Bundle BSW Group Board 2 July 2026

Agenda
Item 1.0 BSW Hospitals Group Board Agenda 020726 Public Session Draft v16.1

1. Opening Business

1.1 Welcome and apologies

1.2 Declarations of Interest

1.3.1 Minutes of previous meetings
(a) Minutes of the meeting of RUH Trust Board in public on 3 June 2026
Item 1.3.1 - DRAFT Public BoD Minutes June 26 v1.0 - 22.06.26

1.3.2 Actions log review [Joint Committee and Trust Boards held in public]

2 Patient / Staff Story

2.1 RUH Patient Story
Item 2.1 BSWHG_BoD_CareReflection_RUH_July26

3 Chair and Chief Executive Reports

3.1 Group Chair's Report
- NED Membership of Committees
- NED Champion roles
Item 3.1_Group_Board_Chair Report_ 020726v0.4

3.2 Group Chief Executive's Report
- Executive Team Objectives
Item 3.2_Group_Board Cover Sheet_CEO report_ JUL26v0.2

4 Group Reports

4.1 Group Integrated Performance Report
Item 4.1 a_Group_Board Cover Sheet_Group IPR_ JUL26v0.1
Item 4.1 b_BSW Group IPR June 2026

4.2 Group Finance Report
Item 4.2 GroupBoardCoverSheet_Month 2 Financial Update_ 22.06.26v0.1
Item 4.2 Appendix Group Finance update M2

4.3 Group People Report
(a) Staff Survey
(b) Lord Mann Letter - Group Response
Item 4.3_Group CPO July Group board V1.0
Item 4.3a_BSW Group Board - Staff Survey July 2026
Item 4.3 b_Public Board - Lord Mann final version

4.4 Group Quality and Safety Report
Item 4.4_ Group Board Q&S report July26.V1.0docx

5 Care Organisation Reports

5.1 SFT Managing Director's Report
Item 5.1_Group_Board Cover Sheet_SFT MD Report_ 240626v0

5.2 RUH Managing Director's Report
    Item 5.2 RUH MD Report to Shadow Group Board July26 v1.5JP

5.3 GWH Managing Director's Report
    Item 5.3 BSW MD - GWH July Board

6 Risk and Assurance

6.1 Group Risk Register
    Item 6.1 BSW July Group Board - GRR cover paper
    Item 6.1 Appendix A BSW Group Risk Register Report July 2026 Group Board

7 Strategic Delivery

7.1 Models of Care Transformation
    Item 7.1__Clinical Transformation Programme - June 2026 v0.2

7.2 Corporate Services Transformation
    Item 7.2 CST July Joint Committee cover sheet
    Item 7.2 Appendix_2026-June JC Slides

7.3 Digital Report: EPR Programme
    Item 7.3_Group_Board Cover Sheet_EPR Update_ 22.06.26v0.1
    Item 7.3_Appendix A. BSW EPR Programme Update Jun 2026
    Item 7.3 Appendix B. BSW EPR Programme Roadmap June 2026

7.4 Group Strategy & Planning Report
    Item 7.4 CSO Report_Group Board_July 2026 v2

8 Decision and approvals

8.1 Governance Documentation
    Item 8.0 BSW July Group Board - Item 8 cover paper.V1.0

8.1.1 Group Risk Management Policy [Refer Reading Room]
    Item 8.1.1_Cover BSW July Group Board - Risk Mngt Policy cover paper

8.1.2 Group Performance Management Policy
    Item 8.1.2 bi_Group_Board Cover Sheet_BSW Performance Management Policy
    Item 8.1.2 bii_BSW_Performance_Management_Policy_v0.2

8.1.3 Initial Group BAF
    Item 8.1.3 ci_Group_Board Cover Sheet_Initial Group BAF_ JUL26v0.1
    Item 8.1.3 cii_BSW Group Initial BAF populated draft v0.2

8.1.4 Maternity Oversight Framework
    Item 8.1.4_Group Board oversight for M&N services in BSW

8.1.5 Group Data Sharing Agreement [Refer Reading Room]
    Item 8.1.5_Cover_Group_Board Cover Sheet_GP DSA_ 180726v0.1

8.1.6 Group Board Cycle of Business [Refer Reading Room]

8.1.7 Register of Interests [Refer Reading Room]

8.1.8 Statutory Responsibilities [Refer Reading Room]
    Item 8.1.8_BSW July Group Board - Stat Duties cover paper

9 Care Organisation Governance

9.1 GWH Unitary Governance
Committee Assurance Reports
- GWH Quality & safety Assurance Report
Item 9.1a_GWH Q&SC Assurance Report Group Board Jul-26

9.2 RUH Unitary Governance
Committee Assurance Reports
- RUH Audit Committee
Item 9.2a RUH Audit and Risk Committee Upward Report - 26.06.26
Item 9.2a_ii RUH People Committee Upward Report - 29.06.26

9.3 SFT Unitary Governance
Committee Assurance Reports
- SFT Audit Committee
Item 9.3a_Group_Board Cover &_SFT Audit Committee Escalation Report_ June26v0.1

10 Close

10 Forward look and closing business

10.1 Forward look (including items for next agenda)

10.2 Any Other Business

10.3 Written Answers to Public Questions

10.4 Reflections

10.5 Date and time of next meeting

10.6 Exclusion of the Public and Press

11 Close

BSW Hospitals Group Board held in Public
2nd July 2026 at 10:00 - 15:30 hrs
to be held at
Jenner House, Unit E3, Langley Park, Avon Way, Chippenham SN15 1GG

AGENDA (Draft)

Timings		Agenda	Presenter	Purpose
	1.	**Opening Business**		
10:00	**1.1**	Welcome and apologies [Apologies, Richard Holmes, John Palmer & Jude Gray]	Chair	
	1.2	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	All	
	1.3	Minutes of previous meetings (a) Minutes of the meeting of RUH Trust Board in public on 3 June 2026 Actions log review [Trust Boards held in public.]	Chair	Approval
	2.	**Patient / Staff Story**		
10:05	**2.1**	RUH Patient Story	JL	Reflection
	3.	**Chair and Chief Executive Reports**		
10.25	**3.1**	Group Chair's Report • NED Membership of Committees • NED Champion roles	Chair	Note
10:35	**3.2**	Group Chief Executive's Report	CCB	Assurance
	4	**Group Reports**		
10:50	**4.1**	Group Integrated Performance Report	ME	Assurance
	4.2	Group Finance Report	SW	
	4.3	Group People Report (a) Staff Survey (b) Lord Mann Letter. Group Response	Matthew Foxon	
	4.4	Group Quality and Safety Report	LG	
11:45		**Break**		

