Great Western Hospitals NHS Foundation Trust

TRUST BOARD

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

AGENDA

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

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

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

Great Western Hospitals NHS Foundation Trust

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

Present:

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

In attendance:

Neil Clark (NC)*	Associate Non-Executive Director
Caroline Coles (CC)	Company Secretary
Samaher Sweity (SS)* **	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Lynsey Hewitson	Chief Register (observing and for item 191/25)
Eleanor Tindall	Chief Register (observing and for item 191/25)
Jill Kick	Head of Clinical Operations & Patient Flow (item 185/25)
Rachel Almond	Site Manager (item 185/25)
Laura Cornell	Site Manager (item 185/25)
Emma Northeast	Site Manager (item 185/25)

Apologies:

Judy Dyos (JDy)	Chief Nursing Officer
Andrew Hollowood (AH)*	Chief Clinical Transformation Officer
Simon Wade (SW)	Chief Financial Officer

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

Number of members of the Public: There were 4 members of the public in attendance (Ashish Channawar, Governor; Mary Day, Governor; Chris Shepherd, Governor)

Matters Open to the Public and Press

Minute	Description	Action
180/25	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	

Minute	Description	Action

181/25 **Declarations of Interest**
There were no declarations of interest.

182/25 **Minutes of the previous meeting (public)**
The minutes of the Board meeting held in public on 15 January 2026 were adopted and agreed as a correct record.

183/25 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list. No updates or amendments were provided.

Minute No. 165/25 - Cyber Security Framework – Board Assurance Report
The Board noted that the cyber security framework and assurance report had been scheduled for January, although no progress update had yet been provided. Jonathan Hinchliffe, Group Chief Digital & Information Officer confirmed that the report would follow and that work was underway to establish the agreed approach to cyber exercises and business continuity planning. It was agreed that the broad action required further breakdown into clear steps and that oversight should sit with the Joint Committee across the three trusts to ensure consistent practice. The Board agreed to close the current item and reopen it under the Joint Committee to ensure continued visibility and appropriate governance.

184/25 **Questions from the public to the Board relating to the work of the Trust**
The Board noted a question from the Lead Governor on assurance of Trust policies following media coverage of a NMC judgement which involved a former employee of the Trust.

The Deputy Chief Nurse had provided a response which outlined actions that had been implemented to reduce the likelihood of recurrence. These included strengthening the Persons in Position of Trust (PiPoT) processes, embedding safeguarding considerations within the four-step model, and implementing a competency framework for triage practice. An action plan to address the identified learning had also been developed and implemented.

The Board **noted** the question and response provided to provide assurance of actions taken.

185/25 **Staff Story – Site Team**
Jill Kick – Head of Clinical Operations & Patient Flow, Rachel Almond – Site Manager, Laura Cornell – Site Manager and Emma Northeast, Site Manager joined the meeting to present this item.

The Board received a comprehensive account from the Site Team of the operational pressures experienced during a sustained critical incident, highlighting communication challenges, inconsistent escalation processes, and the impact on staff resilience and patient safety.

Significant impacts on wellbeing and patient safety, including fatigue, stress, and high sickness levels was noted by the Board. The increasing normalisation of corridor care and double boarding also raised concerns about maintaining safe standards of care. Despite these pressures, strong teamwork and adaptability across ward teams were noted, with improved morale linked to increased senior visibility and in-person support. The Board agreed on the need for clearer escalation processes, improved communication, and greater inclusion of frontline staff in debriefs, committing to strengthen support structures.

The Board also discussed corridor care challenges, noting that up to 70 patients had been cared for outside designated bed spaces at peak periods. A 10 Point Plan, informed by national collaboration and supported by improved reporting tools, had been developed to

Minute	Description	Action

address this. It was further agreed that debrief processes should be broadened to include a wider range of staff to support shared learning and improvement.

The Chair thanked Jill Kick, Emma Northeast, Rachel Almond and Laura Cornell for their presentation and highlighting the experience of the Site Team during a sustained period of critical incident.

The Board **noted** the staff story.

186/25 **Chair's Report**

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

- Stephen Baldwin had been appointed as role of Deputy Lead Governor.
- Tim Poole had been appointed as Swindon Governor representative.
- No Governors attended the Board Safety Visit to Falcon Ward.
- Helen Spice, NED did not attend the Board Safety Walk to Falcon Ward.
- Samaher Sweity, NED also attended the Board Safety Walk to Mercury Ward.

The Board **noted** the report.

187/25 **Chief Executive's Report**

The Board received and considered the Chief Executive's Report.

Cara Charles-Barks, Chief Executive reported that the organisation continued to operate under significant operational pressure, contributing to financial challenges linked to service delivery. A financial variance of £8.5m was noted, however the Group remained on track to achieve a forecast year-end position in line with the plan.

Pressures in emergency care, including capacity and front-door demand, were highlighted, alongside actions to improve performance, including waiting list validation. Upcoming national developments, including potential industrial action and the National Cancer Plan, were noted as additional pressures and strategic considerations.

Progress was reported on key priorities across the group, including finance and performance recovery, clinical transformation through targeted specialty improvement programmes, and corporate services transformation, with several services preparing for formal consultation. Significant work had also been undertaken on forward planning for 2026/27, including performance targets and the medium-term financial plan.

It was noted that a joint Board-to-Board session was to take place in May to support strategic alignment and preparation for the transition to a Group Board in July, providing an opportunity to strengthen collaboration across the three organisations.

The Board **noted** the report.

188/25 **Integrated Performance Report**

The Board received the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in January 2026.

Board Assurance Reports

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meeting on 25 February 2026 the following was highlighted:

Minute	Description	Action

- Corridor care had increased, with 54 patients being treated in corridors in January.
- Type 1 attendances had increased and that seven extra patients within 4-hours were being treated every day through this winter compared to the previous year.
- The Trust was in Tier 2 for urgent and emergency care.
- Non-elective length of stay continued to improve, however Non-Criteria to Reside (NCTR) continued to rise.
- Cancer diagnosis performance continued to show an improved position. Support from Salisbury NHS Foundation Trust for Plastics was currently under discussion.
- Work continued with HCRG around the contract and SLA, particularly in relation to integrated neighbourhood teams proposed by HCRG.

The Board noted that demand over the winter period had increased significantly, with activity approximately 15% higher year on year. Despite this, performance improvements had been achieved and this was reflected in improved team performance, although the scale of demand had masked visible gains. The Board acknowledged the considerable effort of staff in sustaining progress against a backdrop of sustained operational pressure.

Benny Goodman, Chief Operating Officer reported that the Trust had exited critical incident and had seen a recent improvement in 4-hour performance, alongside better patient flow and reduced handover delays. While sustainability remained uncertain, this indicated underlying resilience and a return towards intended operating practices.

In response to questions on RTT performance, it was confirmed that this had declined slightly since summer due to increased demand, reduced elective activity over winter, and process issues affecting waiting list accuracy. Actions were underway to validate waiting lists, increase activity, and improve data and processes. It was acknowledged that urgent care pressures had impacted elective delivery.

The Board sought clarity on the UEC improvement programme and preparedness for next winter. It was confirmed that a draft plan was being developed, including additional bed capacity, clearer clinical standards, and improved ward processes. Further questions highlighted the importance of frailty pathways, health inequalities, and the potential role of external support. It was confirmed that regional input was ongoing and that UEC pressures were being addressed collaboratively across the Group.

The Board **noted** the report.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (QSC) at its meeting on 22 January 2026 and the following was highlighted:

- Assurance for falls had improved following a deep dive review, supported by effective actions plans and oversight.
- Partial assurance was noted in relation to infection prevention and control (IPC) due to persistent high infection rates, exacerbated by overcrowding, limited isolation facilities, and insufficient access to handwashing facilities.
- Concerns were also noted regarding stroke pathways and the complexity of addressing these issues given regional staffing challenges.
- The first integrated front door report was reviewed, with agreement to better reflect quality impacts in future reports.

During discussion, the Board noted pressures were not due to lack of effort but were affecting safety. Questions were raised on whether easing pressures would improve metrics, and it was confirmed that continued monitoring was essential. Group-level

Minute	Description	Action

collaboration was identified as a potential way to address high-pressure areas. The Board agreed on the importance of maintaining oversight and escalation responsibilities while supporting executive teams in implementing interventions.

The Board **noted** the report.

Our People

People & Culture Committee Chair Overview

The Board received an overview of the detailed discussions held at the People & Culture Committee (PCC) at its meeting on 3 March 2026 and the following was highlighted:

- Partial assurance was noted for workforce recovery, progress in leadership development, health and wellbeing initiatives, job planning, and immigration/visa issues.
- The latest staff survey results were not yet publicly available.

Chris Burton, Non-executive Director raised questions on leadership training expectations and mandatory training. It was clarified that core line management skills were covered in leadership programmes and low-priority mandatory modules had been removed to manage time demands.

Budget pressures were also discussed, with corporate services redesign expected to deliver £16.8m savings over two years without direct staffing reductions. The Board also noted the upcoming pilot of the Triumvirate Leadership Team Development Programme to support medical, nursing, and operational leadership across the group.

The Board **noted** the report.

Use of Resources

Finance, Infrastructure & Digital Committee Chair Overview

The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meetings on 26 January 2026 and 23 February 2026 and the following was highlighted.

The Board reviewed the Group's financial position, noting ongoing challenges from operational pressures, under-delivery of efficiency programmes, and workforce recovery shortfalls, particularly at GWH. While governance and controls were robust and auditors provided assurance, recurrent savings remained below target and limited assurance was given for overall financial delivery. Planning processes for finance, infrastructure, and digital were effective but complex, and estates audits required further investment for full remediation.

It was noted that following the September 2025 Dorset & Wiltshire Fire & Rescue Service audit, GWH, THC, and Serco had made significant progress on fire safety improvements. Some actions which required Building Safety Regulator approval, were delayed due to contractor appointment challenges. Additional resources were being used to complete a backlog of fire risk assessments by March 2026 to ensure that fire safety remained a top priority.

Questions raised by the Board Members focused on financial recovery oversight, with a new Group-level structure to be put in place to allow consistent monitoring by the Chief Financial Officer. Queries were raised about SULIS and Royal United Hospitals NHS Foundation Trust support, with SULIS expected to enhance productivity and a business case planned to extend turnaround support to GWH.

The Board **noted** the report.

Minute	Description	Action

189/25 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received a verbal overview of the detailed discussions held at the Audit, Risk & Assurance Committee (ARAC) at its meetings on 19 January 2026 and 5 March 2026 highlighted the following:

- Good assurance was noted with the effectiveness of risk management processes for both the Family & Specialist Services Division and corporate areas. It was acknowledged that while current arrangements were strong, the transition to a group model would present challenges, particularly in maintaining consistency and supporting staff through change, including limitations within existing systems.
- The external audit plan was approved, with Deloitte highlighting potential challenges in relation to financial sustainability within its value for money review. The Board noted that early insight from this work would be beneficial.
- Internal audit findings indicated some more challenging areas, with a focus on improving the delivery and embedding of actions to ensure sustainable change. Assurance was provided that processes for managing and escalating audit actions were improving, although further evidence of effectiveness was requested.

The Board **noted** the report.

190/25 **Charitable Funds Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) at its meeting on 4 March 2026 and highlighted the following:

- An update on charitable funds was received, noting ongoing organisational changes and the need to clarify future reporting arrangements for staff. Limited funding was available at the time of the meeting, and decisions were made to restrict expenditure.
- An income budget of £500k for the coming year was approved, which reflected a more realistic position, with longer-term ambitions to increase income to £1m supported by initiatives such as the Meadows Cancer Appeal and learning from other trusts.
- Progress was also noted on the rationalisation of charitable funds, with implementation on track from 1 April.
- An Internal Audit Report on controls covering the Staff Lottery had been referred to CFC by the Audit, Risk & Assurance Committee. It was noted that discussions outside CFC would determine how senior oversight of the staff lottery at GWH would be strengthened.

Chris Burton, Non-Executive Director raised a question regarding the continuation of funding for medical welfare support. It was confirmed that while this remained a risk if unfunded, efforts were underway to identify alternative funding sources, as charitable funds could not continue to support core services. The Board noted the importance of securing sustainable funding and exploring options across the wider group.

The Board **noted** the report.

191/25 **Resident Doctor Peer Lead Board Report**

Lynsey Hewitson – Chief Registrar and Eleanor Tindall – Chief Register the meeting to present this item.

The Board received and considered the first quarterly report from the Resident Doctor Peer Leads, noting that the role had been established to strengthen representation of resident doctors at Board level. It was confirmed that the report focused on workforce experience, training, and operational concerns. The Board acknowledged key issues raised, particularly workload pressures, which were evidenced by national survey results showing the Trust as

Minute	Description	Action

a negative outlier. In response to questions, it was confirmed that high demand, lower consultant-to-trainee ratios, and winter pressures had contributed to this position, with risks identified relating to patient safety, staff wellbeing and retention.

The Board discussed concerns regarding payroll and work scheduling, including inaccuracies linked to split roles and multiple payslips. It was confirmed that these issues were being investigated, with assurance provided that payroll processes were monitored regularly and further work was underway to address inconsistencies. It was agreed that simplifying pay arrangements should be a priority.
Action: Site Finance Director

In response to questions on wider improvement, it was confirmed that actions were in progress through the 10 Point Plan and existing governance routes, working with Resident Doctors' Peer Lead at Board to enhance reporting on targeted actions to Board. The Board queried how these issues would be managed within the emerging group model. It was acknowledged that some elements, such as education and workforce experience, would benefit from greater consistency across the group, while others would require local solutions. The Board requested further clarity on action plans, accountabilities and how reporting would transition to a group-level approach to ensure sustained oversight and improvement.
Action: Chief Medical Officer

Claudia Paoloni, Non-Executive Director welcomed the support and interactions of executives with resident doctors and questioned if there was also resident doctor representation on the Local Negotiating Committee (LNC). It was agreed that the terms of reference of LNC would be reviewed to confirm this.
Action: Chief People Officer

The Board requested a review of consultant capacity for training, assessing how operational pressures affect the balance between trainers and trainees, identifying root causes, and improving reporting to support targeted actions.
Action: Chief People Officer & Chief Medical Officer

Questions were also raised regarding locally employed doctors in relation to options for equitable training and supervision opportunities. The Board noted that there was a commitment to review options and develop 'options appraisal' regarding educational opportunities and educational supervision by consultants for locally employed doctors, including consultant capacity for training provision and supervisor roles. This was in the context of the Trust's aims to ensure fair treatment to all doctors, provide with equitable access to training and development, and enhance overall training for patient care, balanced with the budgetary and workforce implications of this. This would also include exploring how these opportunities could be coordinated across the three care organisations within the Group to maximise impact despite budget constraints.
Action: Chief Medical Officer & Chief People Officer/Site HR Director

The Board thanked Lynsey Hewitson and Eleanor Tindall for their informative report on the issues being faced by resident doctors together with positive achievements.

The Board **received** the report.

192/25 **Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance**
The Board received and considered the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Report which outlined the continued progress of the EPRR agenda and assurance on Trust compliance with the EPRR core standards following completion of the annual assurance process. It was noted that this assurance report had been previously reviewed and supported by the Performance, Population & Place Committee.

Minute	Description	Action

It was noted that the Trust had been assessed as substantially compliant. Two areas that were reported as partially compliant related to business impact assessments to improve robustness, and the need to improve business continuity plans to address gaps and improve resilience. Progress was underway, with a target of September set for completion. Workforce capacity had impacted delivery during the year, and recruitment to a vacant post was planned to strengthen the team.

Benny Goodman, Chief Operating Officer provided an overview of the Trust's activity to comply with the standards and priority areas for improvement in 2026/27 whilst embedding learning from the Trust's incident response processes. The Board noted plans to undertake a major incident exercise to embed learning and confirmed that, overall, good progress had been made while further work continued.

The Board **noted** the report.

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

193/25 **Ratification of Decisions made via Board Circular**
None.

194/25 **Urgent Public Business (if any)**
None.

195/25 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 9 April 2026 at 9.30am

196/25 **Exclusion of the Public and Press**
The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.

The meeting finished at 12.33hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – April 2026				
ARAC – Audit, Risk and Assurance Committee, CFC – Charitable Funds Committee, FIDC – Finance, Infrastructure & Digital Committee, PPPC – Performance, Population and Place Committee, PCC – People & Culture Committee, QSC – Quality & Safety Committee, RemCom – Remuneration Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
12 March 2026	191/25	**Resident Doctor Peer Lead Board Report** Payroll issues to be investigated to address inconsistencies and simply pay arrangements.	Site Finance Director	The individual case that was raised has been brought to a satisfactory conclusion, and next steps agreed with the Resident Doctor leads for other staff to be reviewed and consulted with, if appropriate, for change of process.
12 March 2026	191/25	**Resident Doctor Peer Lead Board Report** Further clarity on wider improvement action plans, accountabilities and how reporting would transition to a group-level approach to ensure sustained oversight and improvement.	Chief People Officer	Action completed. Chief Medical Officer has met with Resident Doctors' Peer Leads to ensure Trust update/response is included either as part of the paper for next Board, or as a formal 'Response', for clarity. Will build into 2026/27 forward plan for papers going through Care Organisation People & Culture Committees.
12 March 2026	191/25	**Resident Doctor Peer Lead Board Report** Terms of Reference of Local Negotiating Committee (LNC) to be reviewed to confirm resident doctor representation at LNC meetings.	Chief People Officer	GWH JLNC (Joint Local Negotiating Committee) terms of reference includes BMA Trust Representatives (up to a maximum of 2 to 5 representatives).
12 March 2026	191/25	**Resident Doctor Peer Lead Board Report** Review of consultant capacity for training, assessing how operational pressures would affect the balance between trainers and trainees, identifying root causes, and improving reporting to support targeted actions.	Chief People Officer / Chief Medical Officer	In progress. Post Graduate Medical Education (PGME) reviewing data.
12 March 2026	191/25	**Resident Doctor Peer Lead Board Report** Opportunities to be reviewed for locally employed doctors, to ensure fair treatment and provided with equitable access to training and development. Also to explore how these	Chief People Officer	Initial draft complete. Working with Post Graduate Medical Education (PGME) and Resident Doctors. For further review following the proposed

		opportunities could be coordinated across the three care organisations within the Group to maximise impact despite budget constraints.		NHSE expansion in training (due July), it is proposed this action aims for completed in September 2026.

Future Actions				
None				

Report Title	**Care Reflection**				
Meeting	**Board of Directors**				
Date	**09/04/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Luisa Goddard, Chief Nurse				
Report Author	Tania Currie, Head of Patient Experience and Engagement				
Appendices					

Purpose

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

Assurance Level

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

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

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

The Care Reflection provides extremely positive feedback on care received

Report

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

A dedicated ultra-marathon runner and someone who embodied peak fitness, Al never imagined that he would become unwell so suddenly and severely. What began as feeling like he had a cold escalated rapidly, leaving him critically ill and frightened for his life.

In his reflection, Al speaks about the fear he experienced during the first hours and days. He recalls how vulnerable he felt, how quickly his condition deteriorated, and how overwhelming it was to lose control of his own body. Al goes onto describe the reassurance, compassion, and expertise shown by the doctors, nurses, and therapists who cared for him. He talks about the calm confidence of the clinical team, the way they explained what was happening, and the constant presence that made him feel safe even in the darkest moments.

Al wanted to thank our team of doctors, nurses and therapists who he felt provided exceptional care and ultimately saved his life.

Thank fully, Al eventually did recover and returned home to his family and eventually returned to running.

The film can be viewed here: https://youtu.be/GNiM4YTvmlo

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

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

Risk + Oversight	Risk Score
Key risks – risk number & description (Link to BAF / Risk Register)	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	
Next Steps	The feedback received from this care reflection has been shared with the Critical Care Team for reflection, praise and learning. The video is available on the trust intranet and used as part of staff training, reflection and at various meetings.

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

Explanation of above analysis:

Initiatives described in the report may impact on some people more favourably in order to address the inequality they would otherwise experience.
The report shares the trust wide approach to duty of candour which is applied to all cases and includes adaptations as required in line with any identified specific adjustments.

Recommendation / Action Required

The Board/Committee/Group is requested to:

To receive the presentation to note the positive experience of carer and the thanks provided to our critical care team.

Accountable Lead Signature	Luisa Goddard.
Date	**31/03/2026**

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**09/04/2026**	**Part 1 - Public**	✓	**Part 2 - Private**	☐
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 : Register of Board Declarations of Interest				

Purpose

Approve ✓	Receive ☐	Note ✓	Assurance ☐
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Assurance Level

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

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

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

Due process followed.

Report

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

This is a regular report for information and accountability, summarising Chair and Non-Executive Director (NED) activities and key events relating to the governor activities for the period March-April 2026. Activities relating to formal Committees of the Board are reported through custom reports. The report also includes the Declarations of Interest Register for Board Directors.

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

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

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

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

Recommendation / Action Required
The Board/Committee/Group is requested to:
The Board is requested to note the updates.

Accountable Lead Signature	Liam Coleman, Chair
Date	**21/03/2026**

Chair's Board Report

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

1. Council of Governors

1.1 We are sad to receive the resignation of Sarah Marshall, the Wiltshire Northern Constituency Governor Representative, due to other time commitments. The Trust would like to extend its sincere thanks to Sarah for her time, dedication, and commitment during her term of office as Governor.

