service fee for the services provided by the operator such as portering and catering. In October 2003 the Trust entered into a variation of the original agreement for the construction of the Brunel Treatment Centre which is an extension to the original hospital. The construction of the Treatment Centre has resulted in increased availability and service charges, however the main terms of the contract including the termination date remain unchanged. Subsequently, in September 2006, the Trust entered into a refinancing agreement which resulted in a reduction in the annual availability payment again with no change to the contract term. The amount of the availability payment is determined annually and increased based on a combination of the annual increase in the Retail Price Index (RPI) and a fixed percentage increase of 2.5%. The operator is obliged to maintain the buildings and replace lifecycle elements of the buildings where necessary. At the end of the contract term the hospital buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the hospital buildings are treated as an asset under property, plant and equipment with the resultant liability being treated as a finance lease under IAS 17.

Downsview Residences

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Downsview staff residences on the Hospital site for the provision of housing to hospital staff. At commencement of the contract the Trust made a capital contribution of £649k towards the construction cost of the building. The residences are managed by the operator company who rent the accommodation units to, primarily, Trust staff. The Trust does not pay the operator company an availability fee. Instead a monthly service fee is paid for the servicing of the units which is based on usage. The operator is responsible for maintaining the buildings over the contract term. At the end of the contract term the accommodation buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the residences are recognised as an asset under property, plant and equipment. The cost of the building less the capital contribution has been accounted for as deferred income and is released to income equally over the entire contract term.

Note 29 On-SoFP PFI, LIFT or other service concession arrangements

Note 29.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**105,664**	**130,625**
Of which liabilities are due		
- not later than one year;	29,727.00	24,962
- later than one year and not later than five years;	75,937.00	105,663
- later than five years.	-	-
Finance charges allocated to future periods	(21,321.00)	(33,374)
Net PFI, LIFT or other service concession arrangement obligation	**84,343**	**97,251**
- not later than one year;	20,118	12,458
- later than one year and not later than five years;	64,225	84,793
- later than five years.	-	-

Note 29.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**179,525**	**227,987**
Of which payments are due:		
- not later than one year;	49,674	48,462
- later than one year and not later than five years;	129,851	179,525

Note 29.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust	
	2025/26	2024/25
	£000	£000
Unitary payment payable to service concession operator	**48,505**	**47,014**
Consisting of:		
- Interest charge	8,311	9,436
- Repayment of balance sheet obligation	16,651	14,178
- Service element and other charges to operating expenditure	17,965	17,286
- Capital lifecycle maintenance	3,122	3,596
- Addition to lifecycle prepayment	2,456	2,518
Total amount paid to service concession operator	**48,505**	**47,014**

Note 30 Financial instruments

Note 30.1 Financial risk management

Group and Trust
The key risks that the Trust has identified relating to its financial instruments are as follows:-

Financial Risk
The continuing service provider relationship that the Trust has with Integrated Care Boards (ICBs), and the way they are financed has not exposed the Trust to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Finance, Infrastructure & Digital Committee.

Currency Risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust, therefore, has low exposure to currency rate fluctuations.

Credit Risk
The majority of the Trust's income comes from contracts with other public sector bodies, resulting in a low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from The Hospital Company for PFI Lifecycle, and customers, as disclosed in note 22.1 to the accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the period end.

The following shows the age of such financial assets that are past due and for which no provision for bad or doubtful debts has been raised:

	31 March 2026 £000	31 March 2025 £000
By up to three months	4,947	5,101
By three to six months	314	152
By more than six months	200	157
	5,461	5,410

The Trust has not raised bad or doubtful debt provisions against these amounts as they are considered to be recoverable based on previous trading history.

Liquidity Risk
The NHS Trust's net operating costs are incurred under annual service agreements with local ICBs, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 30.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost
	£000
Trade and other receivables excluding non financial assets	8,849
Cash and cash equivalents	20,133
Consolidated NHS Charitable fund financial assets	889
Total at 31 March 2026	**29,871**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost
	£000
Trade and other receivables excluding non financial assets	8,861
Cash and cash equivalents	42,493
Consolidated NHS Charitable fund financial assets	1,069
Total at 31 March 2025	**52,423**

Note 30.3 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost
	£000
Loans from the Department of Health and Social Care	-
Obligations under leases	15,669
Obligations under PFI, LIFT and other service concessions	84,343
Trade and other payables excluding non financial liabilities	43,283
Provisions under contract	3,129
Consolidated NHS charitable fund financial liabilities	60
Total at 31 March 2026	**146,484**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost
	£000
Loans from the Department of Health and Social Care	56
Obligations under leases	19,519
Obligations under PFI, LIFT and other service concessions	97,251
Trade and other payables excluding non financial liabilities	38,620
Provisions under contract	3,412
Consolidated NHS charitable fund financial liabilities	114
Total at 31 March 2025	**158,972**

Book value balances on the Statement of Financial Position are at a reasonable approximation of fair value.

Note 30.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
In one year or less	75,317	66,343
In more than one year but not more than five years	85,024	116,989
In more than five years	9,224	11,469
Total	**169,565**	**194,800**

Note 31 Losses and special payments

	2025/26		2024/25	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	12	3	18	8
Bad debts and claims abandoned	34	50	51	145
Stores losses and damage to property	48	169	18	33
Total losses	**94**	**222**	**87**	**186**
Special payments				
Compensation under court order or legally binding arbitration award	7	56	3	3
Ex-gratia payments	19	5	23	26
Total special payments	**26**	**61**	**26**	**29**
Total losses and special payments	**120**	**283**	**113**	**215**

Compensation payments received

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment or loss for the individual case exceeded £300,000. (2024/25 - nil cases).

Losses and special payments are compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

Note 32 Related parties

Great Western Hospitals NHS Foundation Trust is a body incorporated by the issue of a licence of authorisation from NHS Improvement.

The Trust is under the common control of the Board of Directors. During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Great Western Hospitals NHS Foundation Trust.

The Department of Health and Social Care is regarded as the parent party and thus a related party.

Related parties may include but are not limited to:
- Department of Health and Social Care ministers
- Board members of the trust
- The Department of Health and Social Care
- Other NHS providers
- ICBs and NHS England
- Other health bodies
- Other Government departments
- Local authorities
- Wiltshire Health and Care LLP

Note 33 Events after the reporting date

The Group Chair, Paul von der Heyde for the BSW Hospitals Group was appointed on 1 April 2026.

Great Western Hospitals
NHS Foundation Trust

Annual Report and Accounts 2025/26