	5.	**Care Organisation Reports**		
12:00	**5.1**	SFT Managing Director's Report	NJ	Assurance
12:20	**5.2**	RUH Managing Director's Report	Jason Lugg	
12:40	**5.3**	GWH Managing Director's Report	LT	
13:00		**Lunch**		
	6.	**Risk and Assurance**		
13:30	**6.1**	Group Risk Register	ME	Assurance
	7	**Strategic Delivery**		
13:45	**7.1.**	Models of Care Transformation	AH	Assurance
14:05	**7.2**	Corporate Services Transformation	MF	
14:15	**7.3**	Digital Report: EPR Programme	JH	
14:25	**7.4**	Group Strategy & Planning Report	JD	
	8	**Group Governance**		
14:35	**8.1**	Governance Instruments & Policies for Approval & Adoption		Decision
		(1) Group Risk Management Policy [Refer Reading Room]	ME	
		(2) Group Performance Management Policy	ME	
		(3) Initial Group BAF	ME	
		(4) Maternity Oversight Framework	LG	
		(5) Group Data Sharing Agreement [Refer Reading Room]	JH	
		(6) Group Board Cycle of Business [Refer Reading Room]	CC & BI	
		(7) Register of Interests	CC	
		(8) Statutory Responsibilities [Refer Reading Room]	CC	
	9.	**Care Organisation Governance** *For this meeting, Care Organisation Assurance Committee reports are presented to support transitional governance arrangements and ensure continued Board oversight of Care Organisation committee assurance during implementation of the Group reporting cycle*		
15:00	**9.1**	GWH Unitary Governance (a) Committee Assurance Reports • GWH Quality & Safety Assurance Report	FC	Assurance
	9.2	RUH Unitary Governance (a) Committee Assurance Reports • Audit Committee	JL, SH	Assurance

Time	Item	Description	Lead	Purpose
		• People Committee	PF	
	9.3	SFT Unitary Governance (a) Committee Assurance Reports • Audit Committee Assurance Report The Board will receive any outstanding reports at its September meeting to ensure completeness of the assurance record.	[TBC]	Assurance
	10	**Forward look and closing business**		
15:15	**10.1**	Forward look (including items for next agenda)	Co Sec	Note
15:20	**10.2**	Any Other Business	Chair	Note
15:25	**10.3**	Written Answers to Public Questions	Chair	Note
	10.4	Reflections	All	Reflection
	10.5	Date and time of next meeting	Chair	Note
	10.6	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”		
	11	Close		

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE PUBLIC BOARD OF DIRECTORS
WEDNESDAY 3 JUNE 2026, 09:30 – 12:00
VENUE: ROOM T0.24, BATH SPA UNIVERSITY SION HILL CAMPUS, SION HILL, BATH, BA1 5SF

Present:
Members
Paul von der Heyde, Interim Group Chair *(Chair)*
Sumita Hutchison, Interim Vice-Chair
Antony Durbacz, Non-Executive Director
Paul Fairhurst, Non-Executive Director
Simon Harrod, Non-Executive Director
Joy Luxford, Non-Executive Director
Cara Charles-Barks, Chief Executive
Jude Gray, Group Chief People Officer
Simon Wade, Group Chief Finance Officer
Jonathan Hinchliffe, Group Chief Digital and Information Officer
Mark Ellis, Group Chief Risk Officer
John Palmer, Managing Director
Toni Lynch, Chief Nursing Officer
Kheelna Bavalia, Interim Chief Medical Officer
Bernie Bluhm, Chief Operating Officer

In attendance
Roxy Milbourne, Interim Head of Corporate Governance
Charlotte Nicol, Lead Nurse for Children and Young People *(item 5)*
Sharon Manhi, Head of Patient Experience *(item 5)*
Zita Martinez, Director of Midwifery *(items 14 & 15)*
Para Perera, Freedom to Speak Up Guardian *(item 16)*
Rhiannon Hills, Director of Transformation *(item 17)*
Abby Strange, Corporate Governance Manager *(minute taker)*
Members of the public
Governor observers

Apologies
Judy Dyos, Group Chief Strategic Officer
Liam Coleman, Non-Executive Director
Andrew Hollowood, Clinical Strategic Transformation Director

BD/26/06/01 Chair's Welcome, Introductions, Apologies and Declarations of Interest:
The Chair welcomed everyone to the meeting, noting the significance of the forthcoming transition to a Group Board structure. Apologies had been received from those listed above and the Board confirmed that they had no additional interests to declare.

BD/26/06/02 Written questions from the public
The Chair confirmed that no written questions had been received from the public.

BD/26/06/03 Minutes of the Board of Directors meeting held in public on 1st April 2026

The minutes of the meeting held on 1st April 2026 were approved as a true and accurate record.

BD/26/06/04 Action List and Matters Arising

The actions presented for closure were approved. The following action was discussed in further detail:

PB642 – The Chief People Officer confirmed that an aggregated update on Trust-level themes from the 2025 Staff Survey and local action would be provided through the next People Committee Upward Report.

The Board discussed the implications of the transition to the Group Board, noting that a number of actions would be escalated and consolidated through Group governance routes. The Chief Executive confirmed that arrangements were in place to ensure continuity and tracking of outstanding actions across the transition.

BD/26/06/05 Patient Story

The Chief Nursing Officer welcomed the Lead Nurse for Children and Young People and Head of Patient Experience to the meeting. She introduced the patient story, which centred on the experiences of children and young people accessing services across the Trust. A film developed with patients aged 5 to 17 years was presented, capturing their perspectives on care, environment and communication.

The Lead Nurse for Children and Young People highlighted the diversity of needs across paediatric populations and the challenges of ensuring appropriate physical and emotional environments for different age groups. She emphasised the importance of supporting transition to adult services, noting the risk that young people with complex needs could fall between service boundaries if pathways were not clearly defined and coordinated.

The Board reflected on the strength of the patient voice presented and discussed how learning from the programme could be more systematically embedded into service design. Members emphasised the importance of engaging directly with children, young people and families to inform future service development, including consideration of a more formalised youth engagement mechanism.

Discussion also highlighted wider system considerations, including the growing impact of mental health needs, adverse childhood experiences and the importance of trauma-informed care. Members acknowledged that while acute services did not provide primary mental health provision, they were required to manage this demand safely and appropriately. They also reflected on the importance of connecting acute services with the wider health landscape.

The Board noted the patient story and welcomed the insight provided, recognising its importance in shaping future service development.

BD/26/06/06 CEO and Managing Director's Report

The Chief Executive introduced the report, highlighting the continued focus on sustaining performance improvement and delivering financial recovery within a challenging environment. Urgent and Emergency Care (UEC) remained the most significant operational risk, with recent increases in attendances, and system-wide work was

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ongoing to reset demand management, particularly in relation to community provision and local authority support. The overall direction of travel set by the Secretary of State for Health and Social Care remained unchanged, with a strong emphasis on digital transformation. The opportunities presented by Artificial Intelligence needed to be maximised, particularly through incorporating capabilities into development plans for the shared Electronic Patient Record.

The Managing Director provided a detailed update on performance, noting significant improvement across a number of key standards. The Trust had achieved improvement trajectories across six of seven key targets, including strong progress in diagnostics and elective recovery, and significant gains in 4-hour performance. Performance against the 62-day cancer standard remained a key area of concern, with a renewed focus on applying improvement methodologies successfully deployed for the 28-day standard. Sustaining performance improvement was essential and delivery continued to depend on operational discipline, infrastructure support and system alignment. The scale of the financial challenge remained significant, with delivery of Cost Improvement Programme (CIP) schemes identified as a critical risk. A programme board had been established to explore and identify commercial opportunities.

The Chief Nursing Officer reported that a Nursing and Midwifery Council (NMC) investigation had identified that systems and processes relating to the screening of applicants seeking to join the NMC register had not been followed for 12 years. The NMC had identified 421 nursing and midwifery professionals who were required to provide further information for assessment by an Assistant Registrar. Employers had been advised that no action was required unless contacted directly by the NMC, and the Trust had developed a plan to support any staff member who received a letter from the NMC. Any cases involving Trust staff would be reported through the appropriate governance route.