1.2 The following table outlines the key meetings, training and events during March – April 2026 that governors participated in:-

March to April 2026 – Council of Governors		
Date	**Event**	**Purpose**
3 March 2026	Governwell Webinar – What the 10 year health plan means for your governors	To update governors on the 10 year health plan
5 March 2026	Council of Governors meeting	Regular meeting to update and discuss Trust issues. Additional to the standard agenda items there were reports on Quality Accounts

		and the priorities for 2026/27, governor development 2025/26.
9 March 2026	BSW Joint Nomination and Remuneration Committee	To agree preferred candidate for CoG approval
13 March 2026	Extraordinary Council of Governors Meeting	To support Group NED Model
18 March 2026	People's Experience and Quality Working Group	To identify key issues in relation to service users and staff experience and the quality of the work of the trust.
20 March 2026	BSW Joint Remuneration and Nomination Committee	To approve Group NED Model
23 March 2026	Board Safety visit – Saturn Ward	Attended by governors
8 April 2026	Business & Planning Governor Working Group	To identify key issues in relation to Trust finance
13 April 2026	Learning from Deaths Quarterly meeting	Governor representative
20 April 2026	Informal Governor meeting with NEDs	Relationship building with Non-Executive Directors Julian Duxfield and Samaher Sueity
21 April 2026	Extraordinary Council of Governors meeting	Approve Appointment Group NED roles
30 April 2026	BSW Hospitals Group Councils of Governors	Workshop

2. Non-Executive Directors

2.1 Safety Visits

There were two Board safety visit during the period covered by this report as follows:-

Date	Area	Board Member
4 March 2026	Ampney Ward	Kathryn Bateman, Chief Medical Officer Julian Duxfield, Non-Executive Director
23 March 2026	Saturn Ward	Benny Goodman, Chief Operating Officer Bernie Morley, Non-Executive Director

3. Trust Chair Key Meetings during March – April 2026

Meeting
BSW Hospitals Group Joint Committee
BSW Hospitals Group Joint Remuneration & Nomination Committee
BSW Hospitals Group Joint Committee
BSW Hospital Group Chairs Meeting
BSW Recovery Briefing Meeting
GWH Board of Directors Meeting
GWH Council of Governors Meeting
GWH Extraordinary Council of Governors Meetings
GWH Meeting with Swindon & Wiltshire MPs
GWH NEDs/ANEDs Meeting
RUH Board of Directors Meeting
RUH NEDs Meeting
RUH Lead Governors Meeting
RUH Staff Governor & NED Monthly Feedback Meeting
RUH Subsidiary Oversight Meeting
RUH Provider Oversight Meeting
RUH Meeting with Sulis Chair
1:1s with Vice Chairs
1:1s with Managing Directors
1:1s with Chief Executive

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
4	**Declarations of Interest Trust Board of Director - March 2026**						**Dates**		**Type of interest**							
5	**Date Confirmed**	**First Name**	**Last Name**	**Position Title**	**Interests to declare**	**Description of interest / Action taken**	**To**	**From**	**Clinical Private Practice**	**Strategic Decision Making**	**Outside Employment / Directorships**	**Gifts and Hospitality**	**Loyalty**	**Shareholdings**	**Membership of Committees / Charites / Networks etc**	**Personal connections**
6	**Voting Board Members**															
7	15-Oct-25	Kathryn	Bateman	Chief Medical Officer	N											
8	20-Dec-25	Emily	Beardshall	Deputy Director of Improvement and Partnerships	Y	Trustee, National Deaf Children's Society. Husband employee of Becton Dickenson (NHS supplier)Friends with Andrew New, CEO NHS Supply Chain									X	X
9	03-Nov-25	Chris	Burton	Non Executive Director 2025	Y	Bristol Beacon, Silver Patron, Music Concerts									X	
10	03-Nov-25	Neil	Clark	Non Executive Director 2025	Y	BooByBiome LTD					X					
11	21-Nov-25	Liam	Coleman	Trust Chair from February 2019 to 31 January 2025 Role of Chair from September 2024 at Board of L&Q , joining 1 June 2024	Y	Chair of Board - Financial Ombudsman Service Chair of Board - London Quadrant Holding Chair - interim - RUH	Ongoing				X			X		

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
12	12-Feb-26	Cara	Charles-Barks	Chief Executive	Y	Group CEO for Royal United Hospitals, Great Western Hospitals and Salisbury Foundation Trust. Visiting Professor in the Faculty of Health and Applied Sciences at the University of the West of England to **31/07/25** Chair of NHS Quest, a leadership/development provider. Previously Deputy Chair until August 2024. Appointed Honorary Colonel of 243 Multi-role Medical Regiment, part of the Army Reserve Medical Services. Chatham Row Management Company Ltd, Director	Ongoing				X					
13	01-Dec-25	Faried	Chopdat	Non Executive Director from April 2021	Y	Non Executive Director Grant Thornton UK Equarios Ltd - Director Blossom CIC - Non-Executive Director Finance, Infrastructure & Digital Committee, Chair ARAC, NED People & Culture Committee, NED REMCOM, NED	Ongoing				X				X	
14	22-Jan-26	Judith	Dyos	Chief Nursing Officer SFT	N											
15	08-May-25	Julian	Duxfield	Non Executive Director from April 2023	Y	Chair of Mountain Heritage Trust Charity	Ongoing								X	
16	26-Feb-26	Mark	Ellis	Chief Risk Officer	Y	Director: STL - wholly owned subsidiary of SFT SSL - JV between SFT and STeris					X					
17	02-Jun-25	Luisa	Goddard	Chief Nurse	N											
18	14-Nov-25	Benny	Goodman	Chief Operating Officer	Y	Director of Cornbow Properties Ltd Chair of Trustees for Finchampstead Baptist Church, which runs a combined Church and Community Centre/coffee shop/sports facility in Finchampstead, Berkshire.					X				X	
19	03-Nov-25	Sandra	Gordon	Non Executive Director 2025	N											
20	07-Nov-25	Judith	Gray	Chief People Officer	Y	Trustee for ICP Support. ICP is a charity which supports women and their families who develop intrahepatic cholestasis of pregnancy Son is a Senior Manager for our external auditors, Deloitte Gympanzees Trustee	Ongoing								X	X

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
21	24-Mar-26	Andrew	Hollowood	Chief Medical Officer RUH	Y	Wife is GP in Hartcliffe, Bristol Daughter Foundation Doctor, Southmead Hospital, Bristol	Ongoing									X
22		Jonathan	Hinchcliffe	Group Chief Digital & Information Officer												
23	08-Nov-25	Bernie	Morley	Non Executive Director from April 2023 to 31 March 2026 Bernard Morley Limited (Consultancy)	Y	Chairman of trustees and research committee, Bath Institute of Rheumatic Diseases Member of Court of University of Bath The Corsham School Trust Academy - Chair of Trust and local governing body BIRD - possible research grants Consulting work with a number of universities including Bath, Bath Spa and Brunel Bernard Morley Ltd - Director	ongoing				X				X	
24	08-Dec-25	Claudia	Paoloni	Non-Executive Director from April 2021	Y	Director/Shareholder of Calm Water Ltd Director/Shareholder MPower Mental Health Ltd Director of Lecrahurst Ltd HCSA Executive Committee - Vice President	Ongoing				X					
25	24-Nov-25	Will	Smart	Non Executive Director from April 2023 to 31 March 2026	Y	Alcidion Group LTD - Director Caretech Partners LTD - Director The Federation for Informatics Professionals in Health and Social Care - Director British Computer Society, Health and Care Faculty Board - Chair	ongoing			X	X				X	
26	04-Nov-25	Helen	Spice	Non Executive Director from April 2021	Y	Make a Wish Foundation -Non Executive Director Trustee Non-Executive Director Barts Health NHS Trust	Ongoing				X					
27	03-Nov-25	Samaher	Sweity	Non Executive Director from 2025	N											
28	01-Sep-25	Lisa	Thomas	Managing Director	Y	Governor of Lavington Secondary School - Vice Chair Vice Chair Dauntsey Academy, Lavington Primary School	Ongoing								X	
29	19-Nov-25	Simon	Wade	Director of Finance & Strategy from November 2020	N										X	

Report Title	**CEO report**				
Meeting	**Trust Board**				
Date	**09/04/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Cara Charles-Barks, Chief Executive				
Appendices					

Purpose

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

Assurance Level

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

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

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

Report

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

The Chief Executive's report covers:

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

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

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

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

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

Explanation of above analysis:

The report covers the NHS staff survey results. Scores related to one of our priority measures - whether staff feel they are respected by their colleagues - have improved since last year, indicating that our focus on building a more compassionate and inclusive culture is having a positive impact. The results also indicate that fewer colleagues are experiencing discrimination from colleagues.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	**02/04/2026**

1. Risks

1.1 Financial position and recovery

The financial recovery plan across the Group requires delivery of a £42m year-end deficit across the 3 Care Organisations. At month 11 there was a cumulative deficit of £42.9m, which was in line with the recovery trajectory. Month 11 again saw a series of operational challenges resulting in additional bed capacity requirements and led to restrictions on capacity for additional elective work, though the impact of these was anticipated and mitigated. At Care Organisation level the year to date deficit positions are Great Western Hospitals (£12.3m), Royal United Hospitals Bath (£19.5m) and Salisbury Hospital (£11.2m).

Moving into the final month of the year it is anticipated the impact of improved elective performance, reduced escalation costs and technical measures will be sufficient to ensure the Group achieves the revised financial trajectory of £42m deficit.

Following a resubmission process during early March, the 2026/27 Operating and Financial plan was submitted on March 18th.

1.2 Urgent & Emergency Care (UEC) Update

UEC remains challenged across all three acutes in terms of demand and system flow. Internal actions are underway and will continue over the next few months. There are some slight improvements across some indicators due to reduced IPC challenges as we emerge out of the winter period.

There has been a decline in the average time for ambulance handovers at all three acute Trusts due to the impacts of winter; high demand, and IPC issues. Each of our hospitals are focusing on increasing P0 discharges and ensuring decisions regarding care are taken in a timely way to improve flow through our EDs. BSW Hospitals Group has submitted a plan to reduce and eliminate corridor care and the actions will form part of each acute UEC improvement plan.

The number of patients waiting to leave acute Trust beds remains a challenge – with continuing high numbers of No Criteria to Reside across all three care organisations. The internal improvement plans and support from GIRFT is focusing attention on the introduction of Clinical Operational Standards which focus on internal improvements that will support improved internal flow.

A system wide winter debrief is being planned for April where lessons learnt, and improvements will be captured and fed back to all system partners.

1.3 Elective

Some of the risks currently being managed across the group on elective care include:

- Year-end delivery. As the year concludes, performance is being closely monitored across the Group particularly for 18 weeks RTT due to sprint funding and activity. All Care Organisations are working to maximise performance through validation, sprint clinics, and existing RTT improvement work.
- The Referral Support Service, which manages referrals across BSW, is closing partially from April and then fully by June as part of ICB restructures. This may

cause a demand spike to Trusts as fewer referrals are triaged away from hospitals, plans are being developed to mitigate impact.

2. National update

2.1 NHS Staff Survey

The NHS Staff Survey results were published on 12th March 2025 utilising data gathered from across the three Care Organisations last autumn at what was a challenging time for each Trust and the wider NHS.

Across BSW Hospitals Group, over 9,000 staff took the time to complete the survey, 56.8% of our workforce, which is above the national average. The survey is a valuable way of helping us understand colleagues' experiences and where we should focus our efforts both to build on what we are getting right, and where we need to make improvements.

One of the concerns staff have raised through the survey is their own career development, and this is one of the many things we are looking to address as we continue to build our Group, improved career opportunities, and opportunities to share learning will be benefits of our closer collaboration

Staff wellbeing scores remained in line with the national average and supporting the wellbeing of our people is fundamental to delivering excellent patient care, and it will continue to remain a priority for our Group.

Over the coming months we will review the results in more detail with teams across the Care Organisations and work together to identify practical actions that will make a real difference to our staff.

2.2 2026/27 NHS Pay Award

The Government recently announced that NHS staff are to receive a 3.3% pay award in 2026/27, which BSW Hospitals Group will be applying for all colleagues on Agenda for Change terms and conditions from 1st April 2026.

2.3 National Oversight Framework

Under the NHS Oversight Framework, on 18th March 2026 NHS England published the 2025/26 quarter three segmentation results and league tables figures, an outline of performance within BSW Hospitals Group is outlined below:

Great Western Hospitals NHS Foundation Trust was ranked 85 out of 134 Trust's in the country, the previous quarter's ranking was 82 (3 places lower than in quarter two).

Royal United Hospitals Bath NHS Foundation Trust was ranked 102 out of 134 Trust's in the country, the previous quarter's ranking was 105 (3 places higher than in quarter two).

Salisbury NHS Foundation Trust was ranked 67 out of 134 Trust's in the country, the previous quarter's ranking was 70 (3 places higher than in quarter 2).

The segmentation rating for each Trust remained the same since the last quarter, with both GWH and SFT rating 3 and the RUH 4.

There is a huge amount of work going on across the three Care Organisations to maintain and improve our position with great progress already being made around our operational performance.

3. Group development

3.1 Joint Committee

Our latest BSW Hospitals Group Joint Committee meeting was held on 20th March 2026 with focus being on discussion of our Strategic Planning Framework, Financial Sustainability & Recovery, Integrated Performance Report Development, the Roadmap for transition to Group Board, the Corporate Services programme, Temporary Staffing Model, Performance Management Framework, the Group Risk Management Policy, and our Organisational Development Programme. A report from the March Group Joint Committee has been included with April Trust Board papers.

3.2 Leadership Team

Following interviews held on 9th March, we have appointed our interim Group Chair. The three Councils of Governors met between 11th and 16th March to approve the appointment of Paul von der Heyde and this has been confirmed by NHSE. Paul joins us on 1st April 2026.

Since Joint Committee review and approval of the Non-Executive model on 18th February, the three Care Organisation Councils of Governors (CoGs) have met, and each has endorsed the recommended NED model. Terms of Reference for a Joint Nominations & Remuneration Committee to oversee the process have been approved by CoGs. The Nominations & Remuneration Committee will meet in March to consider the NED role description and recruitment process, which is expected to run through April 2026.
The Group executive leadership team is almost fully established albeit with two interim positions still in place. The external recruitment for the Chief Digital & Information Officer has been launched, with interviews scheduled for 28th April. In Care Organisations, interviews for the substantive RUH CMO post were held in early March, and the recruitment to the RUH Chief Nursing Officer role has begun following the announcement by our colleague Toni Lynch of her planned retirement in June 2026.

3.3 Group Governance and Assurance Arrangements and Transition Roadmap

The governance development work supporting support safe mobilisation of our new Operating Model, is continuing led by our Governance Working Group. Supporting this work, the Non-Executive Governance Reference Group meets monthly. On 2nd March, the NED team considered the Governance Roadmap and detailed transition timeline. The team also discussed the draft Partnership Collaboration Agreement, which will be finalised in coming weeks.

On 16th March, the pilot Risk and Assurance Committee (RAC) held its inaugural meeting to shape how group-level risk and assurance will operate ahead of go-live planned in July. The committee reviewed and discussed draft Terms of Reference, the approach to developing the initial group Board Assurance Framework (BAF), and the developing group risk register and Risk Management Policy.

3.4 Group Priorities and Prioritisation Approach

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

1. Recovery (Performance & Finance)
2. EPR implementation
3. Clinical transformation through the acute services review and clinical services framework design
4. Completion of the Corporate Services Review
5. 2026/27 planning including Group Mobilisation

The Group Leadership team meets weekly to ensure progress is maintained in these priority areas.

3.5 EPR Deployment Options Appraisal

Following our decision in January to reset the programme timeline, the EPR programme has been working with suppliers on delivery planning. Final costs and draft delivery plan will be presented to the BSW Group Executive, Care Organisations, and BSW Hospitals Group Joint Committee in April 2026, with a final delivery plan to be confirmed in April/May.

3.6 Clinical Transformation Programme

The Clinical Transformation Programme has begun. Clinical Transformation Groups (CTGs) are being established, initially in dermatology, diabetes and paediatric orthopaedics. The CTGs will explore potential service models, using a set of design principles founded on serving our population, supporting our teams and reduction of unwarranted variation. Clinical leads in identified services are being briefed by the CMOs about the programme. A steering group meets monthly and will work to ensure the programme is resourced to enable successful delivery.

3.7 Corporate Services Programme

Our Corporate Services Programme is making progress with the design stage for services nearing completion. The Steering Group and Design Authority meet regularly, and designs have been approved for seven services with consultation planning well underway. SLAs are being developed for each of the shared corporate services. The financial impact of the programme is being tracked for each service, with clear targets set for 26-27 & 27-28. Detailed phasing of benefits is being planned by service leads.

3.8 Group Board-to-Board Development Days

- The 2026/27 Group Board dates including a series of Board development days are being scheduled. From July, Group Boards will be held on the first Thursday of the month.

- The next Board-to-Board development day is planned to take place in Trowbridge on 7th May and will focus on preparations for transition to our new Group Operating Model, our strategic planning framework and major milestones in our draft strategic plan.

3.9 Councils of Governors Workshop

The next Councils of Governors development session will be held on 30th April 2026; the agenda for the day will be co-designed to address local and group priorities.

Great Western Hospitals NHS Foundation Trust update

4. Operational update

4.1 Latest operational position

After a very challenging Winter for the NHS, we continue to experience high levels of demand and declared an internal critical incident in response to site pressures at the hospital on 24 March.

This marks a continuation of the recent spell of very high demand we have seen with many people seeking treatment through our urgent and emergency services and ongoing challenges with being able to discharge patients for onward care in a timely way.

Our work to install a new modular ward on site is continuing, although we recognise that the additional beds this facility will provide us with will not resolve the situation.

4.2 NHS Oversight Framework

The latest NHS Oversight Framework segmentation data was published by the Government last month.

GWH remains in segmentation three, and our national hospital league table rank is 85th out of 134.

5. Quality

5.1 Support for women with high blood pressure who have given birth

We have launched a new service to support women who have given birth and are experiencing high blood pressure.

Developed in partnership with Health Innovation West of England and Greener NHS, this new service enables eligible women to monitor their blood pressure at home after being discharged following birth.

This can reduce the need for frequent face-to-face appointments at the hospital or health centre, while empowering women to take an active role in monitoring their health during the post-natal period.

5.2 Neonatal Transitional Care Unit

We have expanded the service offered by our Neonatal Transitional Care Unit, which is now caring for babies born from 34 weeks' gestation, having previously cared for babies born at 35 weeks and above.

This means more babies can stay with their mothers while receiving the specialist care they need, rather than being cared for on a separate unit.

5.3 Reducing harm from falls

The Trust set an organisation-wide breakthrough objective to reduce avoidable harm, with a clear focus on preventing inpatient falls and falls that result in injury.

We've used our Improving Together methodology and way of working to successfully focus on preventing inpatient falls and reducing avoidable harm.

We introduced a dedicated Falls Clinical Practice Educator and hold weekly Friday Falls Panel reviews and divisional quality meetings.

Ward managers and matrons lead this work within their areas, taking accountability for outcomes and sharing learning across teams.

This work has led to a 15 per cent reduction in inpatient falls, exceeding the 10 per cent improvement target we set ourselves.

There has also been a 37.5 per cent reduction in falls causing moderate or severe harm, with 32 per cent fewer repeat falls.

The next steps are to sustain progress and aim for a further 10 per cent reduction in falls each year.

5.4 Patient and visitor information hub

A new information hub for patients and visitors opened at Great Western Hospital last month.

The Cherwell Information Hub is located on the ground floor of the Brunel Treatment Centre in an accessible, easy to find space.

It offers a wide range of information leaflets and signposting with a focus on unpaid carers and support during the discharge process.

Volunteers are available from Monday to Friday, to provide further advice, support, or simply a friendly chat.

The hub replaces the previous weekly Carers Café and we will work closely with external partners to expand the information and signposting available.

6. Finance

6.1 Financial position

Our financial position remains challenging due to the impact of continued operational pressures and the difficulties of delivering efficiencies in these circumstances.

We started planning for our 2026-27 efficiency programme some time ago and this year plan to focus on the work we can do to transform three areas as priorities. These areas are: outpatients, theatres and urgent and emergency care.

7. Workforce, wellbeing and recognition

7.1 Staff survey results

The results of the national NHS staff survey were published last month.

At GWH, 66 per cent of staff – over 3,638 individuals – completed the survey, giving us a considerable amount of valuable feedback, both from the data and the free text comments.

These insights will be instrumental in shaping our improvement work over the next 12 months, supported by the Improving Together methodology.

Six questions improved compared with last year, and we scored above the national benchmark in 32 areas. Just as importantly, we have sustained our performance in key priority areas despite a demanding year.

Across the People Promise themes, results have remained stable, with improvements in morale, recognition and teamwork. Flexible working continues to be a particular strength, with scores well above the national average. It is also encouraging that more staff feel clear about their responsibilities, fewer report working unpaid overtime, and fewer colleagues are experiencing discrimination from colleagues. These changes represent important progress in creating a more supportive, fair, and sustainable working environment.

While the survey highlights many positives, it also shows us areas where improvement is needed. Perceptions around opportunities for career progression have declined, as well as the number of staff who would recommend the organisation as a place for care.

We have also seen lower scores in areas relating to patient care and safety culture.

Teams will now analyse the results further, using Improving Together to identify key focus areas. Through this approach, everyone is encouraged to contribute and play a part in making positive changes in their own areas of work.

7.2 GWH memorial service

Last month we held our annual memorial service to mark the sixth anniversary of the start of the Covid-19 pandemic.

The service gave staff a chance to come together and remember the patients, colleagues, family members and friends we've lost - both throughout the pandemic and over the last year.

Led by Trust Chaplain Francis Offreh, the service was open to all staff and featured reflections and a performance by local bell-ringing group Belltide.

7.3 STAR of the Month

Our latest STAR of the Month winner is Francesca Butler, Patient Experience Clerk, who was recognised for the kind and compassionate support she provides to women who have experienced pregnancy loss. Francesca is driven to provide high-quality, women-centred care and ensures she works quickly to minimise any distress to the bereaved families.

7.4 Apprenticeship award

Julie Grundill, business administration apprentice, has won a national Apprenticeship of the Year Award, in recognition of two projects she leads:

- Bereavement cards which bring comfort to families and give staff a meaningful way to support relatives
- Coordination of the palliative education programme leading to improved staff knowledge and confidence.

7.5 Pride of Swindon awards

Carol Barwell, Emergency Department Assistant, and our entire volunteer team won Pride of Swindon Awards last month. Carol was recognised for her 40 year long career working in emergency care. The 500+ strong volunteer team were recognised for their dedication to providing an extra special helping hand to our patients, families and staff.

Board Committee Assurance Report

Committee	Finance, Infrastructure & Digital Committee
Meeting Date	23 March 2026
Committee Chair	Faried Chopdat, Non-Executive Director

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Finance Risk Report	Good	x
2. BSW Financial & Recovery Update	Limited	x
3. Month 11 Finance	Partial	x
4. Efficiency Program Update	Partial	x
5. 2026/27 Planning Update	Note	x
6. Seasonal Plan Update	Good	x
7. Divisional Finance Update: Surgery & Planned Care, Medicine, FASS	Partial	x
8. Estate & Facilities Risk Report	Good	x
9. PFI Quarterly Report	Good	x
10. Update on Procurement	Good	x

POINTS OF ESCALATION	None noted.
KEY AREAS TO NOTE	**BSW Financial Recovery:** Following recent operational pressures, the Group has formally reported a revised forecast outturn deficit of £42m to the NHSE Regional team, broken down as follows: GWH £11.5m, RUH £20.5m, and SFT £10m. Despite a slight adverse variance in month 11 and ongoing pressures on income and temporary staffing costs, efficiency improvements and careful financial management are helping to mitigate risks. The Group anticipates that improved elective performance and reduced escalation costs will support meeting the revised target. The Board can be assured that the financial position is closely monitored, with actions in place to achieve the updated forecast.
	GWH Month 11 Finance Position: At month 11, the Trust reports a year-to-date adjusted deficit of £10.7m, in line with its most likely forecast. This position reflects significant operational pressures, including critical incidents and increased staffing costs, particularly in emergency and escalation areas. While overall income is £6.4m ahead of plan, mainly due to patient care and other offsetting income sources, the Trust faces ongoing challenges from the loss of deficit support funding, underperformance in private patient income, and efficiency savings not yet delivered. Pay and non-pay costs are both adverse to plan, driven by temporary staffing needs, unfilled efficiency targets, and continued escalation measures. Despite these challenges, the financial position is well-understood, risks are identified, and mitigating actions are in place to manage the underlying deficit. Each of the divisions provided an update on their financial plans, recovery and progress on delivery. Whilst good progress was noted regarding governance and controls, each of the divisions were challenged in their delivery of their respective plans.
	Efficiency Update: At month 11, the Trust's adjusted year-to-date deficit is £10.7m, which aligns with the previously forecast 'most likely' position. Despite significant operational challenges, including critical incidents and increased staffing needs, the Trust's income is

	£6.4m above plan, offsetting some cost pressures. While pay and non-pay costs remain adverse to plan due to efficiency savings shortfalls and escalation measures, these factors and associated risks have been clearly identified and are being actively managed. The Trust continues to monitor its financial position closely, with robust controls and mitigation strategies in place to manage the underlying deficit and deliver against financial targets.
	Seasonal Plan Update: The Trust has faced unprecedented demand this winter but has responded proactively, improving ambulance offload times and same-day discharges despite operational pressures. Targeted investment has supported resilience, with most winter schemes delivered, and any overspend managed within budget. The Board can be assured that patient safety, performance, and financial control are being maintained through effective management and governance.
BOARD ASSURANCE FRAMEWORK & RISKS	The Committee noted the Finance and the Estates and Facilities Risk Management reports respectively and was assured that the risk management process was adequate and effective.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	None noted.
REFERRALS TO OTHER BOARD COMMITTEES	None noted.

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

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

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**09/04/2026**	**Part 1 - Public**	☐	**Part 2 - Private**	☐
Accountable Lead	Benny Goodman, Chief Operating Officer Luisa Goddard, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Rob Presland – Deputy Chief Operating Officer Ana Gardete – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer Johanna Bogle – Deputy Chief Financial Officer				
Appendices	Use of Resources: • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

Purpose

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

Assurance Level

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

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

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

Report

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

Our Performance

During this period it should be noted that GWH experienced a prolonged period of critical incidents and business continuity events due to flow and operational pressures lasting from 1st February to 4th March. This was largely driven by an extended period of bed closures due to norovirus outbreaks that peaked at 30 closed and empty beds. The use of temporary escalation space including corridor care therefore peaked in the month. Elective performance and income was also affected as non-routine work was rescheduled. The elective position has also been further affected by a national bone cement supply issue that affected orthopaedic activity for 7-10 days from the 13th February.

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

STRATEGIC Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

RTT performance remains off plan in February with 57.3% of patients on the wait list under 18 weeks (2.6% below plan), 779 patients over 52 weeks (411 patients worse than plan) and with 1.8% of the total wait list over 52 weeks (0.6% worse than plan). At the end of February there were 8 patients reported as ongoing over 65 weeks, an increase of 3 from previous month. 3 x Plastics patients remain at risk of breaching in March.

Waiting list pressures are most prominent in the specialties of General Surgery, Trauma and Orthopaedics and Gastroenterology. The RTT recovery plan is focusing on the following areas in March to address the variance to year end plan:

- Non admitted PTL outpatient sprint with targeted waiting list initiatives and validation in top contributing specialties for patients over 18 weeks
- Additional validation support following a PTL diagnostic with Source Group Ltd, targeting a review of 4,000 ongoing clocks that have a high potential for being stopped in the month (e.g. duplicate referrals, latest outcome of discharged etc)
- Waiting list cleansing for internal referrals in specialties where there has been high growth such as paediatrics, and where audit activity has shown clock starts are likely to have been incorrectly applied
- Targeted reduction of unoutcomed appointments to support the month end income position and ensure all patients have clarity on next steps where they are on an RTT pathway
- Further ring fencing of elective capacity to support recovery on the admitted RTT PTL, with the objective of increasing day case activity and general theatre efficiency in March

Revised Elective Performance Assurance Group meetings between the COO office and clinical specialty management teams have also started this month, reporting to the weekly meeting between the COO and Divisional Operations Directors. Operating plans are being established to recover towards 67% within 18 weeks during 2026/27.