The Board noted the significant improvement in performance delivered during the latter half of 25/26. The ongoing challenges were discussed, including the 100 day UEC improvement challenge and the ambition to halve Non-Criteria to Reside (NCTR) during the course of the year through strengthened partnership working. The Board noted that the organisation had commenced tracking indicators relating to discharge pathways to better identify the most significant areas of challenge. The Board also considered the ongoing pressures on staff and the importance of continuing to provide help and support. The Chief Executive advised that a significant component of the BSW Hospitals Group Strategy would focus on workforce matters, including how the Group and individual Care Organisations could support staff to navigate the challenging environment while fostering optimism and confidence in the future direction of the Group.

The Board of Directors noted the report.

BD/26/06/07 Chairs Report

The Chair reported on recent developments, including the signing of the updated Group Partnership Agreement, which set out expectations for collaboration, shared leadership and mutual support across the partner organisations. He acknowledged the significant contribution of the previous Chair and emphasised the importance of maintaining strong relationships with the Council of Governors, while ensuring that governance arrangements supported transparency and accountability within the new Group structure.

The Board of Directors noted the report.

BD/26/06/08 Board Assurance Framework (BAF) Summary and Closure
The Interim Head of Corporate Governance provided an overview of the report and reported that the position remained materially stable. The BAF continued to comprise of 13 principal strategic risks, with no substantive changes to risk descriptions, controls or assurances since the previous reporting cycle. The only movement was an increase in estate Risk 3.4 from 16 to 20 to reflect current risk exposure, with underlying controls unchanged. In light of the planned transition to a Group BAF from July 2026, the current BAF would remain in place as the Trust's formal statement of strategic risk until formally superseded.

The Board discussed the treatment of regulatory risk, including the potential for increased oversight or intervention. Members considered whether this should be explicitly reflected within the BAF or captured as a consequence of existing risks. The Chief Executive and Chief Risk Officer identified regulatory intervention as a consequence rather than a risk but indicated that this would be appropriately considered within the evolving Group risk framework, particularly given variation in risk profiles across organisations.

The Board of Directors noted the stable overall position and increase in Risk 3.4. They supported the continuation of the current BAF through to transition to a Group BAF.

BD/26/06/09 Management Executive Committee Upward Report
The Managing Director summarised the report, noting ongoing local authority scrutiny in relation to temporary staffing and confirming that oversight would continue, alongside further engagement at Group level. Fire safety remained a key local risk, with detailed mitigation plans in place, and issues escalated through Group governance. The financial position continued to present, requiring a sustained organisational focus on recovery. Challenging findings from the GMC survey were also noted, with extensive engagement undertaken with clinical leaders and actions in progress to strengthen listening, engagement and targeted resourcing. The Board was further advised that additional industrial action was anticipated, with appropriate preparations underway.

The Board discussed frailty as a key strategic priority, noting that while a number of promising proposals had been identified, these carried associated resource implications. The Board acknowledged the intention to engage further with the Integrated Care Board (ICB) to support a more integrated, neighbourhood-based approach. The Chief Executive added that a deep dive into UEC, incorporating frailty, was being prepared for the July Board meeting to inform future clinical pathway development and the evolving clinical strategy.

The Board considered progress in strengthening the Trust's risk management capability through the Risk Management Improvement Group and noted the positive response to the external review of risk, led by the Deputy Chief Nursing Officer. Significant improvements in data quality and Group-level reporting were highlighted.

The Board of Directors noted the report.

BD/26/06/10 Finance and Performance Committee Upward Report
Antony Durbacz summarised the report, highlighting the strong improvement in performance and confidence in the forward trajectories. While delivery of the 62-day cancer standard remained challenging, achievement of the planned trajectory would place the Trust within the top performance percentile, illustrating both the scale of the

task ahead and the opportunity for improvement. The financial position continued to be more challenging, particularly in relation to the underlying cash balance, which was below the agreed £19m working parameter

The Board acknowledged that work was ongoing to strengthen cash management arrangements, including the establishment of a Group Cash Committee and exploration of options with commissioners and opportunities for mutual support between Care Organisations. The Chief Finance Officer advised that access to revenue or capital support was increasingly constrained and dependent on meeting challenging criteria, with the external financial regime expected to become more demanding.

The Board recognised that financial performance in the first month was behind plan, with delivery of a sell and leaseback transaction identified as important to achieving the Q1 CIP target. It was acknowledged that delivery was complex and that the timing of benefits remained uncertain. Ongoing discussions with regional colleagues were confirmed, and it was emphasised that the proposal would support the staff offer in the absence of available capital funding. The importance of early engagement with the external auditors to validate the proposed accounting treatment was highlighted.

The Board of Directors noted the report.

BD/26/06/11 Quality Assurance Committee Upward Report

Simon Harrod summarised the report, highlighting improvements in coding and reducing the backlog of clinical letters. He advised that digital solutions had been identified as an important enabler, while recognising the need to ensure accessibility for patients who were digitally excluded. The audit of the Patient Safety Incident Response Framework (PSIRF) was discussed, with investigations described as resource-intensive and delays in completion presenting a quality and safety risk. Although some improvement had been made since the time of the report, limited governance and administrative capacity continued to constrain progress, and a related risk had been added to the risk register. Ongoing issues were also highlighted in relation to maternity digital systems and resolution would require investment.

The Board acknowledged the resourcing issues associated with PSIRF were a national issue and that, while the framework was viewed as a positive step in strengthening learning from incidents, it had not been accompanied by additional funding. It was reported that the Management Executive Committee had approved additional resource, but this had not been implemented due to the Trust’s financial position. Discussions were ongoing regarding opportunities to strengthen capacity through Group working and shared learning across the three hospitals. The Board emphasised the importance of timely learning from incidents and it was recognised that incremental progress in embedding existing learning would help mitigate risk, while work continued to identify sustainable solutions to strengthen governance and quality oversight.

The Board of Directors noted the report.

BD/26/06/12 Integrated Performance Report (IPR)

The Chair introduced the IPR, advising that it had been updated to better align to the Trust’s business plan. Measures had been revised to highlight system pressures and direct Board attention to areas where joint action with partners would have the greatest impact. The report also sought to provide a clearer forward view to support decision-making.

The Chief Operating Officer reiterated that UEC was the most challenged area in April, despite an improvement in 4-hour mapped performance to 71.1%. This had been delivered against a 3.6% increase in Emergency Department (ED) attendances and a 12.4% rise in non-elective admissions. Referral to Treatment performance in April was strong, with diagnostics delivered and cancer standards expected to meet 28-day and 31-day targets, alongside slight improvement against the 62-day standard. A programme of interventions and specialty-level improvement work was underway to support further progress.

The Chief Nursing Officer reported concerns that incident reporting may have been constrained by staff capacity during periods of pressure, with benchmarking underway. Focused work was also taking place to improve data quality, particularly around recognition of deterioration. Pressure ulcers were increasing, linked to staffing levels and delays in front-door areas, while nursing fill rates remained low, largely due to sickness absence, with actions in place to address this. Eleven cases of C. difficile were reported in the month with no evidence of cross-infection and complaints had reduced slightly overall. In maternity services, staffing remained below plan due to acuity, with further insight expected from the Birthrate Plus review; no neonatal deaths were reported and one stillbirth remained under investigation.

The Chief People Officer advised that workforce metrics showed a stable staffing base overall, with sickness absence and appraisal completion identified as key drivers impacting staff engagement and wellbeing. Actions aligned to the Healthy Workforce Programme and People Plan were in progress.

The Chief Finance Officer provided an update on the efficiency programme, noting good progress with firm plans in place for 69% of the overall target, while recognising the importance of maintaining delivery momentum and addressing the remaining unidentified savings.

The Board of Directors noted the report.