- Cancer waiting times

Cancer performance for the 28-day faster diagnosis standard dropped to 64.9% in January. Current performance is 15.4% behind plan for the month, with capacity constraints seen in the Skin, Colorectal and Breast tumour sites. The drop off in performance was anticipated because waiting list initiatives in high volume areas such as Breast started in late January. Additional financial support from the cancer alliance has been secured to help with backlog clearance and the end of year forecasts in the month of March suggest that 75%-80% end of year performance remains achievable.

62-day performance for urgent suspected cancer referral to treatment was 61.6% and is currently 13.8% below operating plan. Tumour site trajectories are most challenged within Urology, Breast and Plastics. Cancer pathways for Plastic patients remain under review with mutual aid being discussed with Salisbury NHS Foundation Trust. 62 day performance typically lags 28 day recovery and therefore year end performance is anticipated to improve but there remain systemic pathway challenges in Urology and Plastics that are affecting full recovery to plan

Cancer 31-day performance was at 85.5% and with outpatient capacity in Plastics and Breast being the top contributors to breaches.

- Time in Emergency Department

Combined 4-hour performance was 69.3% in February and 5.3% worse than operating plan. Recovery plan counter-measures initiated in November have been sustained for Type 3 UTC but the high level of bed occupancy and use of escalation spaces during this period has impacted upon Type 1 admitted flow.

However, it should also be noted that there has been exceptional growth in Type 1 attendances which were 7% higher than plan in February and 5.8% above plan for the year to date. Most of this additional activity has been seen in the second half of the year and special cause variation can be seen in the mean length of wait in ED as a result during January and February.

Ambulance handover performance in February was 56 minutes and remains above the 33 minute trajectory for the second consecutive month. However, this remains a significant improvement on 12 months ago and conveyances continue to average at 75 per day (15-20 more than were typically conveyed before July when offload times began to improve.

Tactical and operational plans continue to focus on reducing length of stay in assessment areas to maximise same day emergency care opportunity and pull from ED. Plans are being developed to safely reduce the expanded footprint following winter, whilst reducing the incidence of temporary escalation use and corridor care.

OPERATIONAL BREAKTHROUGH OBJECTIVES

- Non-Elective Length of Stay

Data shows that non-elective length of stay was 6.6 days in February, which is 0.2 days better than 12 months ago but an increase in 0.4 days from January. There has been a 0.2 day reduction since the start of the financial year in April. The priority areas of focus are currently as follows:

Implementation of the Clinical Operational Standards monitoring tool following a successful launch event with clinical leads on 3rd February. Follow up event with CMO team and clinical leads scheduled in March

- Design of the discharge planning workstream to inform best practice for Board rounds and complex discharge team support
- Deep dive in Trauma length of stay given high volumes of patients meeting criteria to reside and needs in excess of community provision
- 4 hour performance recovery actions in March including review of non-admitted 4 hour Type 1 counter-measures and review of national policy changes relating to classification of patients within Extended Emergency Medicine Ambulatory Care areas
- Ongoing delivery of projects within the existing programme including evaluation of the Swindon DVT pathway
- Frailty pathway improvements

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

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

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

Performance for March is expected to improve given the inter-dependencies with the RTT recovery plan for the non-admitted PTL which is 80% of the overall RTT waitlist.

ALERTING WATCH METRICS

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

Diagnostics – February DM01 performance was 93.9%. MRI, CT and Dexa scans are all achieving the national constitutional standard and the Trust is currently achieving the end of year target earlier than planned. Additional Endoscopy capacity from the Community Diagnostics Centre is now running at full capacity and focused recovery efforts on Cystoscopy and Audiology are expected to sustain the good performance and mitigate risks from seasonal pressures and demand on non-DM01 diagnostic work. Additional space has also been created to increase non obstetric ultrasound capacity and wait list recovery.

Temporary Escalation Spaces (TES) and No Criteria to reside patients – The use of TES increased in February with an average of 59 spaces in use across front door and ward areas, compared to 54 in the previous month.

Overall no criteria to reside was 20.3% of the bed base and this relates to higher than planned number of days delayed waiting for pathway 2 (inpatient rehabilitation) capacity in Swindon. Multi-agency discharge planning events have continued throughout this period with support

for community hospital and acute hospital beds to maintain flow. Daily discharge planning meetings with Matrons and Ward managers have also taken place as part of the Trust incident response to support earlier pathway navigation decisions and early intervention for complex discharge planning. During this period GIRFT support has also commenced to embed our approach to long length of stay reviews for patients over 21 days and national benchmarking shows GWH is performing well at 8.9% of the bed base compared to the national average of 20%.

Our Care

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

Strategic Pillar Targets

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

The number of harms has decreased slightly in month to 116 compared to 130 in January.

Complaint response rate has decreased in month to 63% compared to 76% in January.

Breakthrough Objectives

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

Aim for 2025/26

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

The numbers of patients who experienced falls that resulted in moderate harm or above increased in month to 4, compared to zero experienced in January.

Alerting Watch Metrics

The overall Family and Friends positive response rate for February was 85.4%, a small reduction from 86.2% in January. Feedback from the Emergency Department and Urgent Treatment Centre showed an improvement, rising to 77.4% from 76%, placing it just below the internal target of 78%. The Day Case positive response rate decreased slightly to 94.2%, compared with 95.7% the previous month, and also sits just below the internal target.

The number of falls has decrease very slightly to 80 compared to 89 in January.

February saw a reduction in concerns raised, falling to 476 from 522 in January. Klebsiella bloodstream infections also improved, with no cases this month, compared with two in January.

Non-alerting Watch Metrics

The number of complaints received in month has increased slightly to 84 compared to 81 in January.

The number of E. coli cases has reduced from 10 in January to 8 in February, although the Trust remains above the threshold. C. difficile cases have also fallen, with 6 recorded this

month compared to 7 in January, placing the Trust slightly above trajectory. MSSA bloodstream infections increased from 2 to 3 cases, keeping the Trust above the threshold, while no MRSA cases were reported in February.

The number of hospital-acquired pressure ulcers has decreased in month to 13 compared to 16 in January.

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

- Safer staffing fill rates remain above the National target of 85%.
- 2 Patient Safety Incident Investigations have been declared in February.

Our People

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

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

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

- **Staff Survey – Recommend as a Place to Work**
  Target: 63%
  Q2 Pulse Survey: **50.6%** (decline compared to Q1 54.7%)
  2025 Staff Survey score: **59.1%** (marginal decrease compared to 2024)

- **Staff Sickness Absence**
  Target: 3.5%
  January 2026 figure: **4.3%**, (improvement from previous month 4.5%)

- **Equality, Diversity & Inclusion (EDI) – Disparity in Experience**
  Target: 9.4%
  Q2 pulse survey: **15.6%**, (decline of 10.6% compared to Q1)
  2025 Staff Survey: **6.9%** (improvement from 11.9% in 2024)

Breakthrough Objectives
The 2025 Staff Survey results show a slight decline in the Trust's pillar metric "Recommend as a place to work," which reduced to 59.1%. This trend is reflected nationally and is likely indicative of the increasing operational pressures experienced both at GWH and across the NHS.

Following initial analysis of the results, the Trust is refocussing improvement efforts on Question 25a: "Care of patients / service users is my organisation's top priority," which sits within the same advocacy theme and is closely linked to staff willingness to recommend the organisation as a place to work. This question also deteriorated in 2025, reducing from 75.3% to 72.4%.

The Trust Staff Survey Group, alongside Divisional teams, has begun identifying targeted countermeasures to support improvement in this area. A dedicated session with TMC in April will further refine root cause analysis and develop improvement actions aligned to the Trust's breakthrough objective.

In addition, the Q4 Pulse Survey will launch in April, providing more real-time insight into performance against these key questions following the annual survey results in Q3.

Sickness Absence
The Trust's ambition remains to create a healthy, supportive, and inclusive work environment. Trust sickness absence decreased to 4.3% in January, compared to 4.5% in December, although remaining above the Trust target of 3.5%. Long-term sickness absence improved significantly in-month to 1.8%, reducing to below the 2% KPI for the first time in 12 months. Short-term sickness absence was at 2.5% in January and remains the focus of the Sickness Absence Working Group.

The Trust's Sickness Absence Working Group continues to drive improvements through coordinated wellbeing and absence management initiatives. Burnout toolkits have been rolled out across hotspot areas, alongside enhanced promotion of "in the moment" wellbeing support via Vivup EAP and active engagement from wellbeing champions across services. In addition, a QR code pilot for medical sickness reporting is underway, showing early signs of improved reporting accuracy and enabling clearer identification of areas requiring targeted absence management support.

Vacancy Rate
The Trust vacancy rate improved further in February, reducing to 38 WTE / 0.7%. Medical and Nursing are over-established in-month following further recruitment activity, with Nursing at -89 WTE and Medical at -12 WTE over-established.

Allied Health Professional and Healthcare Scientist vacancy continue to perform better than target, at 17 WTE (2.1%) in February. This is an improved position compared to 24 WTE in January.

Admin & Clerical vacancy has decreased slightly in February, although remains high in line with current vacancy controls. In-month the vacancy rate for this staff group was 121 WTE (11%).

Temporary Staffing
Bank usage saw a slight decrease in February reducing from 334 WTE to 318 WTE. This remains over plan by 140 WTE but is an improved position against plan compared to January. Bank spend is at £24.2M YTD, £4.8M above planned spend.

Agency usage decreased in February from 31 WTE to 23 WTE, in line with December levels and benefitting from reduced Mental Health Nursing pressure in-month. Agency spend is at £4.8M YTD, £3.1M above plan. As a percentage of overall workforce spend, agency usage is at 1.1%, significantly below the 4.5% target.

Workforce Recovery
We used 5,360 WTE to deliver our services in February against a planned 5,048 WTE representing an adverse position to plan of +312 WTE. The substantive workforce increased by 34 WTE in February, rising to 5,019 WTE and remaining significantly above plan. This variance is primarily attributable to Medical & Dental and Nursing recruitment, in line with February rotation and planned recruitment activity.

Temporary staffing decreased marginally by 24 WTE during the month. However, this reduction was not sufficient to offset substantive growth, resulting in a net workforce increase of +10 WTE overall compared to January. Temporary staffing remains above plan, reflecting additional staffing required to manage the recent critical incident, higher sickness absence, and enhanced care requirements.

Reviewing current performance against plan at staff group level:

- All Nursing: +226 WTE
- AHP/STT: +25 WTE
- Medical & Dental: +70 WTE
- Admin & Clerical: -7 WTE

Use of Resources

For M11 2025/26 the Trust has an adjusted deficit position of £10.7m YTD, which represents a £10.7m adverse variance to plan. In M11 the Trust had a £2.1m forecast deficit as part of a 'most likely' position and has finished in line with this position. This excludes £0.8m of deficit support funding, which the Trust will not receive for Q4. Operational challenges have remained in February, with the Trust in critical incident for the majority of the month. This has led to additional staffing in ED and other escalation areas, impacting on both income and the cost base.

On a year-to-date basis, income is £6.4m ahead of plan, with total patient care income accounting for £3.1m. ERF income is £0.1m ahead plan. Elective performance is impacted by the ongoing critical incidents, but BSW income is matched to commissioner affordability assuming performance can be recovered in March (c£0.6m risk). Other patient income is £3.0m over plan including depreciation and vaccination funding, overseas income recovery and other sources of income, most of which have offsetting cost. The Trust will not receive deficit support funding for Q4, leading to a £1.6m adverse variance year to date, however this is offset by £1.6m of industrial action funding received (net of lost income associated with strikes). Private patient income is underperforming by £0.7m while operating income is £4.0m ahead of plan driven by education & training money and programmes such as EPR and CDC, which have corresponding pay and non-pay costs.

The pay position is £12.5m adverse to plan, with undelivered cash releasing efficiency savings accounting for £6.4m. This includes a Trustwide target of £3.1m with no associated plans, with service transformation / benchmarking schemes within Divisions accounting for the remainder. Offsetting this is a £3.0m underspend against Corporate admin lines due to unfilled posts. The remainder of the variance is due to industrial action costs of £1.3m and £7.9m of temporary staffing overspends, the majority against medical and dental staff covering 62 WTE of clinical vacancies, sickness and escalation costs. It should be noted that the Trust has continued to run with over 50 additional beds and escalation areas due to critical incidents remaining in place for most of February.

Non-pay is £4.7m adverse to plan. Undelivered cash-releasing efficiency savings accounts for £3.2m with a Trustwide target of £1.5m with no associated plans. There are also efficiency plan underperformances against Procurement and Specialty Review schemes within the clinical divisions. Clinical supply and outsourcing costs across the Trust are overspent by £3.7m, while the position also includes a £0.3m provision for car parking VAT costs and a PFI technical adjustment of £0.4m. Additional run rate savings from prior year benefits total £1.7m with a further £1.2m benefit from education and finance-related costs.

At M11 total recurrent efficiency delivery is expected to be £11.5m against a plan to deliver 2/3rds of the target (£21.6m) recurrently. If we cannot improve this delivery, we are carrying an additional £10.1m deficit into our underlying position. The plan only includes £9.5m of carry forward, so the remaining £0.6m is a risk.

Breakthrough Objectives

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

As at M11 the Trust is £10.7m overspent against budget. A key driver of this is an underperformance of £10.9m against the cash releasing efficiency savings programme, delivering £17.5m year-to-date against a target of £28.4m. Of the £17.5m delivered, 59% was recurrent. It should be noted that the Trust has also delivered £5.6m of cost avoidance/run rate reductions due to prior year benefits taken in year and exiting escalation areas. While not removing budget, they are crucial in helping to reduce the overspent position. Our underlying position remains challenging and the objective for all divisions and specialties is to find recurrent saving schemes.

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

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

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

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

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

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

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

Explanation of above analysis:

The IPR report identifies issues where minoritized protected groups experience is less favourable than other groups. This is specifically around the staff survey question 16B and

experience of discrimination from colleague or manager. The staff survey provides this data by ethnicity, and it is likely that other groups both protected and non-protected have reported discrimination. The report identifies a number of countermeasures and actions are underway and planned to reduce discrimination for all staff and specifically those in protected groups.

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

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	Benny Goodman, Chief Operating Officer
Date	**30/03/2026**

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

March 2026

February 2026 & January 2026 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

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Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Target/Thres.	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Percentage of RTT patients treated within 18 weeks		58.0%	57.8%	59.6%	60.8%	61.2%	60.5%	60.7%	60.6%	59.8%	59.0%	58.0%	57.3%
Percentage of RTT patients waiting over one year		2.5%	2.2%	2.0%	1.8%	1.8%	1.6%	1.4%	1.3%	1.4%	1.5%	1.7%	1.8%
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	75% (Nat)	83.5%	80.4%	76.8%	79.2%	74.5%	65.6%	61.4%	63.9%	61.6%	71.6%	64.9%	Reported one month
Percentage of patients treated for cancer within 62 days of referral	85% (Nat)	82.1%	70.8%	69.7%	78.2%	69.3%	65.6%	65.8%	66.7%	65.6%	71.0%	61.6%	Reported one month
Percentage of Emergency Attendances within Four Hours	95% (Nat)	69.9%	69.5%	70.1%	69.1%	69.1%	67.8%	68.1%	69.9%	71.0%	71.3%	66.5%	69.3%
Percentage of Emergency Attendances over Twelve Hours	2% (Nat)	8.3%	9.0%	8.5%	5.6%	5.6%	5.8%	7.4%	7.4%	7.5%	7.2%	10.7%	10.5%
Planned surplus/deficit		690	-2149	-3476	-1173	-801	-1411	-1105	-480	-1484	-929	-2734	-2145
Rate of productivity		-14.0%	-11.0%	-13.0%	-13.0%	-8.1%	-10.0%	-14.0%	-12.0%	-15.0%	-13.0%	-10.0%	Reported one month
Readmission rate		15.4%	15.3%	16.0%	15.3%	17.0%	17.4%	15.5%	15.1%	16.3%	15.2%	14.8%	17.2%
Summary Hospital Level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
Average number of days between planned and actual discharge date		2.7	2.6	2.4	2.2	2.3	2.7	2.7	2.9	2.9	2.7	2.8	2.4
Percentage of inpatients referred to stop smoking services		11.1%	11.5%	11.9%	12.0%	12.1%	11.3%	11.4%	11.3%	11.2%	11.5%	10.5%	9.2%
Percentage of people waiting over six weeks for a diagnostic procedure or test	99% (Nat)	91%	85%	85%	84%	86%	89%	90%	93%	92%	90%	91%	Reported one month
Rates of MRSA		5.5	0.0	0.0	0.0	5.8	0.0	0.0	0.0	0.0	0.0	5.9	One month behind
Rates of C-Difficile		27.7	28.1	48.9	33.7	23.0	11.9	11.9	23.0	6.1	17.7	41.2	One month behind
Rates of E-Coli		33.3	56.1	43.4	39.3	51.8	50.7	41.7	63.4	42.6	58.9	58.9	One month behind
Percentage of NHS Trust staff to leave in the last 12 months	14.8% (Int)	10.9%	10.3%	11.7%	11.6%	11.9%	13.1%	12.8%	11.4%	11.2%	11.1%	9.9%	One month behind
Sickness absence rate	3.5% (Int)	4.5%	4.1%	4.1%	4.2%	4.4%	4.3%	4.1%	4.3%	4.2%	4.5%	4.3%	One month behind
Rate of annual growth in under 18s elective activity		27.7%	16.4%	11.8%	9.6%	4.9%	4.2%	4.5%	4.1%	0.0%	0.0%	0.0%	0.0%

Key Indicators

Great Western Hospitals NHS Foundation Trust

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

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

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

Metrics	2020
CQC safe inspection score	Requires improvement

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

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

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

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

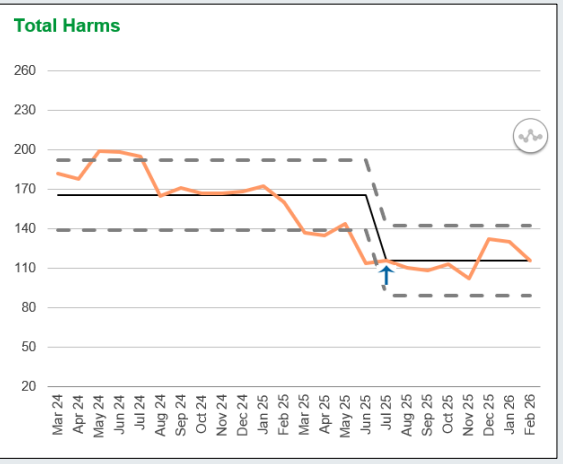
This metric reflects the Trust's commitment to learning from patient feedback and ensuring timely, high-quality responses to concerns raised.

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

Complaints response rate is tracked each month against timescale.

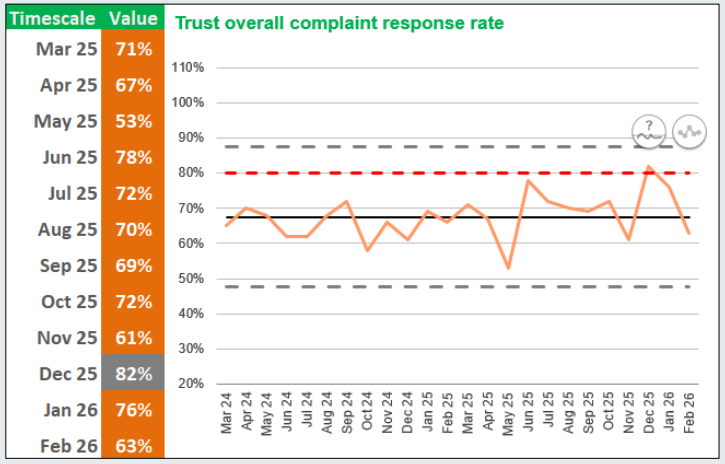
Total Harms
To achieve and sustain zero avoidable harm.

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



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

Timescale	Value
Mar 25	71%
Apr 25	67%
May 25	53%
Jun 25	78%
Jul 25	72%
Aug 25	70%
Sep 25	69%
Oct 25	72%
Nov 25	61%
Dec 25	82%
Jan 26	76%
Feb 26	63%



Counter Measures

The total number of harms in February was 116, representing a slight decrease from January (130). This is a marked improvement compared with February last year, when 161 harms were reported.

Falls decreased slightly to 80 compared to 89 in January, with 4 resulting in moderate harm or above.

Methicillin-Sensitive Staphylococcus Aureus (MSSA) cases increased from 2 to 3 in February, while Escherichia coli (E. coli) bloodstream infections reduced from 10 cases to 9 cases in February.
There were 5 Clostridioides difficile (C. diff), reduced from 7 in January, which is slightly above the Trust's annual trajectory. Hospital-acquired pressure ulcers have reduced to 13 in month compared to 16 in January.

In February, the complaint response rate was 63%. While this represents a decrease from January's rate of 76%, divisional teams continue to embedded countermeasures for improvement. These actions include strengthening weekly divisional oversight meetings and reviewing the main themes contributing to delays, with a particular focus on enhancing communication with patients who are on waiting lists.

Full day complaint writing training co-delivered with a legal firm was received positively by attendees.

Executive Summary

NHS Great Western Hospitals NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance

In January, 66 pathways breached the standard with 52.0 being allocated to GWH resulting in performance of 61.6%. Of these, 30% are attributed to the Urology pathways & 21% to Skin. Breast pathways made up 17% of breaches. These pathways are seeing issues with capacity for appointments and diagnostics. A number of pathways are also impacted by the need for multiple and repeat diagnostics.

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

RTT performance decreased by 0.66%%, to 57.32%, when compared to last month's position. This is due to decreasing <18 week waiting list size and the increasing waiting list size in >18-week patient cohort. The total number of patients waiting over 52 weeks in February increased by 39 to 779, compared to the previous month.

There were 8 patients reported at 65 weeks at the end of February, an increase of 3 from previous month. 3 plastics, 3 x general surgery and 1 x cardiology 1 x urology.

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

A level of risk remains for March across specialties; most critically for General Surgery, Urology and Trauma and Orthopaedics. This is due to trust critical incidents impacting elective lists and supply issues with cement for Trauma and Orthopaedics. For the remainder of Q4 Plastics stands out as our biggest capacity risk and mitigating actions continue with an aspiration to clear all breaches by year end.

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

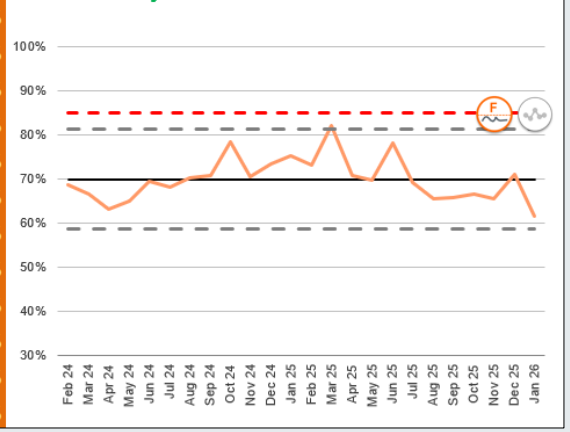
Our position and trajectory plans for clearance have been shared with regional colleagues.