BD/26/06/13 UEC CQC Report

The Chief Nursing Officer provided an update on the outcomes of the Care Quality Commission (CQC) unannounced inspection of UEC in October 2025. The inspection, conducted under the Single Assessment Framework, resulted in an overall rating of ‘Requires Improvement’ for Urgent and Emergency Services. The CQC identified non-compliance with regulations relating to safe care and treatment, good governance and staffing, requiring the Trust to submit an action plan by 8 June 2026. The improvement plan would be monitored through the Trust’s digital audit platform, with oversight provided by the Insight and Improvement Committee and divisional leadership.

The Board noted the report and recognised that effective system working and maximising existing capability would be critical in managing the challenging environment pending resolution of infrastructure issues.

BD/26/06/14 MIS combined Maternity and Neonates Quarterly Report Q3

The Chair welcomed the Director of Midwifery, who presented the report and advised that, despite a small increase in the stillbirth rate, perinatal and mortality outcomes remained strong and below the national average. Assurance was provided on the robustness of procedures, with high compliance with the Perinatal Mortality Review Tool,

and a risk relating to national delays in perinatal pathology was noted with mitigations in place. Progress was reported on equity within perinatal services and a new risk relating to ultrasound and BadgerNet interoperability had been escalated, with a strategic solution now underway. Continued improvement in reducing term admissions to the neonatal unit was noted, although acuity pressures remained and work was ongoing to develop a sustainable workforce model.

The Board sought clarification on the equity plan and was advised that multiple workstreams were in place, with work underway to strengthen coordination across the Group following changes at system level. A Group-wide approach was being developed to bring together equity and deprivation workstreams, support shared learning and increase scrutiny of outcomes. Progress was reported in areas including continuity of care through the home birth team, targeted quality improvement initiatives, culturally responsive training and improved use of data to monitor outcomes. The intended outcome was to improve the experience and equity of care for all women, particularly those from seldom-heard and racially minoritised groups, with ongoing monitoring to ensure progress was maintained.

The Board of Directors noted the report.

BD/26/06/15 Midwifery and Neonatal Bi-Annual Staffing Report

The Director of Midwifery presented the report, providing assurance that safety metrics continued to demonstrate the delivery of safe care, supported by daily safety huddles and the national situation reports enabling proactive escalation. Ongoing pressures were highlighted, particularly within neonatal services, where there was increased acuity and risks around medical cover in line with updated British Association of Perinatal Medicine guidance. Concerns regarding medicines management were noted, with pharmacy improvement required. The Board was advised that a Birthrate Plus review of maternity staffing was underway, with early indications of additional resource requirements to be considered through Group arrangements.

The Board emphasised the need to strengthen Group-level oversight of maternity services in light of increasing national scrutiny and forthcoming reports, noting that continued focus and system-wide collaboration would be essential as services underwent further transformation. It was recognised that maintaining close oversight would support future service delivery models. The Board reflected positively on the standard of governance within maternity services, highlighting the professionalism and transparency demonstrated, which were seen as strong foundations for the next phase of transformation.

The Chief Nursing Officer advised that the Director of Midwifery would be leaving the Trust the following month. The Board acknowledged her pivotal leadership during a period of significant challenge in maternity and neonatal services, recognising her central role in the Trust's journey to achieving an 'Outstanding' CQC rating. Her contribution to the organisation was warmly commended, and she was thanked for her professionalism, leadership and service.

The Board of Directors noted the report and the Chair thanked the Director of Midwifery for attending the meeting.

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BD/26/06/16 Freedom to Speak Up (FTSU)

The Chair welcomed the FTSU Guardian to the meeting who presented the FTSU 25/26 Q4 and Annual Reports. She provided assurance on the effectiveness of FTSU arrangements at the Trust during the reporting period, including access, themes, learning and alignment with national and Group requirements. During 25/26, a total of 134 staff cases had been raised, including 29 anonymously, supported by the established Report and Support platform. FTSU arrangements were operating effectively, with continued staff access, appropriate escalation and executive oversight.

The Board discussed the report and received assurance that the Trust was well prepared for the increased responsibility and accountability transferring to Care Organisations from 1 July. It was confirmed that FTSU arrangements at RUH were operating effectively, with strong relationships in place, no immediate changes to national requirements, and policy updates planned during the year. The Board noted themes relating to leadership behaviours, line management capability, bullying and harassment, and the importance of training managers to listen and respond appropriately, with resources available via the LearnTogether platform. Assurance was provided that concerns were appropriately escalated, feedback loops closed, and that no cases of severe detriment had been identified. The Board emphasised the importance of triangulating FTSU insights with other workforce intelligence to inform the People Strategy, strengthen organisational culture and ensure FTSU remained a credible, accessible and independent route for staff voice, including through continued Group-wide collaboration.

The Board of Directors noted the report and the Chair thanked the FTSU Guardian for attending the meeting.

BD/26/06/17 2026/27 Business and Financial Plan

The Chair welcomed the Director of Transformation to the meeting who provided a summary of the Trust's Medium Term Plan 26/27-28/29, which had been developed in partnership with the BSW Hospitals Group and BSW ICB and submitted to NHS England (NHSE). Following regional feedback, revisions had been made to strengthen the UEC trajectory and financial position. The plan set out the Trust's priorities for performance, workforce, transformation, quality and finance over the next three years, including delivery of significant recurrent savings whilst maintaining a breakeven position, and highlighted the key enablers required to support successful delivery.

The Board discussed the NCTR position, which had been identified as a red-rated risk and included as a specific dataset and Breakthrough Objective to provide greater organisational focus and accountability. It was noted that, for the first time, a consistent set of metrics would be reported through the Integrated Performance Report, with work underway alongside the ICB and analytics teams to establish a single version of the truth and agreed system-wide thresholds for flow. Members emphasised that improvement would require both robust data and a shared leadership approach across system partners, including exploration of business cases and interventions capable of improving patient flow and ensuring a more sustainable position ahead of future winter pressures. Drawing on learning from other systems, it was recognised that success would depend on all organisations adopting a common language, sharing ownership of risk and acknowledging that patients remaining in hospital without meeting criteria to reside represented a collective system concern. The discussion also highlighted the opportunity to build on this work through more integrated planning across the Group, with a proposal to develop a unified approach to reporting, visualisation and delivery planning to support collective oversight and accountability.

The Board of Directors noted the report and the Chair thanked the Director of Transformation for attending the meeting.

BD/26/06/18 Statutory Governance Framework to support the implementation of BSW Hospitals Group

The Interim Head of Corporate Governance provided an overview of the report which sought approval of the final statutory governance documents required to operationalise the Group model on 1 July 2026. The paper brought together the Scheme of Reservation and Delegation, Standing Financial Instructions and aligned Terms of Reference for Committees in Common, confirming that these arrangements enabled joint working at Group level while fully preserving the statutory sovereignty and responsibilities of each individual Trust Board. No new statutory powers were created and changes related solely to how certain functions would be exercised jointly within clear delegation arrangements. There was a proposed amendment to the Group Board quorum to require the presence of at least one Executive Director, and, taken together, the documents provided a lawful, coherent and robust governance framework for effective Group working.

The Board of Directors approved:

1. The Scheme of Reservation and Delegation of Royal United Hospitals Bath NHS Foundation Trust.

2. The Standing Financial Instructions of Royal United Hospitals Bath NHS Foundation Trust and delegated authority to the Group Chief Finance Officer to make any further changes as set out in the report.