Benny Goodman | Chief Operating Officer

Cancer 62 Day

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

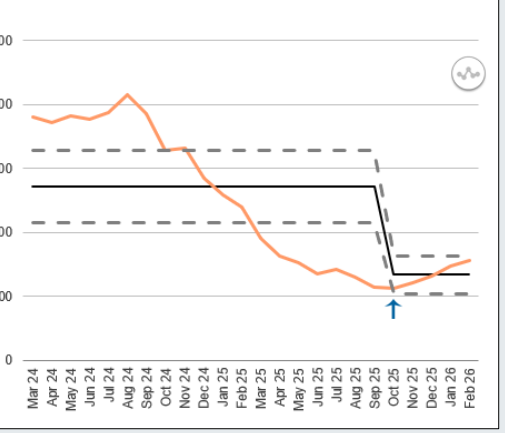
Timescale	Value
Feb 25	73.1%
Mar 25	82.1%
Apr 25	70.9%
May 25	69.7%
Jun 25	78.2%
Jul 25	69.3%
Aug 25	65.6%
Sep 25	65.8%
Oct 25	66.7%
Nov 25	65.6%
Dec 25	71.0%
Jan 26	61.6%



RTT: Number of patients waiting over 52 weeks

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

Timescale	Value
Mar 25	950
Apr 25	816
May 25	764
Jun 25	679
Jul 25	707
Aug 25	646
Sep 25	573
Oct 25	559
Nov 25	602
Dec 25	658
Jan 26	740
Feb 26	779



Counter Measures

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

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

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

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

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

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

ED Attendance as a Percentage of Population by Deprivation Quintile

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

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

February has seen a significant decrease in NCTR Days which has been an extended time of recovery phase prior to Christmas – where we have seen extended periods of being in Critical Incident. Prior to Christmas and over the month of January, a huge focus on LoS reduction, escalation, increasing referrals and planning within CTR across all divisions. Countermeasures that have been introduced and continue to be implemented:

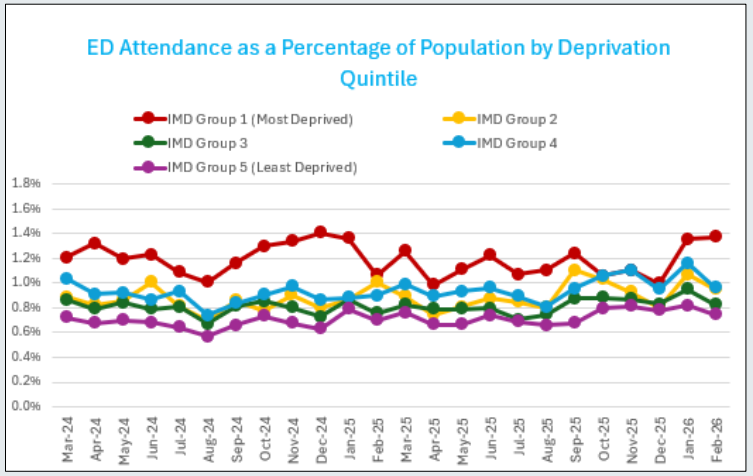
- **MEGA MADE** – impacted on showing a reduction in PW0's, Not set pathways and form of escalation from a ward perspective. These have continued and had a formal review to improving timings/days.
- Early escalation of barriers in CTR now on Nerve Centre for monitoring and utilised – DST utilising and collating.
- DST rep to 'wrap & pack' discharges for the next 24 hours
- Introduction of 48 hours.48 hours ,7 days – target dates for partners continues and is discussed at system calls – those breaching times
- 21 day LoS panel to began on the 12/11/25 for CTR & NCTR – there is a reduction shown on GIRFT latest data 8.9% - nationally this stands at 20%

Discharge Pathway performance all areas:

Discharge Pathway Performance

	Dec-25	Jan-26	Feb-26	Mar-26	Total
Total Spells Discharge Via Pathway P0 (& Not Set), Within 0 Discharge Ready Days	414	422	330	142	1308
Total Spells Discharge Via Pathway P0 (& Not Set)	590	581	465	183	1819
Percent Spells Discharge Via Pathway P0 (& Not Set), Within 0 Discharge Ready Days	70.17%	72.63%	70.97%	77.60%	71.91%
Total Spells Discharge Via Pathway P1, Within 2 Discharge Ready Days	73	65	76	24	238
Total Spells Discharge Via Pathway P1	204	215	197	75	691
Percent Spells Discharge Via Pathway P1, Within 2 Discharge Ready Days	35.78%	30.23%	38.58%	32.00%	34.44%
Total Spells Discharge Via Pathway P2, Within 2 Discharge Ready Days	66	49	46	18	179
Total Spells Discharge Via Pathway P2	143	137	113	34	427
Percent Spells Discharge Via Pathway P2, Within 2 Discharge Ready Days	46.15%	35.77%	40.71%	52.94%	41.92%
Total Spells Discharge Via Pathway P3, Within 07 Discharge Ready Days	8	16	15	3	42
Total Spells Discharge Via Pathway P3	21	32	29	11	93
Percent Spells Discharge Via Pathway P3, Within 7 Discharge Ready Days	38.10%	50.00%	51.72%	27.27%	45.16%

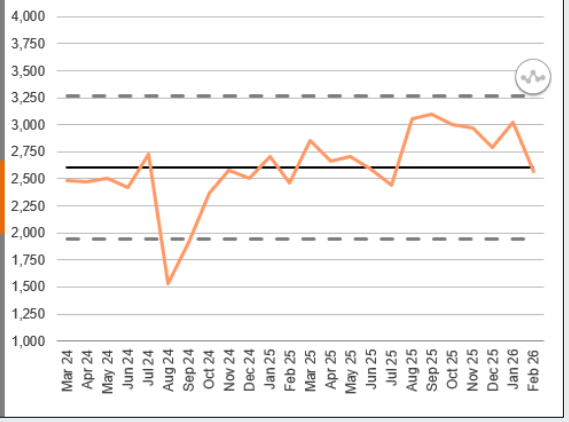
ED Attendance as a Percentage of Population by Deprivation Quintile



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

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

Timescale	Value
Mar 25	2,851
Apr 25	2,663
May 25	2,710
Jun 25	2,594
Jul 25	2,439
Aug 25	3,054
Sep 25	3,095
Oct 25	3,007
Nov 25	2,973
Dec 25	2,793
Jan 26	3,027
Feb 26	2,565



Counter Measures

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

An executive Go & See to high intensity user team MDT has informed forward plans; we need to consider how we gain population insights for the changing use and attendance rate to ED over time. We are reviewing our approach to young people who access ED frequently to review whether similar support would support alternative pathways and earlier intervention. We are working closely with community partners on attendance and admission avoidance activity and will need to ensure that activities take into account the health inequalities and differentials in emergency action.

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

Opportunities:

- 48 hours, 48 hours and 7 days continues to be reported
- To review the approach to criteria led discharge for patients and maximise opportunities for earlier in the day discharge including to discharge lounge. - continuing with positive outcomes Project being undertaken by Chief Registrars in medicine - linked to weekend flow and SOPs being designed
- Power BI report with themes for delays up and running – shared at Transfer of Care A3 working group. There is now a focus on the referral rates – report being reviewed.
- 21 day LoS Panel continues with positive impact
- **Reflections:**
- Applying improving together methodology to change initiatives.
- Workforce planning to improve alignment of Acute Medical clinical Workforce to demand.
- Easter Planning to commence
- Boarding has been enacted to support decompression of ambulance queue and ED internal queues – site/divisional understanding to be respond to risk in delayed access to urgent care. - Ongoing for March is to reduce and have no boarding happening

Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime (ED & CEU) in February 2026 was 485 minutes (comparable to January 2026) against the national standard of 240 minutes, and the highest time since March 2025. Mean length of stay has been affected by continued flow across the organisation, leading to ED outward flow and capacity to manage incoming patients.

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

Emergency Care – Urgent Treatment Centre - Mean Stay

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

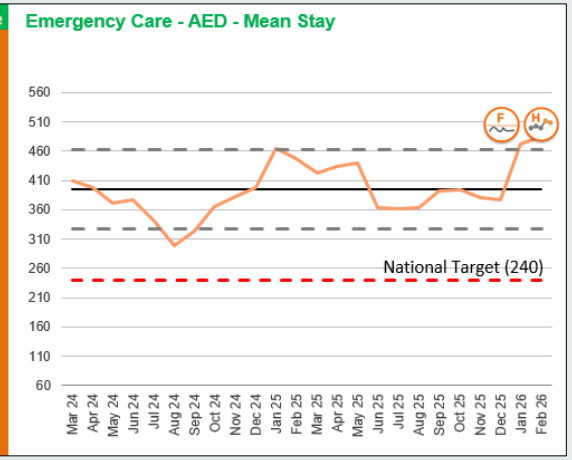
Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

Emergency Care – Emergency Department - Mean Stay

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

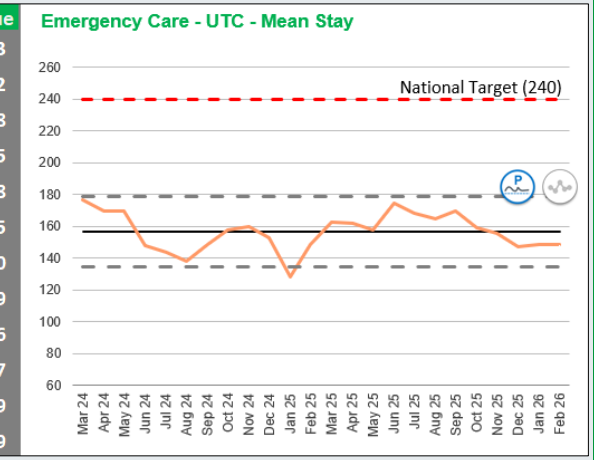
Timescale	Value
Mar 25	423
Apr 25	433
May 25	440
Jun 25	364
Jul 25	361
Aug 25	364
Sep 25	392
Oct 25	394
Nov 25	381
Dec 25	377
Jan 26	472
Feb 26	485



Emergency Care – Urgent Treatment Centre - Mean Stay

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

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



Counter Measures

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

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

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Sickness Absence (rate)

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

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

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

Our target for sickness absence is 3.5%, and performance in January 2026 was 4.3%, an improvement compared to the previous month.

Staff Recommendation as a Place to Work

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

In 2023 and 2024 the Trust achieved 60% performance.

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

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

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

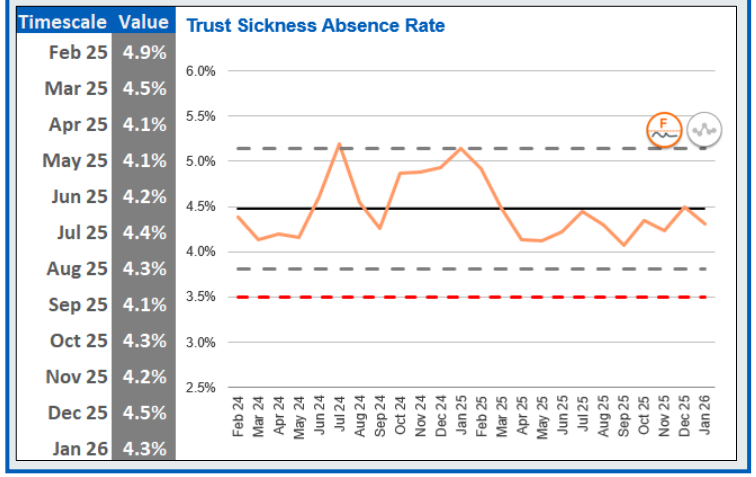
The 2025 Staff Survey shows a small decline in this question, decreasing from 59.6% in 2024 to 59.1% in 2025.

Jude Gray
Director of Human Resources (HR)

Trust sickness absence rate

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

Timescale	Value
Feb 25	4.9%
Mar 25	4.5%
Apr 25	4.1%
May 25	4.1%
Jun 25	4.2%
Jul 25	4.4%
Aug 25	4.3%
Sep 25	4.1%
Oct 25	4.3%
Nov 25	4.2%
Dec 25	4.5%
Jan 26	4.3%



Staff % recommend the organisation as a place to work

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

Counter Measures

- Sickness absence improved in January, decreasing from 4.5% to 4.3%. Following a spike in the previous month and focussed work within People Operations and Divisional teams, long-term absence has decreased to 1.85% whilst short-term continues as the top pressure at 2.46%. Notably, within Medicine Division the absence has reduced to its lowest point in over 12 months at 3.9%.
- To support Trust level absence, the Improving Attendance working group has streamlined its focus to embed and evaluate progress with the following three Trust-wide initiatives:
  - Rollout of a burnout toolkit to hotspot areas
  - Promotion of 'in the moment' support through EAP provider Vivup
  - Implementation of QR-code reporting for Medical absence
- At the February Improving Attendance working group meeting, a representative from Health & Safety presented preventative initiatives to mitigate MSK and Mental-health related absence, including:
  - Improvement to risk assessments
  - Refreshed training and reporting routes from the Never OK campaign
  - Importance of regular DSE self-assessment review

- The number of staff who would recommend GWH as a place to work decreased marginally in the 2025 Staff Survey, moving from 59.6% in 2024 to 59.1% in 2025. Whilst a decline, this is a trend replicated nationally. A review of the breakthrough objective to drive performance in this question has been undertaken and a refreshed focus on the supporting advocacy question "Care of patients / service users is my organisation's top priority" is in place for the coming year.
- The Trust and Group have recognised the critical importance of ensuring a seamless Health and Wellbeing provision across the Group, and are actively developing a Group Health and Wellbeing Strategy. Locally, health and wellbeing initiatives continued in February:
  - Massage event held at the Orbital on 10th February with a tea trolley and massage therapy slots for 30 staff
  - Event held at GWH on 24th February, with 60 staff attending to benefit from massage therapy, pet therapy dogs, arts and crafts, and refreshments
  - 13 staff received Long Service Awards on the 25th Feb
  - Tea trolley in a box delivered to 15 sites for community teams throughout February
  - 9 managers trained in Mental Health Skills for Managers

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

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

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

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

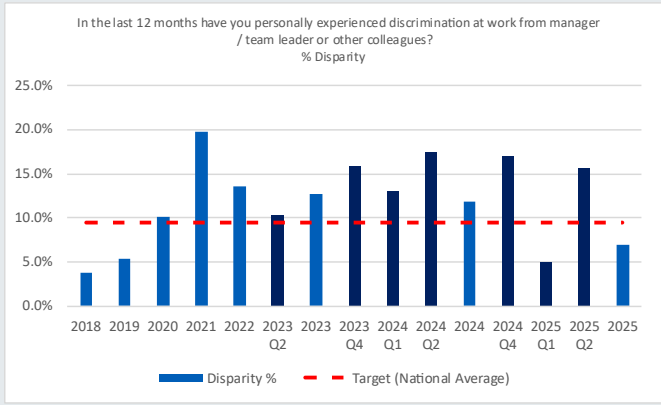
The Trust ambition in 2023 was to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

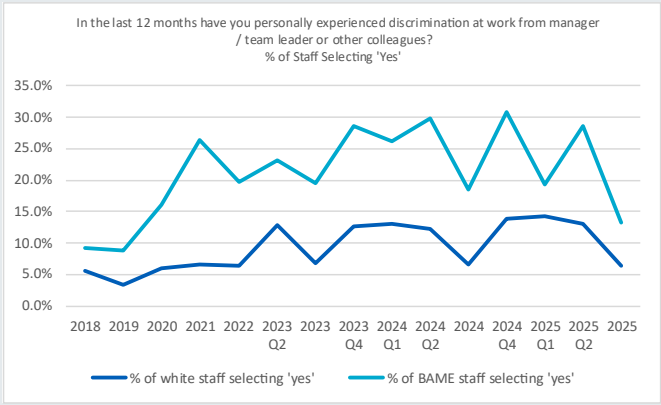
Disparity has further improved in the 2025 staff survey results, reducing from 11.9% in 2024 to 6.9% in 2025.

Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

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





Counter Measures

- EDI Champions evaluation has concluded, a report will be presented at the Inclusion & Health Inequalities Subcommittee meeting in May 2026. Thirty EDI champions completed the survey, compared to forty-two in year one. Champions remain active, with 31% reporting they are regularly active (monthly) and 17% frequently active (weekly); 40% feel they have had a positive impact on their team/department and 16% feel they have made a wider systemic impact (e.g. change in culture, involvement in projects). The net promoter score has reduced from 52 to 7 (how likely are you to recommend the role), the EDI Lead will work with the champions to understand this shift.

- The Trust has become a member of the Business Disability Forum (BDF), this includes associate membership for Bath and Salisbury. BDF is a membership organisation who specialise in disability inclusion. Staff have access to a range of resources including workshops, toolkits, specialist networks and advice and guidance to help improve disability inclusion.

- Forty staff attended the Addressing Unprofessional Behaviours workshop on 18 February, and the Joint Network met on 23 February to celebrate. The network reviewed the EDI policy during the meeting which has been refreshed and two chairs (Women's and Men's) provided an update, the date was selected as a common anniversary date for all networks.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

For M11 2025/26 the Trust has an adjusted deficit position of £10.7m YTD, which represents a £10.7m adverse variance to plan. In M11 the Trust had a £2.1m forecast deficit as part of a 'most likely' position and has finished in line with this position. This excludes £0.8m of deficit support funding, which the Trust will not receive for Q4. Operational challenges have remained in February, with the Trust in critical incident for the majority of the month. This has led to additional staffing in ED and other escalation areas, impacting on both income and the cost base.

On a year-to-date basis, income is £6.4m ahead of plan, with total patient care income accounting for £3.1m. ERF income is £0.1m ahead plan. Elective performance is impacted by the ongoing critical incidents, but BSW income is matched to commissioner affordability assuming performance can be recovered in March (c£0.6m risk). Other patient income is £3.0m over plan including depreciation and vaccination funding, overseas income recovery and other sources of income, most of which have offsetting cost. The Trust will not receive deficit support funding for Q4, leading to a £1.6m adverse variance year to date, however this is offset by £1.6m of industrial action funding received (net of lost income associated with strikes). Private patient income is underperforming by £0.7m while operating income is £4.0m ahead of plan driven by education & training money and programmes such as EPR and CDC, which have corresponding pay and non-pay costs.

The pay position is £12.5m adverse to plan, with undelivered cash releasing efficiency savings accounting for £6.4m. This includes a Trustwide target of £3.1m with no associated plans, with service transformation / benchmarking schemes within Divisions accounting for the remainder. Offsetting this is a £3.0m underspend against Corporate admin lines due to unfilled posts. The remainder of the variance is due to industrial action costs of £1.3m and £7.9m of temporary staffing overspends, the majority against medical and dental staff covering 62 WTE of clinical vacancies, sickness and escalation costs. It should be noted that the Trust has continued to run with over 50 additional beds and escalation areas due to critical incidents remaining in place for most of February.

Non-pay is £4.7m adverse to plan. Undelivered cash-releasing efficiency savings accounts for £3.2m with a Trustwide target of £1.5m with no associated plans. There are also efficiency plan underperformances against Procurement and Specialty Review schemes within the clinical divisions. Clinical supply and outsourcing costs across the Trust are overspent by £3.7m, while the position also includes a £0.3m provision for car parking VAT costs and a PFI technical adjustment of £0.4m. Additional run rate savings from prior year benefits total £1.7m with a further £1.2m benefit from education and finance-related costs.

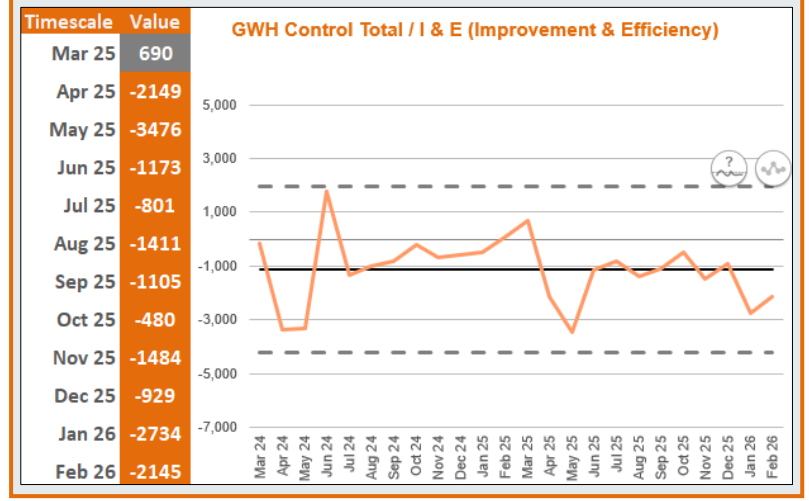
At M11 total recurrent efficiency delivery is expected to be £11.5m against a plan to deliver 2/3rds of the target (£21.6m) recurrently. If we cannot improve this delivery, we are carrying an additional £10.1m deficit into our underlying position. The plan only includes £9.5m of carry forward, so the remaining £0.6m is a risk.

Simon Wade | Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
Mar 25	690
Apr 25	-2149
May 25	-3476
Jun 25	-1173
Jul 25	-801
Aug 25	-1411
Sep 25	-1105
Oct 25	-480
Nov 25	-1484
Dec 25	-929
Jan 26	-2734
Feb 26	-2145



Counter Measures

Cash releasing efficiency savings were £0.9m below target in month. Actual savings delivered were £1.7m against a plan of £2.6m. Pay was £0.5m under plan and non-pay £0.3m under plan, with income £0.1m under plan. Recurrent delivery was 61% in month and is 59% year-to-date, in line with M10. Note that the Trust has also made cost avoidance/run rate savings of £5.5m at M11 relating to prior year benefits transacted in-year and the closure of escalation areas. Divisions and services are included in financial recovery workstreams such as substantive workforce, temporary staffing and better buying to focus on delivery recurrent cash out savings.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Carbon Footprint / Sustainability

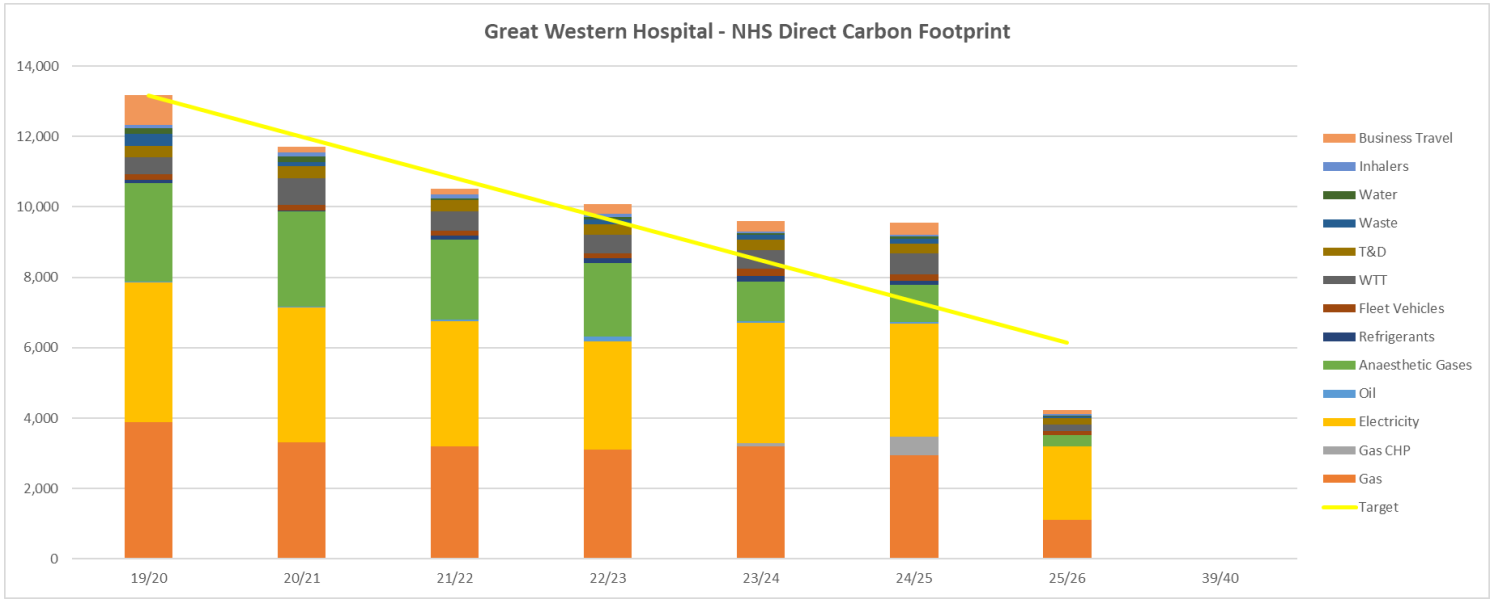
Sustainability is fundamental to maintaining high quality care; to help us meet the needs of today without compromising the needs for future generations.

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

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

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

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



Counter Measures

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

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

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

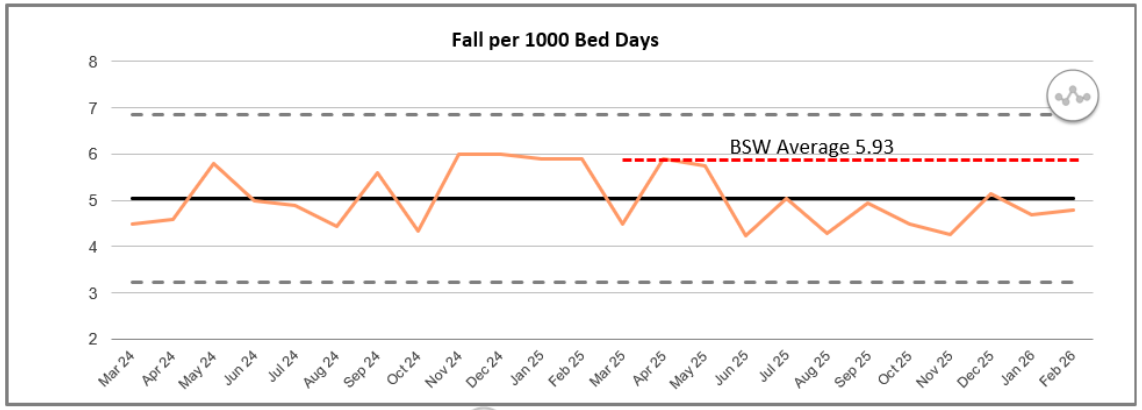
Simon Wade
Chief Financial Officer

2025/26 Breakthrough Objectives

Reducing Falls & Falls With Harm

Great Western Hospitals NHS Foundation Trust

Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
4.50	5.91	5.75	4.23	5.03	4.30	4.95	4.50	4.27	5.15	4.69	4.78



Common cause - no significant change

Understanding the Data

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

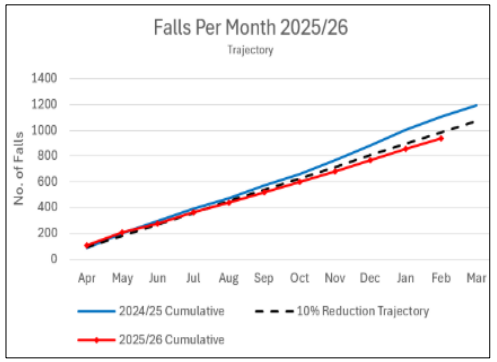
Aim for 2025/26

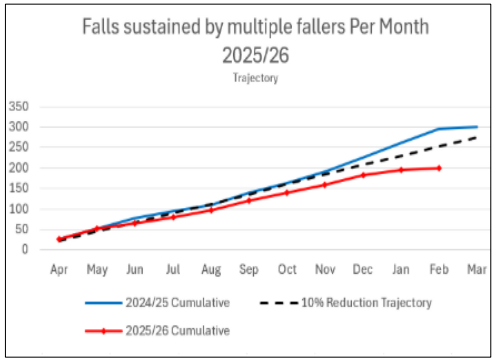
Reduction in the number of Total Falls by 30% over 3 years.
Reduction in the number of patients experiencing moderate harm or above by 10% each year
Reduction in the number of patients that fall more than once by 20%.

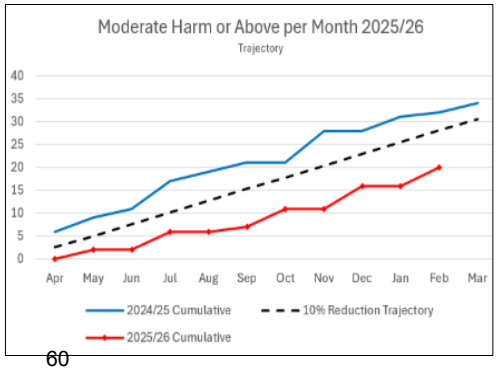
We are driving this measure because…

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

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







Performance

In February 80 falls were reported, a decreased from 89 in January. There were 4 falls resulting in moderate or severe harm in month. Two patient fell more than one in month; this is a significant improve on previous months.

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

Improvement Actions:

The monthly ward-based audit has commenced and this shows good compliance with the enhanced care standards.

A deconditioning project has commenced on Teal and Trauma with the aim to have 75% of patient out of bed for lunch. Results of data collected will be analysed to identify improvements.

The "Call — Don't Fall" campaign encourages patients to press the call bell and wait for help, especially when moving to and from the toilet. A winning poster is being selected from three shortlisted designs, and the final version will be shared trust-wide and on social media.

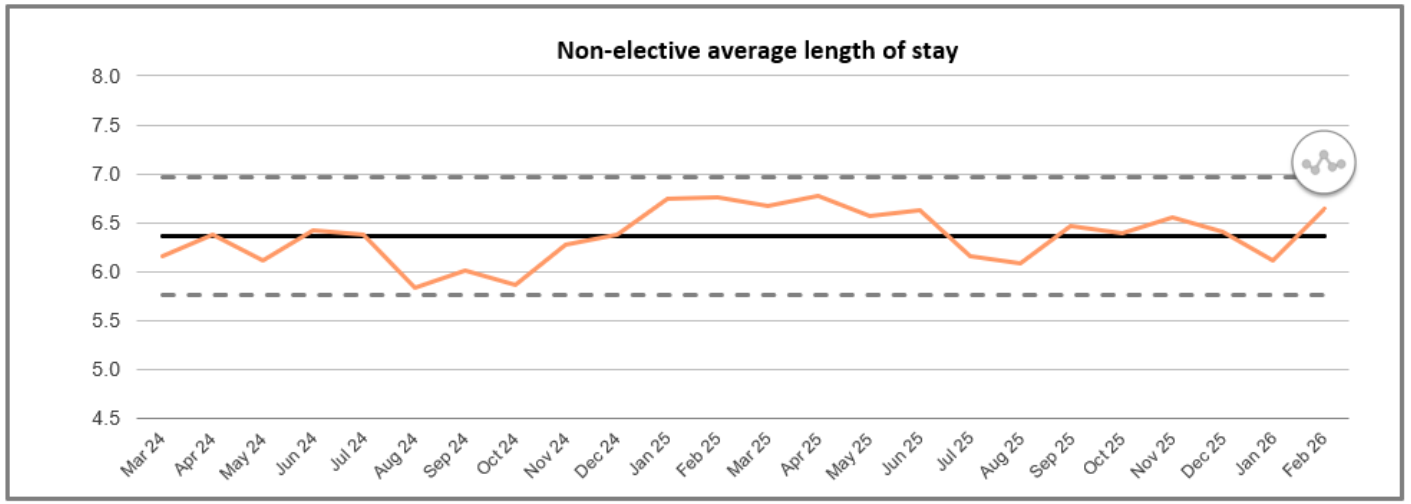
The "Listen and Loiter" campaign supports staff in providing safer toileting care. Education sessions remind colleagues to stay nearby, listen, and loiter after assisting someone, helping them anticipate needs, prevent unassisted standing, and reduce falls.

2025/26 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Non-elective average length of stay

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



Common cause - no significant change

Understanding the Data

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

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

We are driving this measure because...

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

Performance

Data shows that non-elective length of stay was 6.6 days in February, which is 0.2 days better than 12 months ago. There has been a 0.2 day reduction since the start of the financial year in April. The priority areas of focus are currently as follows:

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

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

Risks

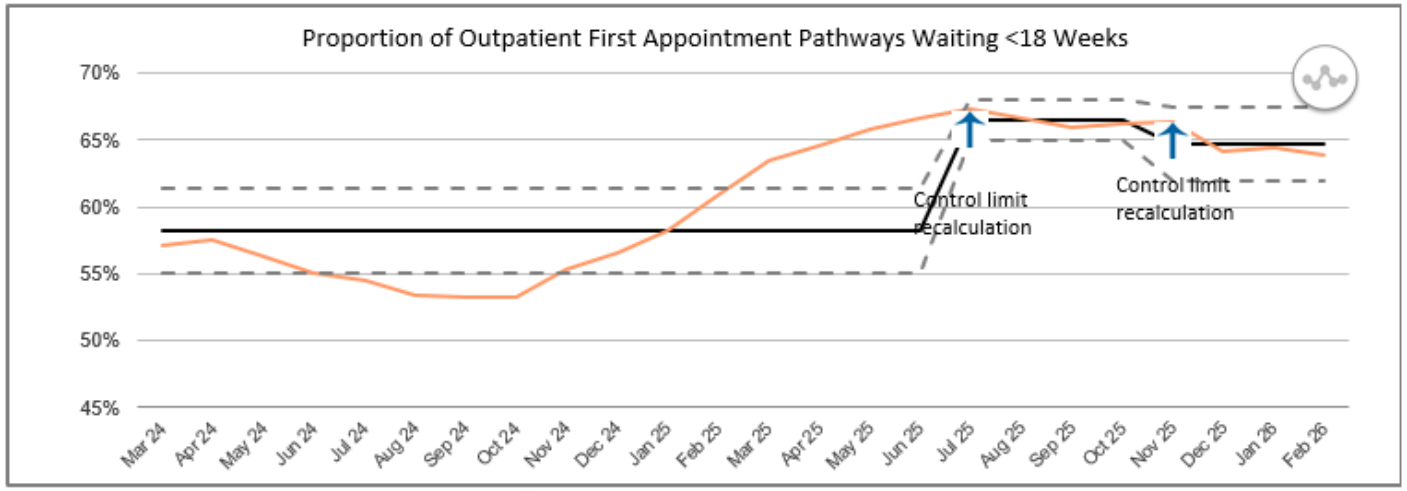
There is a risk that high hospital occupancy leads to poor patient flow through the hospital which impacts on the safe delivery of care. High occupancy resulting in delays to offloading ambulances (risk 731) , overcrowding in ED / ED majors (690) and the use of temporary escalation spaces to deliver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

2025/26 Breakthrough Objectives

Proportion of Outpatient First Appointment Pathways Waiting <18 Weeks

Great Western Hospitals NHS Foundation Trust

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



Common cause - no significant change

Performance

Performance for February remained at 64%, unchanged from both December and January. 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 and 81% of planned activity for February. 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. referrals will now be routed directly into the correct service at the point of triage rather than through the single, generic RAS 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.

Understanding the Data

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

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

We are driving this measure because...

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

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

Risks

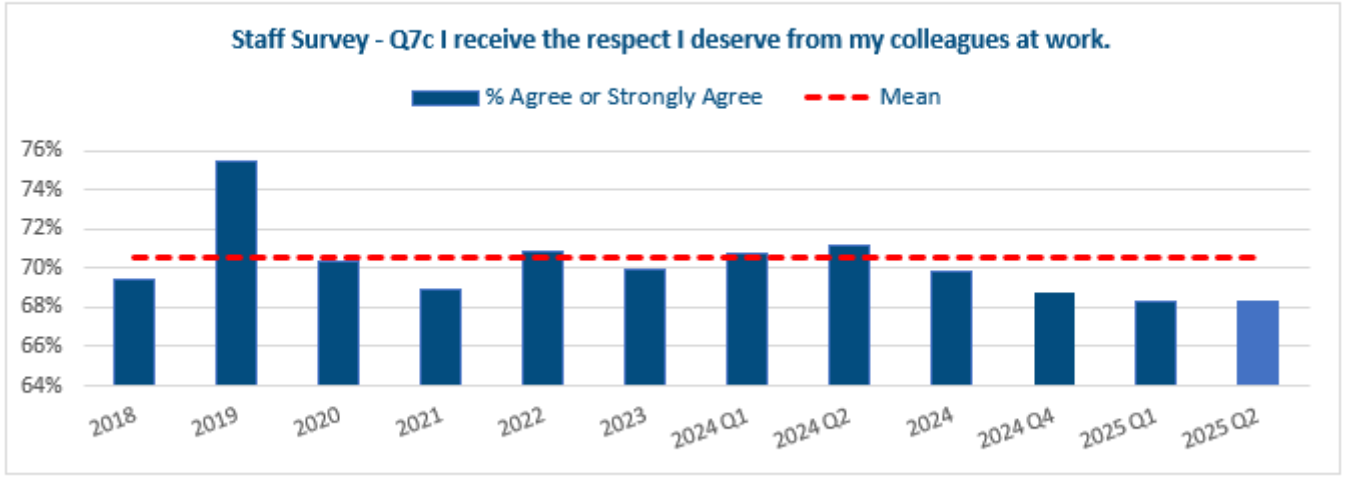
- Administrative capacity to build and support new pathways may result in delays to implementation or pausing of this sub workstream.
- Capacity Constraints: If there is insufficient capacity to handle the increased demand for early appointments, it could delay the overall process and hinder the achievement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

2025/26 Breakthrough Objectives

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

Great Western Hospitals NHS Foundation Trust

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



Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

- The Trust achieved an improvement in its breakthrough objective, increasing the number of staff who report they receive respect at work to 70.3% (+0.5% to 2024). Corporate and FASS Divisions achieved above the overall Trust result at 75.5% and 74.2% respectively. Medicine improved on last year at 69.2%, and Surgery & Planned Care declined compared to last year to 64.6%.
- To continue improvement on this question, respect is a core theme of our values and behaviours and will be supported by the ongoing embedding of 'our behaviours' throughout 2026/27.
- Q25a "Care of patients / service users is my organisation's top priority" has been highlighted as an impacting theme on staff recommending GWH as a place to work, and has been selected as the new breakthrough objective for 2026/27. In 2025, 72.4% of our staff responded positively to this question. The Trust is aiming to make a 5% improvement in this area with countermeasures being developed relating to embedding our behaviours, engaging with all workforce across MDT teams, managing perceptions of corridor care whilst improving occupancy and flow, and engaging our Admin & Clerical workforce in their contribution to patient care.

Risks

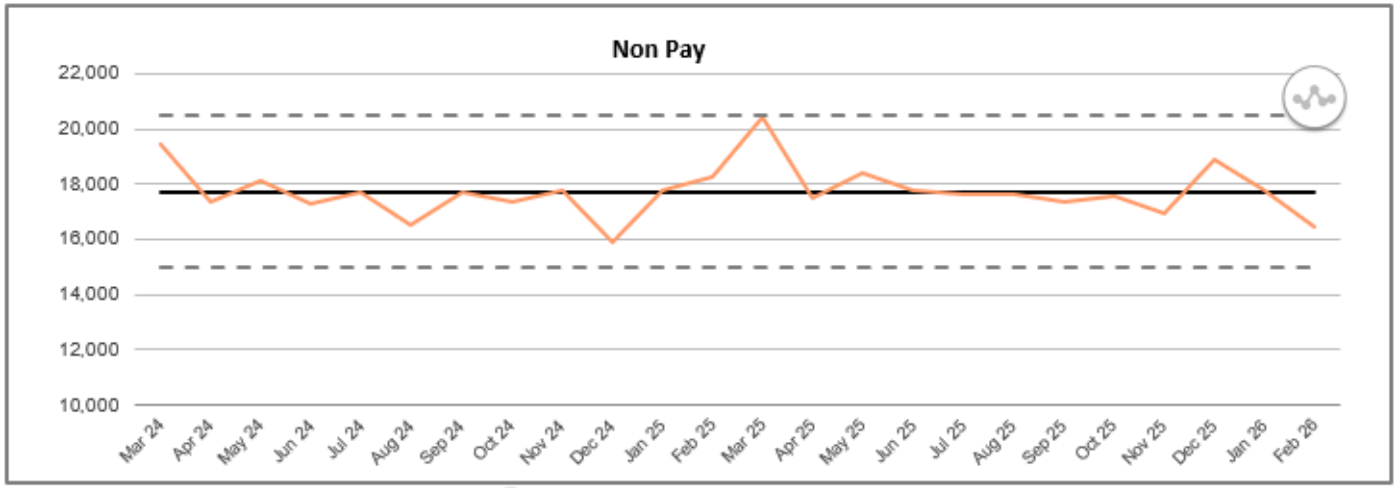
- Significant risk to staff morale and engagement due to current financial challenges, requirement to reduce our workforce, and organisational change. The majority of workforce controls are impacting our non-clinical workforce, however initial results suggest no material impact to our scores in this question.

2025/26 Breakthrough Objectives

Non-Pay run rate stabilisation and reduction

Great Western Hospitals NHS Foundation Trust

Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
20422	17485	18390	17782	17611	17661	17385	17596	16912	18918	17777	16448



Common cause - no significant change

Understanding the Data

The graph shows that non-pay spend has been on an upward trajectory over the previous 2 years. The sharp increase in Mar-25 reflected increase in stocks and accruals pertaining to 24/25. Costs reduced by £1.5m in Feb-26 due to £0.6m of prior year benefits and £0.8m of lower drug costs due to actuals for Q4 so far being less than estimates. While some increase in costs will be driven by inflationary uplifts in supplier contracts and additional activity, the focus of the breakthrough objective will be on highlighting increases within influenceable areas such as clinical supplies, and looking for potential mitigations to current spend.

We are driving this measure because...

The Trust has a £32.4m efficiency savings target for 25/26, which is £2.7m per month. As at M11 the Trust has delivered £17.5m of actual cash releasing savings, leading to an under delivery of £10.8m. Finding recurrent cash releasing savings is crucial if the Trust is to deliver on its savings programme and achieve a breakeven budget.

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

Performance

M11 non-pay costs were £1.5m lower than M10 driven by £0.6m of prior year benefits and £0.8m of lower drugcosts due to actuals for Q4 so far being less than estimates.

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

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

Risks

The risks to achievement include:

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

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26	Trend
Concerns and Complaints	No. of concerns received	SPC	H	435	342	522	475	
IP&C	Klebsiella	2.17 (Int)	?	4	4	2	0	
FFT	Overall response rate (%)	28.9% (Int)	?	21.2%	22.8%	24.0%	22.7%	
	Positive response (%)	90.0% (Int)	?	84.0%	88.2%	86.2%	84.5%	
	ED & UTC Response Rate	19.6% (Int)	?	18.4%	19.3%	19.6%	19.4%	
	ED & UTC Positive Responses	78% (Int)	?	78.8%	82.7%	76.0%	77.4%	
	Inpatients Response Rate	28.3% (Int)	?	26.1%	26.0%	24.9%	24.7%	
	Maternity Response Rate	45.1% (Int)	?	18.4%	25.7%	30.2%	26.7%	

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

Performance & Counter Measure

The PALS service received 475 concerns in January, a decrease from 522 in December. Waiting times accounted for 42% of all concerns, highlighting the impact that service demand and elective waiting list pressures have on patient experience.

There were no Klebsiella bloodstream infection cases reported in February. A review showed good catheter care practice across wards, including better use of stabilisation devices and improved documentation. Ongoing improvement work will focus on strengthening Matron oversight of catheter care assessments, ensuring regular clinical reviews of whether a catheter is still needed, and increasing awareness of correct catheter bag positioning to prevent bags from touching the floor.

The IPC team is supporting a QI project to strengthen hand hygiene practice through pocket gel rollout, UV light box training, and increased Practice Education support.

Family and Friends Test (FFT) response rates decreased in February , from 24% to 22.7%, with the main reduction driven by maternity services.
The overall Trust positive response rate decreased further from previous months to 84.5%, although a slight increase in month noted within ED & UTC.

Risks

The risks around FFT procurement remain on the register until the transition to a new provider is complete, this is anticipated by April 2026.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26
Harm	Patient safety incident investigation	SPC		3	1	0	2
	No. of Falls in month	SPC		76	91	89	80
	No. falls with moderate harm or above	SPC		0	6	0	4
	Medication incidents with moderate harm	SPC		1	2	1	3
	Pressure Ulcer (Hospital Acquired)	SPC		10	16	16	13
Concerns and Complaints	No. of complaints received	SPC		106	94	81	84
	Number of reopened complaints	SPC		3	4	3	4
IP&C	C.Diff	4.50 (Int)		1	3	7	6
	MRSA	0 (Int)		0	0	1	0
	MSSA	1.92 (Int)		1	5	2	3
	E.coli	7.50 (Int)		7	10	10	8
	Pseudomonas	1.75 (Int)		0	0	2	3

Performance & Counter Measure

In February there were 2 Patient Safety Incident Investigation (PSII) declared. Currently, 13 investigations are in progress, with 6 overdue against set timelines. The Lead Incident Investigator is working with each division to provide early support to each investigation manager. In addition After Action Review training has been procured, which will support early recognition of learning.

The number of falls reported in month is 80, a decrease from 89 reported in January. There has been 4 falls with moderate or above harm in month.

The number of Hospital-acquired pressure ulcers has decreased in month to 13, compared to 16 in January. The overall cumulative rate remains below the Trust's planned reduction trajectory with a rate of 0.78 per 1000 bed days for total pressure ulcer harms. There were three category 3 pressure harms.
There were 3 medication incident recorded as moderate harm or above, with no common themes. Each incident had immediate learning identified.

The Trust remains above trajectory for E. coli and Klebsiella bloodstream infections, while rates of Pseudomonas infections remain below target. A detailed review of all recent E. coli cases has been completed. This has shown that many infections were multifactorial, including the patients underlying health conditions. It also identified that that hand hygiene at the bedside can be strengthened, particularly by ensuring that hand sanitiser dispensers are consistently available and in good working order.

There have been 3 cases of Methicillin-Sensitive Staphylococcus Aureus (MSSA) and 0 case of Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection. To strengthen prevention measures, the divisions have commenced a project to update the Visual Infusion Phlebitis (VIP) score, supporting improved monitoring and management of peripheral lines.

Risks

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

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26
Safer Staffing	Safer Staffing – average fill rate RN (%)	85.0% (Nat)	P	92.9%	90.7%	93.6%	91.6%
	Safer Staffing – average fill rate HCA (%)	85.0% (Nat)	P	116.3%	119.4%	118.8%	116.8%
FFT	Inpatients Positive Responses	90.2% (Int)	?	89.7%	90.6%	91.6%	85.8%
	Daycases Response Rate	29.8% (Int)	?	28.9%	28.4%	28.7%	29.3%
	Daycases Positive Responses	95.1% (Int)	?	94.8%	95.5%	95.7%	94.2%
	Outpatients Positive Responses	92.8% (Int)	?	78.8%	100.0%	100.0%	83.3%
	Maternity Positive Responses	93.2% (Int)	?	86.7%	94.4%	95.3%	96.7%

Performance & Counter Measures

In February, the Trust opened additional escalation spaces to accommodate sustained increases in patient demand. Despite the higher activity levels, staffing levels remained stable, with fill rates consistently above national expectations and within the thresholds required to maintain safe and effective care.

As part of the Trust's FFT relaunch, a newly designed FFT card will be created, and relaunched to improve feedback opportunities.

The Trust's new FFT provider can support more survey questions to be asked through digital methods, questions have been chosen to align with the Trusts Quality Priorities, allowing for deeper insight into patient experience. Using the new provider will also allow better real time feedback.

The new family and carer information hub plans are progressing well, with plans to signpost using posters that direct patients, families, and carers there, for access to support services.

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

Our Performance

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26	Trend
RTT	No. of >=18 weeks waiters		H	16827	17583	18469	18906	
	No. of >=52 weeks waiters		L	602	658	740	779	
DM01	No. of patients on DM01 waitlist		L	6949	6670	6638	One month behind	
	DM01 performance %	99% (Nat)	F	92.0%	90.1%	91.1%	One month behind	
	DM01 6 week wait breaches		L	553	660	593	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	F	65.6%	71.0%	61.6%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	89.4%	91.4%	85.5%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	47.6%	62.4%	62.3%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	F	61.6%	71.6%	64.9%	One month behind	

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Performance & Counter Measure

DM01

February's validated DM01 performance improved significantly from 91.1% in January to 93.9%, representing the strongest position since February 2020 and exceeding the year-end target of 92.35%. This improvement has been driven by a substantial reduction in patients waiting over six weeks, falling from 593 to 430. While the total diagnostic waiting list increased slightly from 6,638 to 7,100, the reduction in aged pathways has supported the improvement in overall performance. Imaging modalities continue to underpin the Trust's performance, with MRI, DEXA and Neurophysiology delivering 100% compliance, and CT performing at 99.9%. Ultrasound performance also improved to 96.9%, reflecting targeted backlog management. However, endoscopy remains the principal area of pressure, with colonoscopy (81.7%), flexi-sigmoidoscopy (81.9%) and cystoscopy (61.4%) continuing to impact overall DM01 compliance. Total activity in February was 11,121 tests and procedures, reflecting continued delivery across diagnostic services.

Countermeasures

Ultrasound remains the largest waiting list at 2,740 patients, with 84 patients waiting over six weeks, though performance has improved to 96.9% following additional clinics and expanded capacity at Cherwell. Audiology performance has improved to 90.1%, although it remains below the 95% standard and continues to require active management to prevent further ageing. Endoscopy performance is expected to remain variable in the short term as services continue to embed within the new CDC endoscopy unit in West Swindon, which opened in October. Ongoing operational stabilisation and pathway management will be key to improving compliance across colonoscopy, flexi-sigmoidoscopy and cystoscopy pathways.

Cancer

62 Day performance remains heavily impacted by pathway issues in Urology, where diagnostic reporting delays and all options nature of prostate patients means a large number of breaches continue. 30% of the 52.0 breaches allocated to GWH were on a Urology pathway

31D performance fell short in January due to capacity issues in outpatients. Of the 25 pathways that breaches, 12 were in Skin.

Cancer waiting times for first appointment remain below standard. Breast is the largest contributors with 51% of all breaches, with Colorectal next with 31%. Capacity was the main reason for breaches, being responsible for 66% of breaches. Capacity for Appointments /Diagnostics in an Outpatient setting accounted for 80% of the capacity breaches.

Cancer Faster Diagnosis is heavily impacted by the capacity issues seen in the Breast & Colorectal pathways. Breast accounted for 42% of all breaches, where 99% related to outpatient capacity.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	71.0%	71.5%	66.5%	69.3%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	7.5%	7.2%	10.7%	10.5%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	52.0%	51.9%	44.0%	47.6%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	14.1%	13.3%	19.6%	20.2%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	92.4%	94.4%	93.6%	93.5%	
	Total ED Type 1 Attendances (all arrival methods)	SPC	H	6142	6312	6337	5608	
	Emergency Care - AED - Median Stay	240 (Int)	F	240	240	326	290	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4-hour performance (type 1 and 3) increased to 69.3% (up 2.8%). This is below the 25/26 national target. The increase in overall performance relates to type 1 performance increasing slightly continuing with an average of around 50%.

Total % over 12 hours (Type 1) in February 20.2% increased by 0.6% from last month at 19.6%. Any prolonged length of stay in ED leads to overcrowding and subsequent delays in ambulance offload.