3. The Terms of Reference for the Audit Committee.

4. The Terms of Reference for the Remuneration Committee

5. The amendment to the quoracy of the General Purpose Joint Committee (Group Board) to ensure at least one Executive Director was present.

BD/26/06/19 Annual Review of Directors' Fit and Proper Persons Test (FPPT)

The Interim Head of Corporate Governance confirmed that all required FPPT checks and self-declarations had been completed in line with the Trust's policy and the national framework, and that all current Board members continued to meet the requirements of the Test. An overall summary would be submitted to the NHSE Regional Team by the required deadline.

The Board of Directors noted completion of the annual FPPT process.

BD/26/06/20 Annual Review of Declarations of Interest

The Board received the annual review of Directors' Declarations of Interest, which confirmed that all relevant interests had been appropriately declared, recorded on the Trust's central register and authorised in line with the Trust's policy. The Board was reminded of the ongoing requirement for Directors to declare interests at meetings and withdraw where appropriate.

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The Chair advised that his interests had been declared as part of his recruitment process and would be forwarded to the Interim Head of Corporate Governance for inclusion on the register.

Action: Chair

The Board of Directors approved the Register of Directors' Interests as at 3 June 2026, subject to the inclusion of the Chair's interests.

BD/26/06/21 Any Other Business

The Chair noted that this was the final public Board meeting to be held in the current setting and recorded thanks to Bath Spa University for the use of their facilities at no cost.

The Board expressed its appreciation to the Chief Nursing Officer, Interim Chief Medical Officer, Antony Durbacz and Sumita Hutchison for their significant contributions, support and constructive challenge, noting that this was their final Board meeting in post at the Trust. The Managing Director paid particular tribute to the Chief Nursing Officer and Interim Chief Medical Officer and advised that new appointments had been put in place to ensure continuity and a well-supported transition.

BD/26/06/22 Resolution to exclude the press and public

The Chair proposed that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

The Board of Directors approved the resolution.

The Meeting closed at 12:35

DRAFT

BSW Hospitals Group Board

Agenda item	2.1
Report title	Care reflection story
Date of meeting	1st July 2026
Sponsor	Jason Lugg, Chief Nursing Officer Royal United Hospitals Bath
Prepared by	Sharon Manhi, Head of Patient Experience Royal United Hospitals Bath Chris Lafferty, Associate Director of Patient Safety and Quality Becky Bell, Trust Videographer
Approval Process: (where has this paper been reviewed and approved)	Jason Lugg, Chief Nursing Officer Royal United Hospitals Bath

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☒ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	**Principal risk title**

KEY MESSAGES

Patient stories help to bring patient experiences to life. The BSW Hospitals Group is committed to listening and acting on what matters most to patients and their families.

Background and context

This video shares a son's account of his mother's end-of-life care, highlighting where her care in her final days fell short of expected standards.

The multidisciplinary team review (MDT) found that the care received fell below acceptable standards due to lack of coordination, communication, and symptom management. It highlighted critical delays in accessing pain relief, gaps in out-of-hours pharmacy stock, and inconsistent palliative assessment to manage his mum's symptoms. These gaps contributed to a deeply distressing experience at a time when care should have been compassionate, coordinated, and focused on comfort.

The MDT report is a learning response within the Patient Safety Incident Response Framework (PSIRF). It focusses on system-based learning to inform improvement.

The film highlights the importance of engaging families with compassion, openness and respect, ensuring they feel listened to, supported, and meaningfully involved when concerns arise. It reinforces the need for clear communication, acknowledgement of harm, and visible learning that leads to improvement.

Next steps: The film will be used in staff training to strengthen compassionate communication, support openness and transparency, and embed learning to improve care for patients and families.

Please note: the video contains discussion regarding palliative and end-of-life care. It is recognised that this subject matter may be sensitive and could be upsetting.

RECOMMENDATION

The Group Board is asked to:

1. Receive and note the care reflection

APPENDICES

None

BSW Hospitals Group Board

Agenda item	3.1
Report title	Chair Report
Date of meeting	2nd July
Sponsor	Paul Von Der Heyde
Prepared by	Ben Irvine, Caroline Coles and Roxy Milbourne
Approval Process: (where has this paper been reviewed and approved)	Chair approved

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*	
☒ Developing an engaged workforce	☒ Making our teams diverse and inclusive
☒ Making our services safer	☒ Improving timely access to our services
☒ Improving the experience of those who use our services	☒ Improving our financial sustainability
☒ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	**Principal risk title**
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

This report outlines the Chair's activity and key areas of focus since the previous Board of Directors meeting, including:

- Governance Developments
- Non-Executive Directors Update
- Council of Governors – Key Meeting Dates
- Chair - Key Meetings

RECOMMENDATION

The Group Board is asked to:

1. Note the Chair's Report.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix 1	Non-Executive Team Deployment

Chair's Board Report

1. Introduction

May and June have been a pivotal period in preparing for the transition to a formal Group Board.

Key milestones achieved include:

- Formal agreement of the BSW Hospitals Group Partnership Agreement
- Approval by the three Councils of Governors of the Group Non-Executive Director (NED) appointments
- A successful two-day development session for members of the new Group Board

These developments represent significant progress in establishing the leadership, governance arrangements and collective ambition of the Group.

2. Establishment of the Group Board

From 1 July 2026, the Boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust will operate collectively as a Group Board.

This arrangement is intended to:

- Strengthen strategic alignment across organisations
- Improve consistency of oversight of quality, performance and finance
- Enable delivery of shared priorities at scale

Each Trust Board and its Council of Governors will continue to retain its statutory duties and accountabilities under the NHS Act 2006.

3. Governance and Assurance

A revised governance framework is being established to support the Group Board in discharging its responsibilities effectively.

Key developments include:

- Establishment of a Group Risk and Assurance Committee, following pilot arrangements, with formal operation commencing August
- Creation of a NED-led Financial Sustainability Task and Finish Group
- Implementation of a coordinated annual cycle of business (refer Group Board Reading Room document 1).

These arrangements are designed to:

- Provide robust Board assurance
- Maintain clarity of accountability
- Avoid duplication between Group and Care Organisation governance

4. Non-Executive Directors

In June all three Councils of Governors at Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust formally approved the proposed Group Non-Executive Director appointments. This represents an important milestone in establishing a unified Group Board and demonstrates collective support across the membership.

The appointed NEDs are:

Bernie Morley, Chris Burton, Faried Chopdat, Joy Luxford, Paul Fairhurst, Simon Harrod, Paul Cain, Peter Knell, Richard Holmes and Richard Samuel.

The deployment of the NED cohort across committees and key roles has been agreed (refer Appendix 1). Proposals for the appointment of a Senior Independent Director and Vice Chair have been prepared for Group Board consideration.

NEDs will operate as a single, collective Group team, providing independent oversight, scrutiny and challenge across the full range of Group activities.

Monthly NED meetings will be established from July to support alignment across the Group enabling coordinated oversight of risks and priorities.

5. Councils of Governors

The Councils of Governors continue in their statutory roles for each Care Organisation, retaining their existing duties and functions under the NHS Act 2006 and their respective Constitutions.

These arrangements ensure that local accountability to members and the public is maintained alongside the development of the Group model.

Work programme for 2026-27. Lead governors will meet on 7 July with the Chair, CEO and Chief Risk Officer to consider the rhythm and focus of our work together, including finding a balance between our local Care Organisation and collective activities.

Governor Vacancies. Where they arise, each Care Organisation will work through its usual governance processes to fill both vacancies in a timely manner.

I am delighted to welcome Vinay Manro, Swindon Borough Council governor representative and look forward to working with them.