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

Risks

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26
RTT	No. of >=78 weeks waiters	SPC		5	5	2	2
Cancer	No. of referrals received	SPC		1972	1859	1965	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.0%	0.0%	0.0%
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC		88.3%	86.8%	86.9%	87.7%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		60.8%	62.3%	57.8%	59.0%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		51.0%	61.4%	60.7%	61.4%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	196	188	200	190
	Emergency Care - UTC - Median Stay	240 (Int)	P	149	137	141	139

Performance & Counter Measure

ED, CEU & UTC

ED – 4,418, CEU – 982, UTC – 5,153

Triage performance for ED for 15-minute increased 1.2% from 57.8% to 59.0%

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

Risks

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

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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26
ED	Total Number of Ambulance Handovers	SPC		2296	2474	2107	2081
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		547.41	562.70	1063.15	1468.90
	Number of Ambulance Handover Over 15 Minute Waits	SPC		1681	1809	1682	1788
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC		73.2%	73.1%	79.8%	85.9%
	Number of Ambulance Handover 30 Minute Waits	SPC		730	929	904	1010
	Percentage of Ambulance Handover Over 30 Minutes	SPC		31.8%	37.6%	42.9%	48.5%
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		728	924	772	770
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		32%	37%	37%	37%
	Average hours lost to ambulance handover delays per day	SPC		18	18	38	52

Performance & Counter Measure

ED, CEU & UTC

Number of ambulance conveyances decreased in February to 2081 a decrease of 26 on January. Average daily hours lost increased to 52, an increase of 14 from January.

Ambulance arrivals averaging 74per day in February 2026 compared to 75 in January 2026

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

Risks

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Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		578	558	708	791
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		277	276	343	323
	Elective Patients Average Length of Stay (Days)	SPC		3.0	2.7	3.2	3.2
	Non-Elective Patients Average Length of Stay (Days)	SPC		6.6	6.4	6.1	6.6
	GWH Discharges by Noon (%)	SPC		16.6%	15.7%	18.5%	17.8%
	Number of Stranded Patients (over 14 days)	SPC		132	119	141	145
	Number of Super Stranded Patients (over 21 days)	SPC		78	64	76	88
	Adult general and acute type 1 bed occupancy	SPC		99.3%	98.0%	98.5%	98.1%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	H	21.7%	20.9%	21.4%	20.3%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.88%	95.29%	95.29%	95.49%
	The Number of Patients in Temporary Escalation Spaces within ED	SPC		29	27	35	33
	Total adult general and acute Temporary Escalation Space beds occupied	SPC		12	10	19	26
	Total paediatric general and acute Temporary Escalation Space beds occupied	SPC		0	0	0	0
	Total Temporary Escalation Space beds occupied	SPC		12	10	19	26

Performance & Counter Measure

Patient Flow

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

Risks

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

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Use of Resources

Great Western Hospitals NHS Foundation Trust

Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26
Use of Resources	Capital Expenditure (£'000)	SPC	H	1693	1878	1835	7197
	Pay (£'000)	SPC	L	28109	28203	27668	28190
	Non Pay (£'000)	SPC		16912	18918	17777	16448

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

Performance & Counter Measure

Capital spend at M11 is £16.5m against a plan of £21.9m, giving an underspend against plan of £5.5m. The £16.5m includes a £2.6m disposal of community property. Other key underspend drivers are EPR (£1.4m), estate schemes (£0.6m) and medicine / equipment replacement (£0.4m) with the remainder due to divisional related CDEL scheme underspends. The Trust was advised to slow its capital schemes due to its revenue position in M02, which has now been reversed , but contributed to the profile of spend being behind plan.

M11 pay costs are £0.5m higher than M10 due to higher escalation and winter pressure costs as a result of ongoing critical incidents.

Non-Pay costs are £1.5m lower than M10 driven by £0.6m of prior year benefits and £0.8m of lower drug costs as actual costs for Q4 so far were lower than estimated.

Risks

The £10.8m shortfall on the Trust's cash releasing efficiency savings programme at M11 is a key driver behind the £10.7m adverse variance to budget. Delivering on the overall efficiency savings target of £32.4m through recurrent cash out schemes, particularly on pay with associated WTE reduction, is vital if the Trust if to achieve its breakeven plan in 25/26.

Our People

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Nov-25	Dec-25	Jan-26	Feb-26
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	11.2%	11.1%	9.9%	One month behind

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

Performance & Counter Measure

- Improvement for the fourth consecutive month to leavers within their first year of employment, decreasing to 9.9% and remaining below target.
- The 2025 Staff Survey closed on 28th November with a final response rate of 66%

Risks

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

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Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	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	Trend Vs Last Month	Trend Vs Feb-25
		Vacancy																	
	W	Vacancy Rate	%	7.00%	3.06%	2.98%	4.28%	4.26%	4.18%	4.25%	3.67%	3.04%	2.40%	1.82%	1.39%	1.40%	0.74%	↓	↓
	W	Vacancy Rate	WTE	-	167.40	162.89	215.93	215.09	210.64	214.60	185.13	153.23	120.97	91.70	70.16	70.46	37.36		
	W	All Nursing Vacancy	%	7.00%	1.2%	1.0%	0.1%	0.1%	0.1%	0.0%	-0.7%	-1.4%	-1.8%	-2.7%	-3.0%	-3.2%	-3.7%	↓	↓
	W	All Nursing Vacancy (Reg & Unreg)	WTE	-	33.37	27.15	3.52	1.47	1.23	-1.17	-16.13	-33.00	-43.91	-65.00	-71.04	-75.82	-88.95		
	W	All Registered Nursing Vacancy	WTE	-	-10.00	-8.16	-10.86	-7.52	-9.24	-10.35	-17.41	-37.44	-52.63	-61.21	-64.62	-65.86	-71.99		
	W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	-37.51	-33.85	-41.18	-38.96	-38.48	-40.30	-44.56	-61.01	-71.45	-74.96	-78.25	-68.28	-71.01		
	W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	43.37	35.31	14.38	8.99	10.47	9.18	1.28	4.44	8.72	-3.79	-6.42	-9.96	-16.96		
	W	Medical Vacancy	%	7.00%	8.92%	8.25%	8.31%	8.05%	8.10%	8.00%	4.60%	2.55%	0.09%	0.08%	0.10%	-0.56%	-1.59%	↓	↓
	W	Medical Vacancy	WTE	-	66.79	61.77	61.95	59.95	60.35	59.64	34.29	18.97	0.70	0.57	0.76	-4.15	-11.88		
	W	STT/AHP Vacancy	%	7.00%	1.7%	1.9%	8.3%	7.7%	7.1%	7.4%	7.5%	6.4%	5.5%	4.6%	2.7%	3.0%	2.1%	↓	↑
	W	STT/AHP Vacancy	WTE	-	14.42	16.50	66.18	61.87	56.78	59.15	59.90	51.32	44.34	37.17	21.65	23.85	16.78		
	W	SMA Vacancy	%	7.00%	4.5%	4.9%	7.5%	8.2%	8.3%	8.7%	9.6%	10.4%	10.7%	10.7%	10.6%	11.3%	10.9%	↓	↑
	W	SMA Vacancy	WTE	-	52.82	57.47	84.28	91.80	92.28	96.98	107.07	115.94	119.84	118.96	118.79	126.58	121.41		
	W	Recruitment Time to Hire - AFC	Days	46.00	44.30	33.60	34.80	36.40	39.70	37.70	41.30	40.30	39.10	36.20	37.80	38.90	37.50	↓	↓
	W	Recruitment Time to Hire - Bank	Days	46.00	42.70	38.30	40.00	18.00	40.20	61.10	51.70	28.50	26.50	18.80	21.80	30.60	18.50	↓	↓
	W	Recruitment Time to Hire - Medical	Days	46.00	41.00	36.50	38.00	37.40	40.20	49.00	40.10	39.50	35.50	39.10	39.20	42.40	45.50	↑	↑

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	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	Trend Vs Last Month	Trend Vs Feb-25
		Workforce Utilisation																	
	W	Substantive WTE	WTE	-	5,303.02	5,307.53	4,827.81	4,828.65	4,833.10	4,829.14	4,858.61	4,890.51	4,922.77	4,952.04	4,973.58	4,974.68	5,006.38		
	W	Additional Substantive WTE	WTE	-	13.66	16.45	11.97	11.84	9.79	9.54	10.88	11.32	11.83	11.15	10.34	10.54	12.97		
	W	Bank WTE	WTE	-	305.77	413.99	311.69	306.31	270.91	287.37	304.15	241.73	274.78	298.19	287.23	333.51	317.94		
	W	Agency WTE	WTE	-	31.77	64.42	48.54	54.27	45.68	44.12	29.32	27.72	26.43	26.99	24.18	31.36	22.75		
	W	Total WTE Utilised	WTE	-	**5,654.22**	**5,802.39**	**5,200.01**	**5,201.07**	**5,159.48**	**5,170.17**	**5,202.96**	**5,171.28**	**5,235.82**	**5,288.37**	**5,295.33**	**5,350.09**	**5,360.05**		
	W	Planned Establishment WTE	WTE	-	5,470.42	5,470.42	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,045.14	5,043.74		
	W	Variance to planned est	WTE	-	183.80	331.97	156.27	157.33	115.74	126.43	159.22	127.54	192.08	244.63	251.59	304.95	316.31		
	W	GL Funded Establishment WTE	WTE	-	5,470.42	5,470.42	5,043.74	5,043.74	5,043.74	5,043.74	5,215.77	5,204.43	5,202.37	5,200.96	5,210.18	5,215.34	5,215.57		
	W	Variance to GL funded	WTE	-	183.80	331.97	156.27	157.33	115.74	126.43	-12.81	-33.1	33.4	87.4	85.1	134.7	144.48		
	W	Planned Est, vs GL Funded	WTE	-	0.0	0.0	0.0	0.0	0.0	0.0	-172.0	-160.7	-158.6	-157.2	-166.4	-170.2	-171.83		
	W	Actual Worked vs Planned Establishment	%	-	103.36%	106.07%	103.10%	103.12%	102.29%	102.51%	103.16%	102.53%	103.81%	104.85%	104.99%	106.04%	106.27%		
	W	Total Workforce Cost £	£	-	£27.93M	£28.58M	£26.55M	£26.60M	£26.34M	£25.70M	£30.78M	£27.60M	£27.27M	£27.86M	£28.11M	£27.86M	£28.15M		
	W	Agency Spend as % of Total Spend	%	4.50%	1.97%	2.14%	2.26%	2.40%	2.75%	1.82%	1.70%	1.78%	0.97%	1.05%	0.59%	1.17%	1.09%	↓	↓
	W	Agency Spend £	£	-	£0.55M	£0.61M	£0.60M	£0.64M	£0.72M	£0.47M	£0.52M	£0.49M	£0.26M	£0.29M	£0.17M	£0.33M	£0.31M		
	W	Agency Target £	£		£0.37M	£0.36M	£0.20M	£0.19M	£0.18M	£0.17M	£0.16M	£0.16M	£0.15M	£0.14M	£0.13M	£0.12M	£0.11M		
	W	Agency Spend vs Target £	£ Diff	£0.00M	£0.18M	£0.25M	£0.40M	£0.45M	£0.55M	£0.30M	£0.36M	£0.33M	£0.12M	£0.15M	£0.04M	£0.20M	£0.19M	↓	↑
	W	Bank Spend £	£	-	£2.66M	£2.70M	£2.21M	£2.18M	£2.05M	£1.92M	£2.36M	£1.97M	£1.94M	£2.50M	£2.67M	£2.11M	£2.29M		
	W	Bank Target £	£		£1.42M	£1.34M	£2.90M	£2.56M	£2.22M	£1.88M	£1.53M	£1.19M	£1.31M	£1.38M	£1.45M	£1.47M	£1.48M		
	W	Bank Spend vs Target £	£ Diff	£0.00M	£1.24M	£1.36M	-£0.69M	-£0.38M	-£0.17M	£0.05M	£0.83M	£0.78M	£0.63M	£1.13M	£1.22M	£0.64M	£0.80M	↑	↓
		Retention																	
	W	All Turnover %	%	13.00%	11.01%	11.26%	11.31%	11.16%	10.85%	10.74%	10.38%	10.20%	9.94%	9.65%	9.62%	9.50%	-	↓	↓
	W	Voluntary Turnover %	%	11.00%	8.48%	8.55%	8.41%	8.29%	8.13%	7.94%	7.68%	7.49%	7.19%	7.00%	6.90%	6.88%	-	↓	↓
	W	Number of Leavers	Headcount	-	30	70	38	32	43	41	43	50	43	30	41	32	-		
	W	Number of RN Leavers	Headcount	-	8	12	8	8	11	9	9	13	11	6	13	7	-		
	W	Registered Nursing Vol Turnover	%	-	7.28%	6.96%	6.51%	6.16%	6.01%	5.80%	5.46%	5.69%	5.50%	5.44%	5.33%	5.14%	-		
	W	Number of Unreg Nursing Leavers	Headcount	-	5	9	6	10	9	8	8	8	8	9	10	4	-		
	W	Unregistered Nursing Vol Turnover	%	-	9.77%	10.06%	9.45%	9.81%	9.21%	9.38%	9.49%	9.13%	8.94%	8.97%	8.79%	8.88%	-		
	W	Leavers within 1st Year - Rolling 12 Month	%	-	10.37%	10.94%	10.30%	11.68%	11.62%	11.93%	13.09%	12.84%	11.35%	11.24%	11.09%	9.94%	-		
	W	Number of starters	Headcount	-	60	61	43	28	49	40	50	93	58	67	36	55	-		

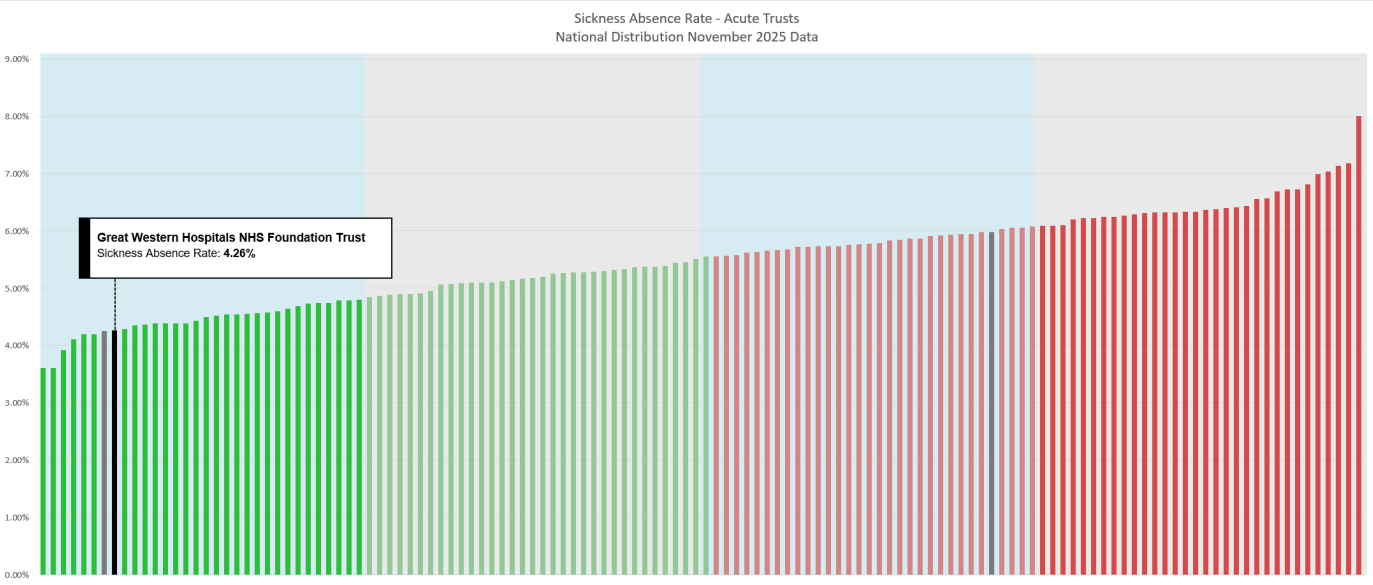
Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	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	Trend Vs Last Month	Trend Vs Feb-25
		Absence																	
	D	Sickness Absence % Rolling 12 Month	%	3.50%	4.65%	4.68%	4.68%	4.68%	4.65%	4.59%	4.57%	4.55%	4.51%	4.46%	4.42%	4.34%	-	↓	↓
	D	Sickness Absence %	%	3.50%	4.92%	4.49%	4.13%	4.11%	4.22%	4.44%	4.29%	4.08%	4.35%	4.24%	4.50%	4.31%	-	↓	↓
	W	Long Term Sickness %	%	2.00%	2.49%	2.22%	2.12%	2.09%	2.24%	2.30%	2.40%	2.05%	2.02%	2.01%	2.28%	1.85%	-	↓	↓
	W	Short Term Sickness %	%	1.50%	2.42%	2.26%	2.01%	2.02%	1.98%	2.14%	1.88%	2.03%	2.33%	2.23%	2.22%	2.46%	-	↑	↑
	W	Sickness Absence Cost £	£	-	£773.1k	£815.5k	£681.0k	£702.2k	£685.5k	£769.3k	£760.1k	£742.3k	£791.4k	£748.6k	£806.7k	£0k	-		
	W	WTE Days Lost	WTE	-	7,299.3	7,397.7	5,979.0	6,159.6	6,117.3	6,674.6	6,456.8	5,979.9	6,638.5	6,303.8	6,943.7	6,650.8	-		
		Learning & Development																	
	W	Mandatory Training Compliance %	%	85.00%	90.03%	90.03%	90.46%	90.94%	91.66%	91.60%	91.10%	91.38%	91.23%	91.55%	91.47%	91.31%	91.08%	↓	↑
	W	Role Essential MT %	%	85.00%	89.70%	89.86%	90.57%	90.95%	91.77%	91.95%	91.33%	91.70%	91.68%	92.05%	91.98%	91.95%	91.81%	↓	↑
	W	CQC Safe MT %	%	85.00%	90.45%	90.24%	90.33%	90.92%	91.52%	91.15%	90.79%	90.99%	90.67%	90.91%	90.83%	90.49%	90.16%	↓	↓
	W	Bank-Only Mandatory Training Compliance %	%	85.00%	81.72%	80.81%	65.69%	64.67%	64.11%	73.77%	79.71%	77.67%	76.14%	78.59%	78.32%	78.63%	54.55%	↓	↓
	W	Appraisal Compliance %	%	85.00%	84.35%	84.40%	83.88%	81.56%	80.36%	80.08%	80.91%	80.81%	79.02%	78.86%	78.39%	76.91%	79.60%	↑	↓
	W	Non Medical Appraisal Compliance %	%	85.00%	84.44%	84.24%	84.15%	82.14%	81.04%	80.45%	80.90%	80.30%	78.65%	78.80%	78.51%	77.75%	78.88%	↑	↓
	W	Medical Appraisal Compliance %	%	85.00%	83.68%	85.48%	82.08%	77.82%	76.02%	77.75%	80.99%	83.98%	81.21%	79.20%	77.67%	72.12%	83.73%	↑	↑
		Demographics																	
	W	Staff in Leadership Roles % (B8a+)	%	-	4.25%	4.27%	4.30%	4.36%	4.30%	4.20%	4.15%	4.14%	4.20%	4.27%	4.30%	4.31%	4.26%		
	W	Staff in Leadership Roles WTE (B8a+)	WTE	-	276.00	277.00	255.00	259.00	256.00	252.00	248.00	249.00	254.00	260.00	263.00	264.00	263.00		
	W	% of Leadership Roles who are Female (B8a+	%	-	69.93%	69.68%	68.24%	68.34%	67.58%	67.86%	68.15%	68.67%	69.29%	69.23%	68.82%	68.94%	68.82%		
	W	% of Leadership Roles who from BME (B8a+)	%	-	6.52%	6.50%	5.88%	6.18%	5.47%	5.56%	5.65%	6.02%	6.30%	6.15%	6.84%	6.82%	6.46%		
	W	Staff in Leadership Roles % (B8c+)	%	-	0.94%	0.92%	1.01%	1.03%	1.01%	1.00%	1.00%	1.00%	1.01%	0.98%	0.98%	1.03%	1.02%		
	W	Staff in Leadership Roles WTE (B8c+)	WTE	-	61.00	60.00	60.00	61.00	60.00	60.00	60.00	60.00	61.00	60.00	60.00	63.00	63.00		
	W	% of Leadership Roles who are Female (B8c+	%	-	54.10%	53.33%	53.33%	52.46%	51.67%	53.33%	53.33%	55.00%	57.38%	56.67%	56.67%	58.73%	58.73%		
	W	% of Leadership Roles who from BME (B8c+)	%	-	4.92%	6.67%	5.00%	4.92%	5.00%	5.00%	5.00%	5.00%	6.56%	5.00%	5.00%	6.35%	6.35%		
	W	% of Leadership Roles who are disabled (B8c	%	-	3.28%	3.33%	3.33%	3.28%	3.33%	3.33%	3.33%	3.33%	3.28%	3.33%	3.33%	4.76%	4.76%		
	W	Male % of Workforce	%	-	18.61%	18.67%	19.33%	19.44%	19.51%	19.67%	19.87%	20.00%	19.98%	20.06%	20.08%	20.05%	20.23%		
	W	Female % of Workforce	%	-	81.39%	81.33%	80.67%	80.56%	80.49%	80.33%	80.13%	80.00%	80.02%	79.94%	79.92%	79.95%	79.77%		
	W	BME % of Workforce	%	-	29.29%	29.43%	30.08%	30.30%	30.65%	30.66%	30.71%	31.50%	31.63%	31.75%	32.19%	32.11%	32.55%		
	W	White % of Workforce	%	-	63.48%	63.22%	62.05%	61.76%	61.35%	61.27%	60.43%	59.79%	60.38%	60.20%	59.90%	60.05%	59.83%		
	W	ER Cases Closed	Number	-	33	41	56	47	50	49	49	56	67	61	55	52	37		

Our People



Performance & Counter Measure

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

Burnout Toolkit Rollout Across Hotspots

Burnout toolkits have been disseminated across all hotspot areas, with consistent themes emerging around workload pressure, emotional fatigue, competing priorities, and reduced control or resources. All Divisions and Corporate have begun rollout activity suited to their teams, and are sharing the following engagement approaches that are being developed and trialled including:

- Embedding into routine wellbeing and performance conversations
- Daily wellbeing huddles and reinforcing value of rest-days
- Introducing 'break-buddy system', time-out opportunities, and promotion of rest time in the day
- Clearer workload allocation and management through wellbeing sessions

Promotion of "In the Moment" Support (Vivup EAP)

EAP support through Vivup continues to be widely promoted across all areas:

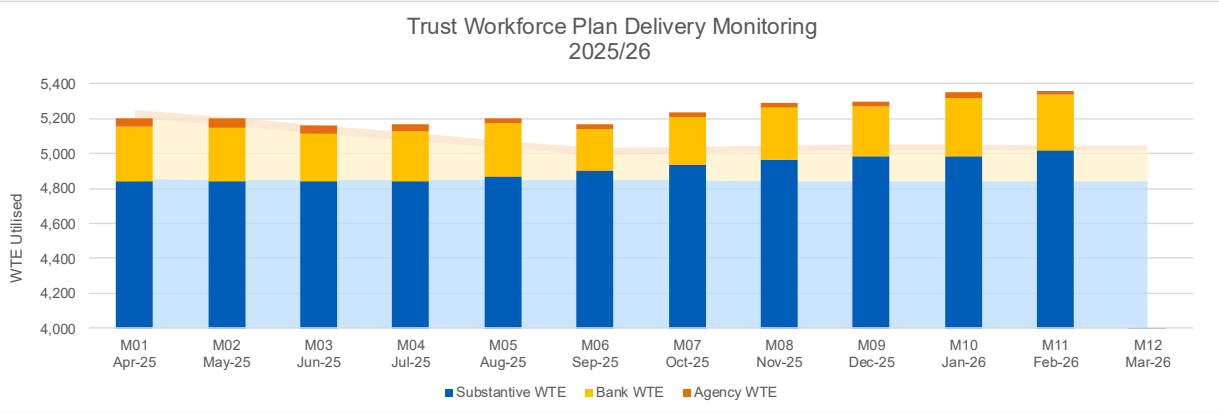
- Integrated into huddles, team meetings, RTW discussions, wellbeing conversations and team briefs.
- Saturn maintains strong communications through newsletters, daily huddles, and check ins.
- Wellbeing Champions and MHFA trained staff active in FASS and Children's services.
- Savernake staff continue to receive HWB reminders through TUPE consultation.

Medical Staffing Sickness – QR Code Rollout

- Initial meetings completed; automated processes being finalised.
- Pilot running throughout March across key areas.
- Early use indicates improved accuracy of reporting dates, increased adoption month on month, and clearer visibility of areas requiring targeted absence management support.

Our People

Workforce Delivery Plan



		M01 Apr-25	M02 May-25	M03 Jun-25	M04 Jul-25	M05 Aug-25	M06 Sep-25	M07 Oct-25	M08 Nov-25	M09 Dec-25	M10 Jan-26	M11 Feb-26	M12 Mar-26
Total Workforce (OPP)	Plan	5,253	5,208	5,164	5,120	5,075	5,031	5,042	5,046	5,051	5,050	5,048	5,047
	Actual	**5,200**	**5,201**	**5,159**	**5,170**	**5,203**	**5,171**	**5,236**	**5,288**	**5,295**	**5,350**	**5,360**	0
	Variance	-53	-7	-5	50	128	141	194	242	244	300	312	-
Substantive	Plan	4,853	4,852	4,851	4,850	4,848	4,847	4,846	4,844	4,843	4,842	4,840	4,839
	Actual	**4,840**	**4,840**	**4,843**	**4,839**	**4,869**	**4,902**	**4,935**	**4,963**	**4,984**	**4,985**	**5,019**	0
	of which Overtime	**12**	**12**	**10**	**10**	**11**	**11**	**12**	**11**	**10**	**11**	**13**	0
	Variance	-13	-11	-8	-11	21	55	89	119	141	144	179	-
Bank	Plan	347	306	265	224	183	142	157	165	174	176	178	180
	Actual	**312**	**306**	**271**	**287**	**304**	**242**	**275**	**298**	**287**	**334**	**318**	0
	Variance	-36	0	5	63	121	99	118	133	114	158	140	-
Agency	Plan	52	50	48	46	43	41	39	37	35	33	30	28
	Actual	**49**	**54**	**46**	**44**	**29**	**28**	**26**	**27**	**24**	**31**	**23**	0
	Variance	-4	4	-2	-2	-14	-14	-13	-10	-11	-1	-8	-

Performance & Counter Measure

- We used 5,360 WTE to deliver our services in February, an increase compared to January of 10 WTE and an adverse variance to our planned usage (5,048 WTE) of +312 WTE.
- Our contract WTE position increased in-month by 34 WTE, rising to 5,019 WTE and significantly above plan. This is mostly attributable to Medical & Dental staff in line with February rotations.
- There was a marginal decrease to temporary staffing levels of -24 WTE however not enough to offset the substantive growth, meaning a net workforce change in February of +10 WTE overall. Although an improved position compared to January, temporary staffing levels were still above plan overall with additional staffing due to critical incident alongside sickness absence and enhanced care contributing to usage.

Total variance to plan by staff group:
- All Nursing: +226 WTE
- AHP/STT: +25 WTE
- Medical & Dental: +70 WTE
- Admin & Clerical: -7 WTE

Impact on Workforce

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

Risks & Mitigations

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

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

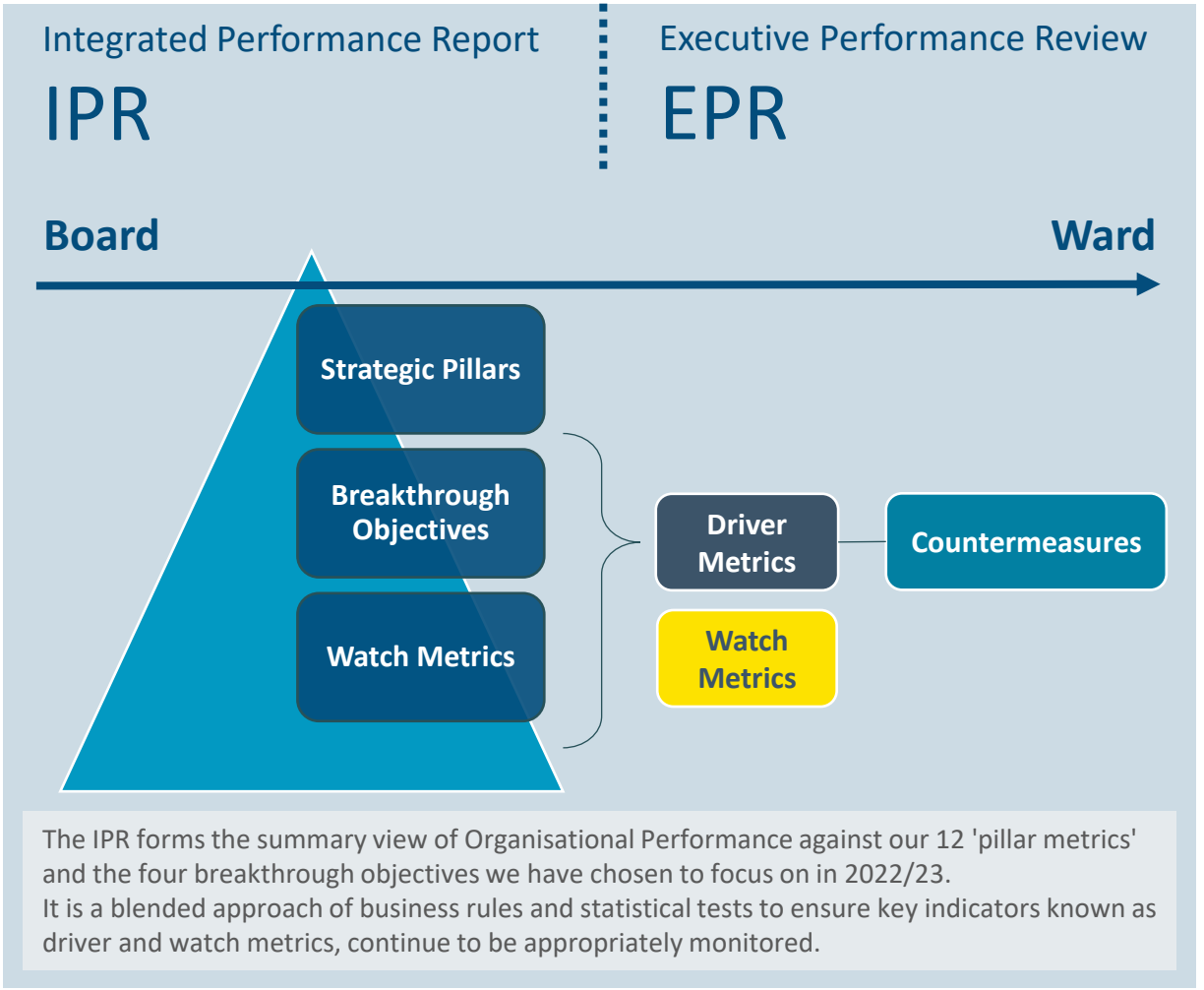
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Vision

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

Our four strategic pillars

Outstanding care

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

Valued teams

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

Better together

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

Sustainable future

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

25/26 Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust

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

1 Our four strategic pillars

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

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

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

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

4 Overlap

Corporate Projects

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

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

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

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust

Continuous Improvement on Drivers

Performance Management on Driver & Watch Metrics

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

Information Flow

Information Flow

Building a culture of continuous improvement

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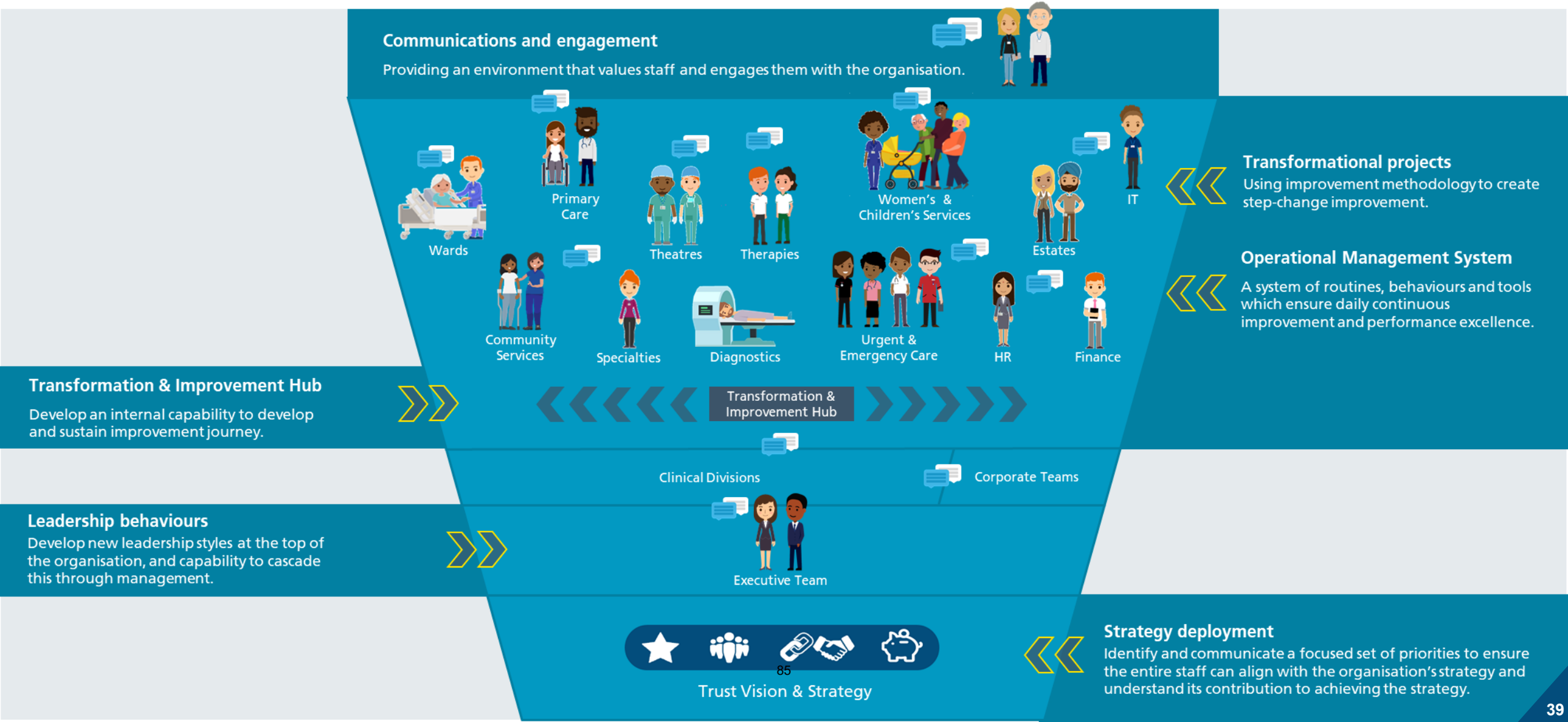


SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

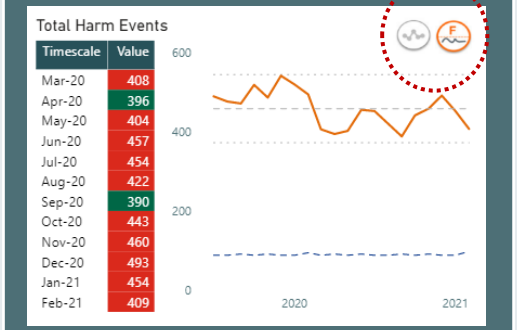
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

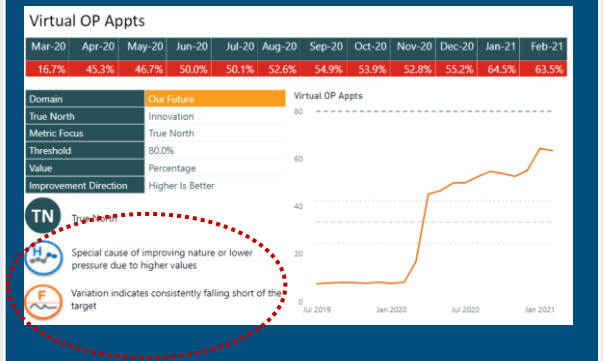
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

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

Agreed Terms

NHS
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NHS Foundation Trust

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Report Title	**Learning from Deaths Q3 2025/2026**				
Meeting	**Trust Board**				
Date	**09/04/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Kathryn Bateman, Chief Medical Officer				
Report Author	Laurie Powell, Learning from Deaths Lead				
Appendices	Learning from Deaths Q3 Report				

Purpose

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

Assurance Level

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

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

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

Report

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

The Trust's overall mortality remained stable and within expected ranges, with no signs of unexpected increases or unusual patterns.

National indicators such as the Summary Hospital-level Mortality Index (SHMI) showed the Trust performing "as expected", and internal reviews of deaths confirmed that the number of patients dying in hospital followed normal winter trends. Although October, November and December saw a gentle rise in deaths, this increase matches historical seasonal patterns and did not trigger any warnings or safety alerts. Emergency Department (ED) attendances were also slightly higher than last year but remained steady and in line with typical winter pressures.

Structured Judgement Reviews (SJRs) completed in Q3 identified elderly/frail patients with multiple complex health conditions. Care delivered was generally rated as good, with prompt assessments, appropriate treatments and early involvement of senior doctors.

Families were involved appropriately and patients requiring end-of-life care was managed accordingly. However, reviews identified opportunities for improvement, particularly around timely recognition of deterioration, earlier palliative care involvement, and better completion of ReSPECT forms. Delays are a recurring issue and communication between teams, along with quality of documentation and communication between teams which collectively present preventable safety risks.

Critical incidents and staffing pressures meant that internal Learning from Deaths (LfD) meetings could not take place as planned. Important improvement work continues, including a Trustwide project focused on learning from discharge and readmission patterns, development of new mortality dashboards, and collaborative work with system partners when meetings resume.

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

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

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)		
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	This report has been presented to the Quality & Safety Committee meeting in March 2026.	
Next Steps		

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

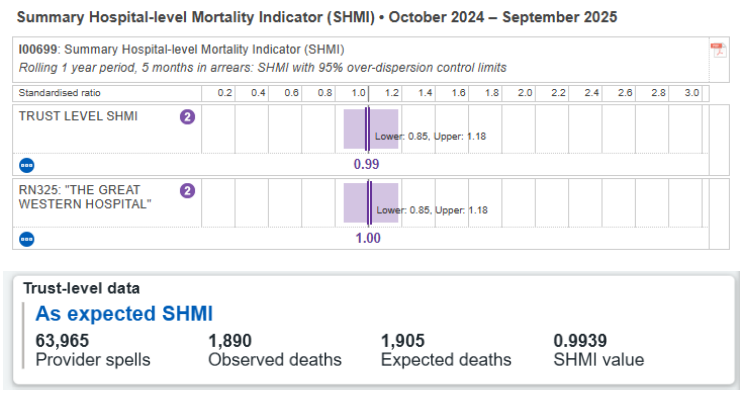
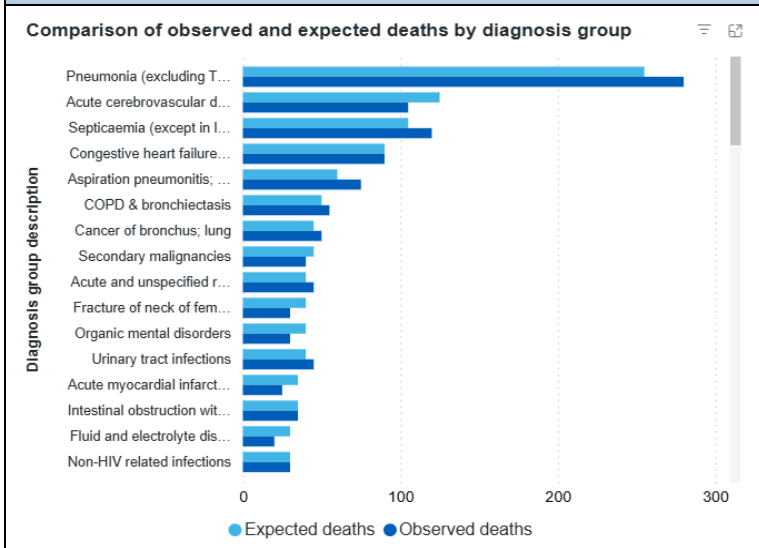
Acknowledge work in progress by the Learning from Deaths Team.

Accountable Lead Signature	K Bakewell
Date	**09/03/2026**

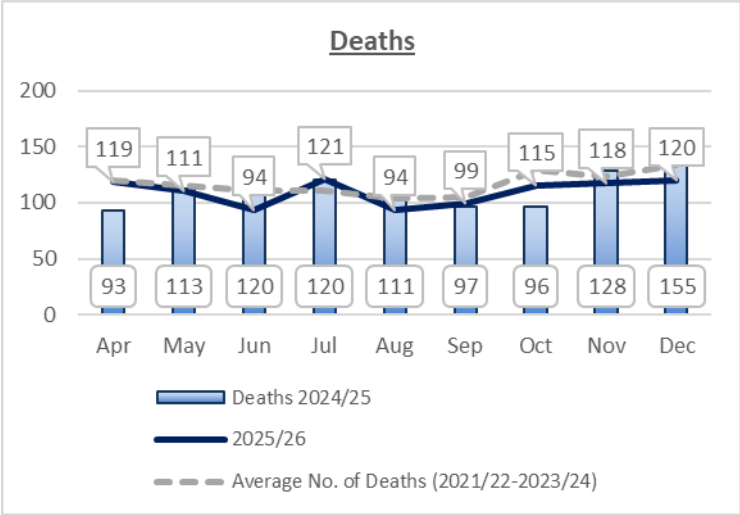
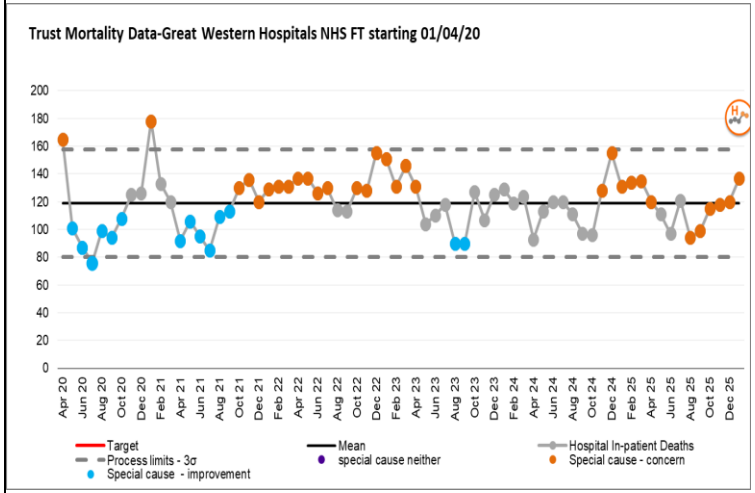
Trust-wide Quarterly Learning from Deaths Report

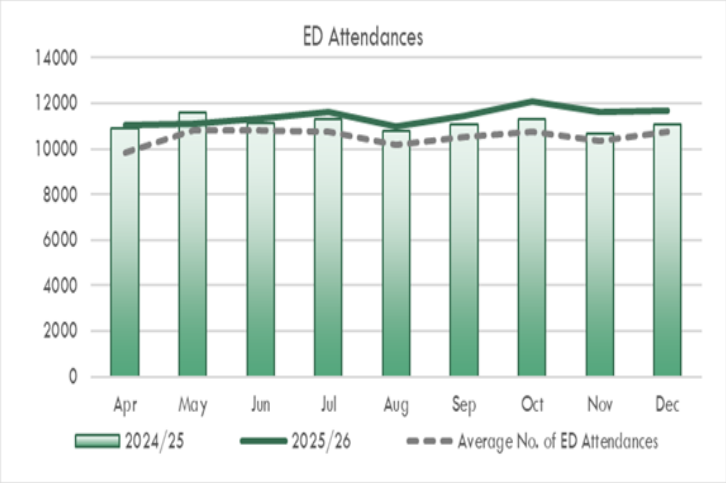
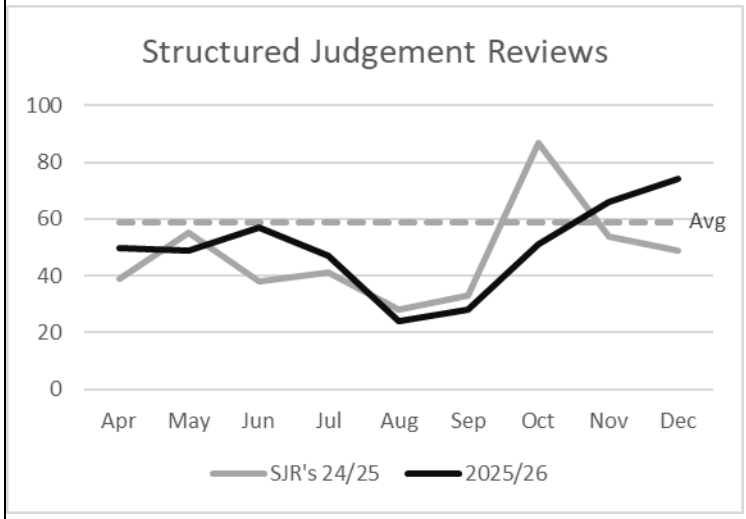
MONTH/YEAR: March 2026 (Q3 Data)

The Trust-wide Quarterly Learning from Deaths Report is produced using a combination of external data sources (Telstra health, NHS Digital), internal data and information gathered from specific internal Coding and Clinical Case note reviews, analysis and outcomes from Structured Judgements Reviews (SJR's), monthly Learning from Deaths sub-group meetings. It aligns with the Quality Schedule for reporting, and headings correlate accordingly.

SHMI (*External Data*)	**UPDATE**	**FORWARD ACTION PLAN**
	The latest SHMI data publication covers the period Oct 2024 to Sept 2025. This shows the Trust to be 'As Expected'.	As described in the previous report, there is a clear correlation between the percentage of spells coded with an invalid primary diagnosis code (i.e. that which is a symptom or sign) and the rise in SHMI seen until mid-2025. The coding backlog has been cleared since May 2025, and the team are confident that they can stay on top of the workload until the end of the financial year, however a rise in SHMI would be expected if there was an increase in invalid primary diagnosis code or depth of coding was adversely affected.
SHMI/NATIONAL ALERTS (*External Data*)	**UPDATE**	**FORWARD ACTION PLAN**
	Diagnostic indicators show much the same as previous reports – marginally higher than expected figures for Pneumonia showing 280 observed deaths during vs 255 expected deaths, aspiration pneumonia (inc. food vomitus) at 75 observed deaths vs 60 expected deaths, and septicaemia showing 120 observed deaths vs 105 expected deaths. There are currently no alerts around these indicators and the numbers remain 'As expected' for the pneumonia group and the septicaemia group as described by the NHSE Clinical Indicator Previewer.	Data for both pneumonia and septicaemia indicators continue to be higher than expected. The respiratory team continue to work on an audit to better-understand mortality around pneumonia – responsibility of this audit and outcomes remains the responsibility of the division, however the mortality team continue to support, and it is expected results will be shared with the mortality team.

MEDICAL EXAMINER *(Internal Updates)*	**UPDATE**	**FORWARD ACTION PLAN**
No visual data available to share	No Medical Examiner update received – due to difficulties with attendance due to business continuity and critical incidents, there were no LfD sub-group meetings between December and February. ME was unable to attend meeting on 9th March.	**In line with Quality Schedule, monthly updates will be requested for LfD sub-group meetings going forwards in order to inform LfD report, but workplans will be actioned and monitored by individual leads.*
PALS (Complaints/Bereavement)	**UPDATE**	**FORWARD ACTION PLAN**
No visual data available to share	JK attended the LfD sub-group meeting on 9th March and shared themes and cases for discussion. We have asked whether it is possible to share trends in complaints or concerns regarding to mortality comparing to previous time periods or years in order to be alert to change.	**In line with Quality Schedule, monthly updates will be requested for LfD sub-group meetings going forwards in order to inform LfD report, but workplans will be actioned and monitored by individual leads.*
Learning from Inquests *(Internal Updates)*	**UPDATE**	**FORWARD ACTION PLAN**
No visual data available to share	SK attended the LfD sub-group meeting on 9th March. Recent discussions with CQC highlight the need to look at incidents thematically, not individually. CQC is already identifying themes from multiple incidents; the organisation should mirror this and use their feedback proactively. The goal is to assure CQC that organisational learning is happening across patterns of incidents, not just single events. High number of inquests this quarter. Coroners are applying significant scrutiny and expect clear, evidenced learning. No Prevention of Future Death (PFD) reports were issued—indicating learning was demonstrated. Learning needs to be embedded before an inquest, not retrofitted at the end; investigations must produce changes that can be evidenced later.	**In line with Quality Schedule, monthly updates will be requested for LfD sub-group meetings going forwards in order to inform LfD report, but workplans will be actioned and monitored by individual leads.*
Patient Safety *(Internal Updates)*	**UPDATE**	**FORWARD ACTION PLAN**
No visual data available to share	Mb attended the LfD sub-group meeting on 9th March. Themes from SJRs broadly match patient safety incident themes, reflecting common system issues. The patient safety team is moving away from root cause analysis because it oversimplifies problems; instead they use a systems approach that considers multiple interacting factors. SJRs focus on clinical review, while patient safety investigations focus on system behaviour and why events unfolded differently than expected—so the two don't always correlate directly. The patient safety team is focusing on supporting divisions to strengthen their own internal processes for incident review. There is value in periodic (e.g., quarterly) updates to LfD meetings to share SJR themes, helping align quality improvement efforts across teams.	**In line with Quality Schedule, monthly updates will be requested for LfD sub-group meetings going forwards in order to inform LfD report, but workplans will be actioned and monitored by individual leads.*
Clinical Coding (Internal Updates)	**UPDATE**	**FORWARD ACTION PLAN**
	ST attended the LfD sub-group meeting on 9th March and provided reassurance in that funding has been secured to continue outsourcing the gap we have in coding to next year. So SHMI should remain unaffected by clinical coding gaps.	**In line with Quality Schedule, monthly updates will be requested for LfD sub-group meetings going forwards in order to inform LfD report, but workplans will be actioned and monitored by individual leads.*

Trust Activity (Internal Data)	UPDATE	FORWARD ACTION PLAN
	The number of deaths during Q3 remained stable; there were higher deaths during October than the previous year, however this remained closely aligned with average levels. October recorded 115 deaths, followed by a slight rise to 118 in November, and 120 deaths in December. The overall pattern suggests a steady upward trend across Q3, but still within expected seasonal variation, there were no unusual increase in numbers or unexpected deviations and remain consistent with the typical winter increase seen in previous years. There are no identified actions in response to the internal data at this present time, however, this continues to be regularly monitored and reported to the LfD Subgroup and LfD Trust Group for oversight.	There are no identified actions in response to the internal data at this present time, however, this continues to be regularly monitored and reported to the LfD Subgroup and LfD Trust Group for oversight.
	The SPC chart shows that mortality remained within expected ranges and is consistent with what would normally be expected based on historical ranges. Although, Q3 deaths show a slight upward movement, this remains within the upper and lower control limits, indicating normal fluctuation. December is a little higher than October and November but still does not trigger an alert. Overall, mortality for this period demonstrates an increasing but stable trend which would be considered expected during winter months and likely to be seen nationally.	