The following table outlines the key meetings, training and events during June 2026 that governors in SFT, GWH and RUH participated in:-

June 2026 – Governor Activity		
Date	**Event**	**Purpose/ Primary Content**
7 June	GWH Board safety visit – Jupiter	To support governor understanding of how the hospital operates while gaining insight into patient safety and care quality.
9 June	GWH Health Talk – Dying Matters	Public health talk hosted by governors.
10 June	RUH Council of Governors - public	Trust and Group performance, strategy and governance arrangements. Approval of the proposed constitutional amendments; introduction of the Scheme of Delegation to support the operation of the BSW Hospitals Group governance model. Updates on operational and organisational priorities.
10 June	RUH Council of Governors - private	Focus on statutory responsibilities in relation to appointments and governance. Governors received assurance through the annual appraisal outcomes for Non-Executive Directors and considered matters supporting the transition to the BSW Hospitals Group governance model.
17 June	GWH 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. The meeting focused on the staff survey, as well as updates from the Chair of People & Culture Committee and Chair of Quality & Safety Committee.
22 June	SFT Governor Development Day	Relationship development. Updating Governors on key governance and assurance matters. Sharing updates and developing awareness of Well-led

June 2026 – Governor Activity		
Date	**Event**	**Purpose/ Primary Content**
		Review process, Improving Together, & DASH Business Case.
22 June	GWH Board Safety visit – Teal	To support governor understanding of how the hospital operates while gaining insight into patient safety and care quality.

5. Trust Chair Meetings during May-June 2026

The table below summarises key meetings held during the past two months.

Meeting	Purpose
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
RUH Council of Governors	Meeting with Governors
BSW Group Joint Committee / Shadow Group Board	Pilot meeting with new Group Board membership.
RUH Trust Board meeting	Meeting of RUH Board ahead of Group Board meeting in July 2026
GWH Trust Board meeting	Meeting of RUH Board ahead of Group Board meeting in July 2026
SFT Trust Board meeting	Meeting of RUH Board ahead of Group Board meeting in July 2026
BSW Chairs' meeting	Regular meeting
BSW Group Board Development Days	Board Development
Gill Morgan, SW Regional Chair	Visit to RUH
HCRG & BSW Group – Chairs and CEO	Introductory meeting

Appendix 1, Non-Executive Director Deployment

BSW Hospitals Group Non Exeecutive Director Committee Membership 26-27

Committee	Group Board	Audit Committees-in-Common	Risk & Assurance Committee	Remuneration Committees-in-Common	EPR Assurance Committee [TAF]	L1 Financial Sustainability [TAF]	Governor Nomination & Remuneration Committee	COGs x 3
Number of NED members	All	4 x NEDs	7 x NEDs	All	4xNEDs	5 x NEDs	1x NED (chair)	All
Frequency	Monthly	Quarterly	Monthly	At least 2 pa	Bi-monthly	Monthly	At least 1 pa	Quarterly
Non-Executive Directors								
Paul Von Der Heyde	**Chair**			**Chair**		**Chair**	**Chair**	**Chair**
Joy Luxford		**Chair**						
Faried Chopdat			**Chair**					
Chris Burton								
Richard Holmes								
Bernie Morley								
Paul Fairhurst								
Paul Cain								
Peter Knell								
Richard Samuel								
Simon Harrod					**Chair**			
Vacancy								

BSW Hospitals Group Non Executive Director - Named Roles 2026-27

Role	Bi-annual Assurance Visits	SID	Vice-Chair	Maternity	Wellbeing	Freedom to Speak Up	Doctors Discplinary & Resident Doctor Lead
	All NEDs	1 x NED	1 x NED	3 NEDs: 1 x NED per Care Organisation*	1 x NED	1 x NED	3 NEDs: 1 x NED per Care Organisation*
Non-Executive Directors							
Paul Von Der Heyde							
Joy Luxford							
Faried Chopdat							
Chris Burton				** RUH*			** RUH*
Richard Holmes							
Bernie Morley							
Paul Fairhurst							
Paul Cain				** GWH*			** GWH*
Peter Knell							
Richard Samuel							
Simon Harrod				**SFT*			** SFT*
Vacancy							

BSW Hospitals Group Board

Agenda item	3.2
Report title	CEO report
Date of meeting	2 July 2026
Sponsor	Cara Charles-Barks, Chief Executive Officer
Prepared by	
Approval Process: (where has this paper been reviewed and approved)	CEO Approved

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☒ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title

KEY MESSAGES

This is the first Group Chief Executive's Report to the BSW Hospitals Group Board meeting held in public, following the constitution of the Group Board under the Partnership Agreement.

Across the three Care Organisations the picture in the period is one of resilience under sustained pressure: continued improvement in elective, diagnostic and cancer recovery alongside persistent urgent and emergency care, flow, workforce and financial challenges.

Resident doctor strike action planned for June was called off, with members balloted on a revised national pay and jobs offer; the outcome is expected shortly.

The publication of the Independent Review of Maternity Services at Nottingham University Hospitals (the Ockenden Report) and the national response, including the extension of Martha's Rule to maternity and neonatal settings, reinforce maternity and neonatal safety as a Board priority.

Quarter 4 National Oversight Framework segmentation confirmed RUH improving from segment 4 to segment 3, SFT remaining in segment 3, and GWH moving to segment 4.

The Group's risk and assurance arrangements are maturing, with an Initial Group Board Assurance Framework and a consistent Group approach to risk now being established.

RECOMMENDATION

The Group Board is asked to:

1. Receive and note the report, and to note the assurance it provides on the position across the three Care Organisations and the BSW system.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

Introduction

This is my first report to the Group Board as a body meeting in public, and the first since the Group Board was formally constituted under the Partnership Agreement. The purpose of this report is to provide the Board, and the public, with strategic context, to draw attention to the most significant developments across our three Care Organisations — Great Western Hospitals (GWH), Royal United Hospitals Bath (RUH) and Salisbury (SFT) — and to highlight the matters the Board should particularly note. It is an information and assurance paper rather than a decision-making one.

1. Strategic initiatives and priority activities for the Group

The five Group strategic initiatives (transforming models of care, our people, increasing sustainability, delivering digital maturity, and developing our Group) remain central to our collective activities.

1.1 Operational performance and recovery

Urgent and emergency care and patient flow

Urgent and emergency care remains the most pressured part of our systems. All three Care Organisations are operating with high bed occupancy — close to or above 97% — sustained demand, and continued reliance on escalation capacity. All three organisations are experiencing exceptionally high occupancy and constrained discharge, and corridor care continues to be used at GWH and RUH to maintain timely ambulance handover. The principal constraint across all three sites is flow: end-to-end movement of patients from the front door through assessment and admission to timely discharge, with delays for patients who no longer meet the criteria to reside a shared system challenge. Each organisation has a structured response in train, including front-door redesign, 100-day urgent and emergency care improvement challenges, and strengthened system working with local authority and community partners on discharge.

Referral to treatment and elective recovery

Elective recovery is a relative area of strength, with continued progress at RUH and SFT. Both are sustaining strong control of long waits, with very low numbers of patients waiting over 52 weeks and no patients waiting beyond 65 weeks. GWH is the outlier: a deterioration in 18-week performance over recent months has attracted regulatory attention and enhanced regional oversight, with a significant share of the position attributable to data and validation issues now being addressed through a dedicated recovery programme and a newly appointed recovery director. Tools developed through

RUH's recovery work are being shared and implemented at GWH, an early example of the benefit of working as a Group.