	ED attendances during Q3 remained higher than previous year and average levels. October shows a notable increase, representing one of the higher attendance points in the year, before activity levels off in November and December. Throughout all three months, attendance figures indicate that demand is following expected seasonal patterns and this is broadly consistent with both the previous year (2024/25) and average trend line. Overall, Q3 reflects a higher but stable ED demand, with no significant increase or fluctuation outside of normal variation for the time of year.	
Structured Judgement Reviews (Internal Data)	**CURRENT POSITION**	**FORWARD ACTION PLAN**
	From the SJR's undertaken in Q3 (191), most patients were very elderly/frail with several long-term illnesses (dementia, heart and lung disease, cancer, or recurrent infections). Many patients presented at hospital extremely unwell, and for the majority, death was expected. The reviews identified good care; patients were assessed quickly, senior doctors were involved early, and treatments (antibiotics, oxygen, fluids) were given promptly. Families appear to have been appropriately involved, and care progressed appropriately when patients were identified nearing the end of life. The reviews also highlighted some areas where care could be improved; Delays present as a recurring theme (recognising end of life, referring to palliative care, ReSPECT forms). Reviews also identified gaps in basic monitoring (missed observations or incomplete fluid balance charts), delays in investigations, or issues with documentation (notes missing, handwritten entries difficult to read, or records scanned out of order). In some cases, communication between clinical teams was felt could have been better, and which may have contributed to unclear plans and potential patient safety issues; these issues did not generally change the outcome but represent risks that could lead to avoidable harm.	SJR outcomes have been shared with the Trust's Learning from Deaths (LfD) Trust group and sub-groups for discussion. It is planned for the key learning to be included in the current Trustwide project (Discharge Data Review), particularly where opportunities for improvement have been identified (signs of deterioration, previous discharge etc).

CODING/CLINICAL REVIEWS *(Internal Data)*	**CURRENT POSITION**	**FORWARD ACTION PLAN**
Learning disability mortality review	An audit has been completed, with participation from the LD team, palliative and end of life care team, mortality team and other clinical colleagues who agreed to support the audit. Discussions regarding actions and dissemination are underway.	Agreement of actions and dissemination of audit report with audit lead. LfD team are supporting but not leading on this, so actions will remain the responsibility of the audit lead.
1. Discharge data review	Local discharge data has been reviewed, and initial methodology drafted, however, this has evolved into a bigger piece of work, as additional opportunities for improvement (highlighted throughout the report) have subsequently been identified for inclusion. This is currently underway by exploring the accessibility of additional data and updating data collection tools as appropriate. The aim is for a Trustwide Review that will focus on discharge/readmissions, and deteriorating patients.	Data Collection for this project is scheduled to commence on 1st April 2026.
2. OTHER UPDATES *(Workplan priorities)*	Local discharge data has been reviewed, and initial methodology drafted, however, this has evolved into a bigger piece of work, as additional opportunities for improvement (highlighted throughout the report) have subsequently been identified for inclusion. This is currently underway by exploring the accessibility of additional data and updating data collection tools as appropriate. The aim is for a Trustwide Review that will focus on discharge/readmissions, and deteriorating patients.	Data Collection for this project is scheduled to commence on 1st April 2026.

- In view of the alerts received over the last 2 years regarding deaths in Trauma and Orthopaedics the LfD have continued to offer support to the department in review and monitoring of deaths following hip fracture, elective hip surgery and trauma – note a further alert was received in July regarding mortality following elective knee surgery. An update was provided at the recent divisional board meeting, and actions will be discussed with the CMO. The LfD lead asked for reassurance that there was oversight of common T&O pathways which may be contributing to alerts in different areas – divisional managers were present and aware of concerns.
- We continue to work with the digital team to develop a PowerBI dashboard to access internal mortality data within the trust, at departmental and divisional level, as well as a separate dashboard in collaboration with SFT and RUH to enable benchmarking and reporting at BSW system mortality meetings.
- It is acknowledged that changes within the structure of the clinical audit team may affect the delivery of mortality activity.
- GWH have now withdrawn from the contract with Telstra as of end of September 2025, so will no longer be including Telstra reports in this report going forward. Internal data monitoring continues at GWH and is reviewed alongside other data including SHMI and national audits to ensure triangulation and oversight of mortality statistics at GWH.

- BSW system mortality meetings are on hold at present due to discussions at cluster level – the GWH LfD team remain keen to collaborate with the RUH and SFT teams and the LfD lead has enquired about the direction of the team and possibility of resuming meetings.
- The LfD team has released it's first issue of a Learning from Deaths newsletter – see appendix. The aim is to raise awareness of learning from deaths with a wider range of staff in the trust, and to consolidate some of the important messages coming out of learning from deaths.

• Learning from Deaths – Subgroup Meetings *(Monthly review of collated data and identification of actions. Attendance from Medical Examiner, legal team, patient safety, clinical coding, LfD team)*

Due difficulties with attendance due to critical incidents and business continuity incidents, no meetings were held between December and February. As a result, the LfD team have revised the terms of reference and attendee list, and agreed that these meetings will now take place 3 monthly which will enable better attendance, allow monitoring of trends and identification of themes, and align with reporting schedules to PQSC and Q&SC. The first meeting with the new format was held on 9th March and the divisional governance teams were invited, with 2 of them being able to attend, with the future aim of bi-directional reporting to/from divisions regarding division-specific themes. See specific updates from teams in sections above.

There continues to be a weekly meeting with the LfD team (TO, SE, LP) with an action action tracker to log workplans and actions. This is available to view if required.

Next Scheduled Meeting: TBC

Trust-wide Learning from Deaths Meetings *(Quarterly review of data summaries & actions, shared learning of review outcomes and speciality M&M Meetings. Attendance expected from departmental M&M leads, Medical Examiner, Learning Disability team)*

Since the last report we have not been able to hold any Trust LfD meetings due to there being a critical incident on the day of the scheduled meeting (8h December), so the meeting was stood-down in accordance to trust guidance.

Next Scheduled Meeting: TBC

BSW System mortality group *(Monthly meeting with mortality teams from Bath and Salisbury, ICB Chief Medical Office, Swindon Borough Council to identify and improve mortality across the system)*

BSW system mortality meetings are on hold at present due to discussions at cluster level – the GWH LfD team remain keen to collaborate with the RUH and SFT teams and the LfD lead has enquired about the direction of the team and possibility of resuming meetings or holding interim meetings with the Bath and Salisbury LfD teams to ensure relationships and collaboration continue – a meeting has been provisionally arranged for 30th March.

Part of the work done previously through the BSW system group focused on inequalities represented in mortality data. The GWH LfD team are planning on looking into this in more detail in the meantime.

Next scheduled meeting: 30th March.

SHMI (Summary Hospital Level Mortality Index)
Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS England Digital

Report Title	**Perinatal Service Update (April 2026)**				
Meeting	**Trust Board**				
Date	**09/04/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Luisa Goddard				
Report Author	Kat Simpson (Director of Midwifery & Neonatal Services) Laura Little (Project Coordinator)				
Appendices	N/A				

Purpose

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

Assurance Level

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

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

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

Continued improvement work against prevention of future deaths notice acknowledged within partial assurance rating. Established governance processes embedded to provide assurance of senior oversight of any identified risks and mitigating actions in place.

Report

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

An overview for Board outlining initial feedback from the CQC inspection which took place in January 2026, current position against national maternity reports and Trust position against Ockenden Immediate and Essential Actions (IEAs).

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

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

Risk + Oversight		Risk Score
Key risks – risk number & description (Link to BAF / Risk Register)	593 - There is a risk that patient safety will be compromised across Maternity Services because of insufficient midwifery staff to fill roster requirements	9
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement		
Next Steps		

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

Explanation of above analysis:

The service focusses on the co-production of a perinatal service which has an emphasis on prioritising hearing the voices of families from minority ethnic groups and areas of deprivation alongside our Maternity & Neonatal Voice Partnership.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the current position and progress against national reports outlined in the presentation and the impact these will have on the development of the perinatal services to make care safer, more personalised and more equitable.

Accountable Lead Signature	Luisa Goddard.
Date	**30/03/2026**

NHS
Great Western Hospitals
NHS Foundation Trust

Perinatal Service Update

April 2026

Kat Simpson, Director of Midwifery and Neonatal Services
Laura Little, Project Coordinator Maternity and Neonatal Services

Overview of CQC Maternity Inspection (January 2026)

- CQC inspection took place on 20th and 21st January 2026.
- The initial feedback findings align with existing improvement priorities and actions will be developed once formal feedback is received.
- Provider Information Request (PIR) completed by the service and returned to CQC prior to the deadline on 9th February 2026.
- The service is awaiting further communication from the CQC.

Initial Positive Findings (Reported by the CQC)

- There was personalised care observed within theatre.
- Huddles and handovers were well attended by staff. Clear and concise information was given and discussed and clear use of SBAR.
- Staff were keen to talk to the team about current projects within the maternity teams.
- Staff were welcoming and happy to talk to the team.

Response to Initial Feedback from CQC

Infection Prevention & Control (IP&C)

- Following CQC feedback, immediate action was taken to increase hand hygiene posters and alcohol gel availability across the unit.
- Continued engagement with the Trust IP&C team to conduct impartial reviews of the area and support with improvement actions identified.
- In response to the feedback received from CQC the Trust has added a prompt question to the digital Delivery Suite MDT handover form that is now completed twice daily.
- Additional supporting data to show ongoing compliance with Bare Below the Elbows provided to the CQC as part of the PIR response (February 2026) and additional evidence submission (March 2026).

Benchmarking & KPI Reporting

- Benchmarking remains a top priority for the Trust to support and enable learning and targeted quality improvement within the service.
- Additional evidence to demonstrate improved compliance for CTG peer reviews and Maternity Triage audit data as part of the PIR response (February 2026) and additional evidence submission (March 2026).

Milk Fridge on Hazel Ward

- Immediate action taken by the service to ensure safe systems were in place for areas identified in the specific feedback received from the CQC.
- Engagement with service users and infant feeding team to ensure long term storage option was suitable to encourage of continued breastfeeding and support families using our services.
- Service wide discussion at Maternity Governance for MDT review of proposed actions and process on 27th January 2026.
- Approval to purchase a new large fridge and freezer was granted on 27th January 2025.
- Purchased fridge and freezer delivered to unit in March 2026 to support the ongoing improvement actions.

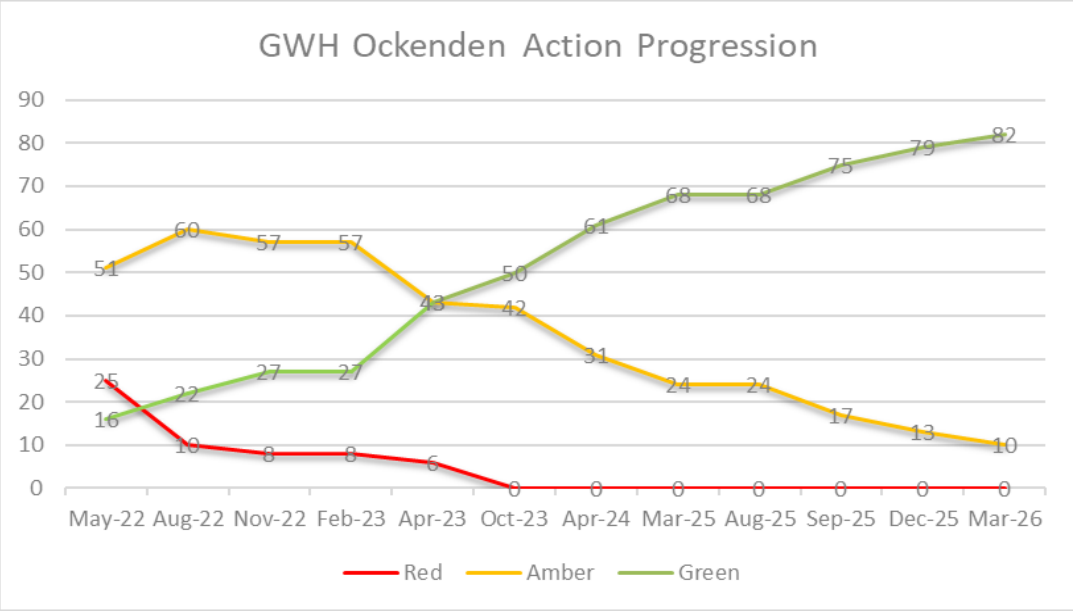
Maternity Triage

- Immediate action was taken to consult with the Trust resuscitation team to ensure appropriate mobile equipment was well located to be easily accessible and increased visible signage in Outpatients Department indicating location of resuscitation equipment for Triage.
- Space and capacity in triage remains a top priority for the Trust with focussed development of a business case underway to enable large scale estates work to the Day Assessment Unit, Triage and Antenatal Clinic area.
- Telephone triage process updated and appropriate workforce models in place to support triage phone requirements.

National Maternity Services Updates

Report	Overview Narrative
National Maternity & Neonatal Review (The Amos Report)	• Initial reflections and impressions were released nationally in December 2025, summarised in a briefing paper for December Quality & Safety Committee. This document did not contain any recommendations. • An interim report released on 26th February 2026 did not contain any specific recommendations but did identify six factors that could be contributing to the pressures on the maternity & neonatal system: capacity pressures, culture and leadership, racism and discrimination, poor responses and lack of accountability, the quality of estates and workforce • Updated briefing paper to be brought to March Quality & Safety Committee for review and discussion
BirthRights Report	• Birthrights' new End Coercion in Maternity Care report highlights widespread concerns about coercive practices in UK maternity services, including inappropriate threats, poor consent processes, and discriminatory patterns of care. • The Trust are undertaking a full review of our local processes and will work closely with our MNVP, service users and the LMNS to co-produce meaningful, rights-based actions that strengthen personalised care and uphold informed choice.
Home Birth Review (following nationally released PFD Report)	• The Coroner's report into the deaths of Jennifer and Agnes Cahill highlights critical national gaps in home-birth guidance, training, risk communication and escalation, with specific concerns about inconsistent practice, lack of specialist preparedness for out-of-hospital births, and failures in informed decision-making. • The Trust have reviewed the findings and developed a local action plan focused on strengthened education for midwives and support workers in out-of-hospital settings, including enhanced maternal and neonatal emergency training, increased exposure of community staff to emergency environments, and improved support for women's choices through informed consent and collaborative, person-centred planning.
Maternity Care Bundle & Postnatal Care Toolkit	• The national maternity and neonatal care bundle was launched across the NHS in Q4 2025/26, setting a consistent, evidence-based framework to improve safety, reduce avoidable harm, and strengthen multidisciplinary working across all maternity settings. • Key areas of focus within the bundle are, • Venous thromboembolism • Epilepsy in pregnancy • Obstetric haemorrhage • Pre-hospital & acute care • Maternal mental health • High level gap analysis commenced led by a multi-disciplinary team across the service. • The national implementation tool is expected to be released in March 2026.
Maternity Incentive Scheme Year 8	• Summary overview received from NHS Resolution in February 2026 with full guidance to be released on 31st March 2026. Attendees from Trusts to attend virtual launch event on 23rd April 2026
Other national reports	• Thirlwell Enquiry expected early 2026. • Nottingham Ockenden Report expected June 2026

Ockenden Report GWH Progress Summary



- A total of three actions were upgraded from amber to green following continued work on improvement actions during Q4 of 2025/26.
- Robust monitoring of outstanding amber actions via Maternity governance meetings and Senior Perinatal team meetings.
- Continued progress against identified improvements for Immediate and Essential actions following focussed engagement with clinical teams for the ‘amber’ actions.

- Trust continues to have no ‘red’ actions within the Immediate and Essential Actions.
- No operational risks identified within the remaining amber actions.
- Continued consideration of Ockenden improvement actions was given during the 2026/27 business planning cycle.
- Currently no identified actions that require additional investment.

Ockenden Ongoing Improvement Actions

IEA				Ongoing Improvement Actions
1	0	0	11	• No continued improvement actions identified
2	0	1	9	• A gap analysis of skills facilitator provision has been completed as part of a broader workforce planning exercise, with associated risks and mitigations formally added to the Trusts risk register in September 2025. The Trust Practice Development & Education midwifery team have taken steps to ensure visibility and support for clinical midwives throughout the service and this will continue to be reviewed at the Perinatal Senior Meetings to monitor progress and explore long term sustainable solutions. The lack of skills facilitators across all practice settings has not been identified as contributing to patient safety events and learning. (Target completion – April 2027)
3	0	0	5	• No continued improvement actions identified
4	0	0	7	• No continued improvement actions identified
5	0	1	6	• Robust action plan in place to deliver timely changes in practice and provides assurance of embedded governance monitoring processes. (Target completion – June 2026)
6	0	0	3	• No continued improvement actions identified
7	0	0	7	• No continued improvement actions identified
8	0	0	5	• No continued improvement actions identified
9	0	0	4	• No continued improvement actions identified
10	0	1	5	• Detailed information on transfer times is available for all mothers who chose to birth outside a hospital setting which is regularly reviewed and updated. Further to changes in electronic documentation system an audit is underway to provide compliance assurance that process is embedded and supporting evidence available in clinical documentation. Ongoing work with digital midwifery team to explore use of electronic patient portal to ensure accessibility of this information to families. Extensive data reviewed throughout end Q2 and Q3 2025, audit to be extended into 2026 to continue data capture alongside Home Birth gap analysis work. New target completion timeline assigned to reflect ongoing work (Target completion – June 2026)

IEA				Ongoing Improvement Actions
11	0	2	6	• Anaesthetic documentation audit underway to provide evidence of full compliance. Progress update provided at Maternity Governance in January 2026 with continued work on the audit to be reviewed by anaesthetic governance and Maternity governance. (Target completion – May 2026). • Continued engagement with national professional bodies to ensure our documentation remains in line with all guidance from Anaesthetic regulatory bodies. System benchmarking undertaken to ensure aligned compliance across the Trusts. (Target completion – May 2026).
12	0	2	2	• Two ongoing improvement actions closely linked and related to ongoing consultant review of post-natal readmissions. • Embedded PSIRF learning culture has enabled the service to monitor this theme through patient safety reviews. Timely consultant involvement and readmissions being seen daily as a minimum has not been identified as contributing to patient safety events and learning. Postnatal readmission audit part of ongoing audit programme with associated improvement actions identified. Robust governance for action monitoring via Maternity Governance prior to future RAG status upgrade. (Target completion – June 2026)
13	0	0	4	• No continued improvement actions identified
14	0	3	5	• Action improvement plans led by Operational Delivery Network for Neonatal Care with ongoing Trust engagement contributing to planning and delivery. Network action plans extend throughout 2026. Trust to update risk register to reflect IEA action 85 and 86 to ensure mitigations are reviewed and managed. (Target completion – ongoing throughout 2026). • Continued engagement with ODN with development of a model for rotation for neonatal nurses. • Trust to continue to development neonatal staffing options to be compliant with the revised BAPM workforce guidelines (nationally released in Q3 2025). Working group established with nursing and medical leads identified to ensure appropriate workforce models are in place for short-term and long-term compliance. (Target completion – ongoing throughout 2026)
15	0	0	3	• No continued improvement actions identified

Any questions?

Report Title	**NHSE Licence Self-Certification – CoS7 (2026/27)**				
Meeting	**Trust Board**				
Date	**09/04/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Roxy Milbourne, Interim Head of Corporate Governance, Royal United Hospitals NHS Foundation Trust (on behalf of Caroline Coles, Company Secretary)				
Appendices	Appendix 1: Self Certification Condition CoS7 – Commissioner Requested Services (CRS) Requirements				

Purpose

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

Assurance Level

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

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

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

Report

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

The Trust operates under an NHS Provider Licence and is required to self-certify on an annual basis whether or not it is compliant with the conditions of the NHS Provider Licence.

With the introduction of a refreshed provider licence in 2023 the self-certification for G6 (3) and FT4 has ceased to remove duplication with the annual report. However, the Trust is still required to self-assess against CoS7 (Commissioner Requested Services).

CoS7(3) requires NHS Foundation Trusts providing Commissioner Requested Services (CRS) to certify that they have a reasonable expectation that the required resources will be available to deliver designated services.

NHS England provides a standard template for this purpose (Appendix 1). Once approved, the template will be completed and signed by the Chair and Chief Executive and published in the Key Publications section of the Trust website.

This report invites the Board to approve the Trust's CoS7 self-certification for 2026/27. In completing the NHS England template, the Board is asked to note the following factors (as reflected in the 'factors to draw attention to' section of the template):

- The 2025/26 annual accounts are prepared on a going concern basis.
- Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the efficiency plans are achieved.
- The year to date and the annual financial position are detailed in the Monthly Integrated Performance Report and regular Finance update reports presented to the Board of Directors and relevant Board sub-committees and Executive Led Groups.
- The Trust is working to achieve the best possible financial position for 2026/27 in agreement with the ICB and NHSE however the emergent nature of the financial settlement for 2026/27 including system wide dependencies and the impact of a restricted ERF cap for example mean that the operational plan will be a challenge to meet full delivery across all domains (financial, operational performance, quality and workforce).
- The financial plan for 2026/27 is challenging with an efficiency and productivity target of £37.6m (6.7% of turnover) which is not without significant risk, and an overall planned breakeven position. Improvement plans are in place, however, the pace and scale required must be considered in the context of operational pressures, capacity and support required from system partners.

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

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

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	n/a	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Code of Governance compliance report to Audit, Risk & Assurance Committee – March 2026	
Next Steps	For Chair and Chief Executive to sign and to publish on the Trust website	

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to approve the Trust's CoS7 self-certification for publication on the Trust website and to authorise the Chair and Chief Executive to sign the NHS England template (Appendix 1) on the Trust's behalf.

In doing so, the Board confirms declaration B within Condition CoS7 as 'Confirmed', based on the evidence and narrative set out within the template.

Accountable Lead Signature	Cara Charles-Barks, Chief Executive
Date	**26/03/2026**

Worksheet CoS7

Financial Year to which self-certification relates: 2026_27

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Confirmed

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

• The 2025/26 annual accounts are prepared on a going concern basis.

• Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the efficiency plans are achieved.

• The year to date and the annual financial position are detailed in the Monthly Integrated Performance Report and regular Finance update reports presented to the Board of Directors and relevant Board sub-committees and Executive Led Groups.

• The Trust is working to achieve the best possible financial position for 2026/27 in agreement with the ICB and NHSE however the emergent nature of the financial settlement for 2026/27 including system wide dependencies and the impact of a restricted ERF cap for example mean that the operational plan will be a challenge to meet full delivery across all domains (financial, operational performance, quality and workforce).

• The financial plan for 2026/27 is challenging with an efficiency and productivity target of £37.6m (6.7% of turnover) which is not without significant risk, and an overall planned breakeven position. Improvement plans are in place, however, the pace and scale required must be considered in the context of operational pressures, capacity and support required from system partners.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Cara Charles-Barks	**Name**	Paul von der Heyde
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	