Cancer

Cancer performance is improving but remains below standard in places. SFT has achieved the 28-day faster diagnosis standard and is reducing its backlog; RUH is close to the 28-day standard with validation expected to improve the position further; and GWH continues to face challenges in 62-day performance, concentrated in a small number of specialties and pathways, including those reliant on other providers. Mutual support through the cancer network and emerging Group pathways is being used to address shared bottlenecks.

Diagnostics

Diagnostic performance is mixed. RUH is performing ahead of trajectory against the six-week standard and reducing breaches, while GWH has seen pressure on diagnostic waits in the period. Development of the Trowbridge Community Diagnostic Centre continues and remains a key enabler of improved access across the system.

Financial sustainability

Financial sustainability is the most significant shared challenge. All three organisations are carrying substantial savings requirements for 2026/27 and are managing delivery alongside sustained operational pressure. Each has stood up strengthened financial governance, turnaround capacity and grip arrangements, and is working to mature its savings programmes. Delivery confidence, rather than identification of schemes, is the common risk, and there is an increasing dependency on Group-level clinical and corporate transformation to realise the scale of savings required. This is considered further in Section 2.

Workforce and culture

Workforce availability — sickness, temporary staffing and staff unavailability — remains a key enabler of, and constraint on, delivery, and is a breakthrough objective at SFT and the focus of healthier-workforce programmes at RUH and GWH. The 2025 staff survey results, considered in detail elsewhere on the agenda, show staff remain highly committed to patient care while reporting the effects of a demanding operational, financial and change environment. Work to respond is underway in each organisation and at Group level.

Quality, safety and maternity

Quality and safety improvement continues across the Group, including measurable reductions in inpatient falls at GWH and focused work on pressure injuries at RUH. Maternity and neonatal safety remains a Board-level priority, with assurance provided through national programmes and continued investment in workforce and culture. The national developments set out below give this added prominence.

1.2 Industrial action

Strike action by resident doctors that had been planned for 15–19 June 2026 was called off after the Government made a revised offer on pay and jobs. The BMA's Resident Doctors Committee suspended the action and opened a member referendum on the offer, which ran from 18 June and

closed at noon on 26 June 2026. The revised offer combines reform of pay progression with this year's pay review body recommendation to deliver an average uplift of around 6.6% by April 2027, together with commitments on specialty training places, reimbursement of examination and membership fees, and improved, substantive contracts for locally employed doctors.

The outcome of the referendum is expected shortly after the ballot closes. If the offer is accepted, the strike mandate will end; if it is rejected, further action is possible. During the period of action our organisations continued to prioritise patient safety and to maintain as much planned activity as possible, and the financial and operational impact of industrial action is reflected in the year-to-date positions.

1.3 Publication of the Ockenden Report into maternity services at Nottingham

On 24 June 2026, Donna Ockenden published the findings of the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust, the largest review of its kind in the history of the NHS. The review examined the care of around 2,500 families and identified a substantial number of avoidable deaths and cases of harm, alongside deep-seated cultural failings and a persistent failure to listen to women and families. The report sets out actions for the trust concerned and system-wide essential actions for maternity care across England.

The Government responded the same day, confirming that Martha's Rule — the right for a patient, parent or family member to request an urgent, independent clinical review where they fear a patient is deteriorating and their concerns are not being heard — will be extended to all maternity and neonatal settings in England, and signalling new powers to compel evidence in maternity investigations. While the findings relate to another provider, they are a sober reminder to every Board of the importance of listening to families, of speaking-up culture, and of robust escalation. Our Care Organisations will review the essential actions and the implications of the national response, and I will ensure maternity and neonatal safety, and our readiness to implement Martha's Rule in these settings, are reported to the Board through the Group Quality arrangements.

1.4 Impact of the heatwave

Late June 2026 has brought an exceptional and record-breaking spell of heat. The UK Health Security Agency issued a red heat-health alert covering several regions of England, including the South West — only the second such alert ever issued, the first having been in July 2022 — alongside a Met Office red extreme-heat warning. National guidance highlighted a risk to life for the whole population, increased demand on health and social care, the potential for internal temperatures in care settings to exceed recommended clinical thresholds, and impacts on the workforce.

Across our sites, teams managed the operational impact of the heat on cooling and estates infrastructure and reinforced guidance on hydration and rest breaks for staff and on the care of vulnerable patients.

1.5 Critical incident at the Royal United Hospital, Bath

During the period a critical incident was declared at the Royal United Hospital following flooding affecting part of the site. The incident was managed under the Trust's emergency preparedness,

resilience and response arrangements, with patient safety the priority, and was subsequently stood down.

1.6 National Oversight Framework — Quarter 4 2025/26 segmentation

NHS England has finalised and published the National Oversight Framework segmentation for Quarter 4 2025/26, the final refresh under the current framework and metrics. The Group's positions are summarised below. By way of context, the South West has the second-highest proportion of trusts in segments 1 and 2 of any region (around 42%), second only to London.

Care Organisation	Q4 2025/26 segment	Change from Q3	Commentary
Royal United Hospitals Bath	3	Improved (from 4)	The largest single improvement of any trust in the South West in the quarter, and among the most improved nationally.
Salisbury	3	No change	Position broadly stable, with a marginal movement in the aggregate metric score.
Great Western Hospitals	4	Moved down (from 3)	Reflects sustained urgent and emergency care and elective access pressure during the period.

RUH's improvement, the largest in the South West in the quarter, reflects a sustained trajectory from recovery to improvement. SFT held its position, and GWH's movement reflects the urgent and emergency care and elective pressures described above. We will use the Group structure to share the practice that has driven RUH's improvement.

2. Risks across the Care Organisations and BSW system

This section draws on the Group Risk Register and the monthly controls analysis to set out the most significant risks being escalated by each Care Organisation, the cross-cutting risks emerging at Group and system level, and how we are strengthening our overall approach to risk.

2.1 Key escalated risks by Care Organisation

For each organisation, an assessment of key risks are highlighted below. These are the risks scoring most highly under the Group's risk-scoring methodology and featuring most consistently — or moving most against baseline — in each organisation's recent governance cycles, and they are the areas of greatest materiality to patients and to delivery. They are necessarily a selection: each organisation manages a wider register of risks, overseen through its governance arrangements and the Group Risk and Assurance Committee.

Great Western Hospitals

Key risk	Why it is being escalated
Patient flow and high bed occupancy	Bed occupancy has remained close to 98%, with routine use of escalation and corridor care and a critical incident over the Easter period. The risk is escalated because it is the most consistently featured operational risk in the period and has a direct bearing on patient safety, privacy and dignity.
Financial sustainability and delivery of the savings programme	The 2026/27 plan requires savings of around 9.6%, the largest single financial exposure facing the organisation, with delivery to be secured alongside significant operational pressure. Turnaround support is in place to strengthen and de-risk the programme.
Elective access and RTT recovery	A deterioration in 18-week performance has attracted regulatory attention and enhanced regional oversight, and waiting times remain the largest single driver of patient concerns. A recovery director and structured recovery programme are now in place.

Royal United Hospitals Bath

Key risk	Why it is being escalated
Urgent and emergency care performance and flow	Following a Care Quality Commission rating of 'requires improvement' for the Emergency Department (published in May 2026), the organisation has seen pressure on four-hour performance and corridor care. The risk is escalated given the regulatory finding; an improvement plan, a 100-day UEC challenge and capital for a new urgent treatment centre are in train.
Delivery of the financial plan and savings programme	Although the plan is balanced, it is heavily front-loaded and there is a year-to-date adverse position, with confidence in the savings trajectory the principal risk to delivery. Cash remains a watch area managed through Group and system arrangements.
Ageing estate, backlog maintenance and fire safety compliance	A significant and growing backlog maintenance and critical infrastructure position, with fire safety the most acute element, has been escalated to Board because its scale now exceeds what can be managed below Board level. A prioritised, risk-based investment and compliance programme is being delivered alongside the wider estate strategy.

Salisbury

Key risk	Why it is being escalated
Financial recovery and delivery of the savings programme	A fully identified savings programme of around £32.5m remains high-risk and dependency-laden, with delivery of Group-led clinical and corporate transformation savings the principal dependency. This is described as the principal organisational risk and is managed through a dedicated delivery cell and Group governance.

Key risk	Why it is being escalated
Urgent care flow and discharge	Numbers of patients no longer meeting the criteria to reside remain well above target and occupancy is high, constrained by system-wide discharge capacity. Escalated because flow is the key operational constraint and is only partly within the organisation's control; a discharge model and strengthened system working are being implemented.
Workforce availability	Staff unavailability remains materially above target and is the primary constraint on delivery across pathways. It is a breakthrough objective for the year, supported by targeted, data-led interventions and divisional accountability.

2.2 Cross-cutting Group and system risks

Several risks recur across the three organisations and are being drawn together as Group-level risks through the Initial Group Board Assurance Framework, which consolidates a single view of strategic exposure into ten Group principal risks. The most significant cross-cutting themes are financial sustainability; urgent and emergency care and patient flow; delivery of the shared Electronic Patient Record and wider digital maturity; the condition of an ageing estate and fire-safety compliance; workforce capacity, retention and wellbeing; and cyber security. Several of these are interdependent — financial, workforce and flow risks in particular reinforce one another — and addressing them is a core purpose of working together as a Group.

3 Group Development programme

3.1 Shaping our Group Strategy – the 'Mattering' engagement

Work to develop our first Group Strategy has been underway since September 2025, building on a decade of collaboration. Having engaged on our vision and a set of draft strategic priorities, in June we opened this work to the people who make our services real every day through an engagement we have called Mattering.

Mattering is a rapid, focused conversation with our staff and volunteers, designed to test whether our vision and priorities are credible, motivating and capable of being translated into everyday work, and to surface where they are already being lived well and what gets in the way. Running over a three-week period from early June, it has been supported by an online portal that allows people to share and respond to ideas anonymously; by 22 June there had been over 2,000 interactions on the portal. In parallel we have engaged system partners and local communities to ensure the strategy reflects shared priorities around prevention, reducing inequalities and integrated working.

The insight from this engagement, together with the views of our Governors, will be brought to a Board Development Strategy Workshop in August. We intend to finalise the strategy over the coming weeks, launch it internally in September and publish it externally in October. This will be an important milestone: a clear, shared direction for the BSW Hospitals Group, set with confidence ahead of another demanding winter, and built with our people rather than for them.

Close.

BSW Hospitals Group Board

Agenda item	4.1(a)
Report title	Group Integrated Performance Report
Date of meeting	2 July 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Mark Ellis, Chief Risk Officer
Approval Process: (where has this paper been reviewed and approved)	N/A – first full committee cycle in place for September Board Steady state process: Group Exec Committee > Group Board

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☒ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R6	Reducing waits
R8	Reducing avoidable harm
R9	Improving staff satisfaction

KEY MESSAGES

This report provides an overview of the Group's performance for the period up to and including April 2026.

The Group demonstrates a direction of travel of improvement, Board attention is best directed to three areas where the position has moved adversely: the GWH elective position (deteriorating 18- and 52-week RTT), urgent-care flow (ED 12-hour above plan, corridor care rising, and worsening NCTR and discharge-ready delays), and workforce sickness at RUH and SFT.

RECOMMENDATION

The Group Board is asked to:

1. Note the contents of the report and triangulate with the escalations of CEO and MD reports.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

Purpose

The purpose of the integrated performance report (IPR) is to give the board a single, triangulated view of organisational performance across the principal domains, in doing so it provides the evidential basis for board assurance, challenge, decision-making and escalation.

The IPR is also a tool for directing the board's attention to where it is most needed. Through exception-based reporting and statistical process control (SPC), it helps the board distinguish genuine signal from ordinary variation, focus on trajectory and trends rather than single data points, and avoid the trap of reacting to month-on-month noise.

Summary

The overall direction of travel remains improving: Elective access, diagnostics and ambulance handover continue to strengthen, and cancer 62- and 28-day performance improved sharply in month.

Board attention is best directed to three areas where the position has moved adversely: the GWH elective position (deteriorating 18- and 52-week RTT), urgent-care flow (ED 12-hour above plan, corridor care rising, and worsening NCTR and discharge-ready delays), and workforce sickness at RUH and SFT. Several signals need careful reading — cancer 62-day improved markedly in month but its SPC run is still concerning; SFT's 'concerning' vacancy signal reflects a deliberate establishment reset; and DM01 dipped in month against an otherwise improving run.

1. Signals at a glance

Metric	Variation	Board read-across
URGENT & EMERGENCY CARE		
ED 12-hour (Group)	Concerning	Run above mean (10.3%); improving but still above plan.
Discharge-ready delays (Group, GWH, SFT)	Concerning	Deteriorated; Group now above upper control limit.
% NCTR (GWH)	Concerning	Largest system challenge; SFT's improving signal has been lost.
ED 4-hour (GWH)	Concerning	No Trust meeting target; GWH/RUH failing assurance.
Ambulance handover (Group, GWH, RUH)	Improving	Continued improvement (Group 33 min).

Metric	Variation	Board read-across
ELECTIVE ACCESS, DIAGNOSTICS & CANCER		
RTT 18 & 52-week (Group, RUH, SFT)	**Improving**	RUH and SFT exceeding target.
RTT 18 & 52-week (GWH)	**Concerning**	Deteriorating; 18-wk below LCL (56.7%), 52-wk increasing run.
Cancer 62-day (Group, SFT)	**Concerning***	*In-month improved sharply (Group 67.9%) but run still below mean.
Cancer 28-day (Group, RUH)	**Improving**	Group above UCL; RUH improving and meeting target.
DM01 diagnostics (Group, GWH, RUH)	**Improving***	*In-month dip across all COs against an improving run.
INFECTION PREVENTION & CONTROL		
MRSA (Group-wide)	**Improving**	Prior concern resolved — no cases across the Group in April.
E. coli / C. difficile (Group, RUH)	**Common***	*Above trajectory; RUH C. difficile increase under review.
MORTALITY		
SHMI (GWH, SFT)	**Improving**	All 'As Expected'; RUH recovered to common cause (98.4%).
PATIENT SAFETY & HARMS		
Falls (Group)	**Common**	Below national average, second month below mean.
Pressure ulcers (RUH)	**Concerning**	Above UCL and increasing trend but remains low in absolute terms; SFT improved to 2.7 (common).
CHPPD (SFT)	**Concerning**	SFT link to sickness and escalation. GWH improving but data integrity (HealthRoster/Power BI) under review.
MATERNITY & PERINATAL		
Stillbirths (Group-wide)	**Common**	All stillbirths reviewed per governance and PSIRF frameworks.
Neonatal deaths (Group-wide)	**Common**	Zero deaths across all Trusts in April.
WORKFORCE		
% sickness absence (RUH, SFT)	**Concerning**	RUH 5.63% (improving over 4 months); neither meeting target.

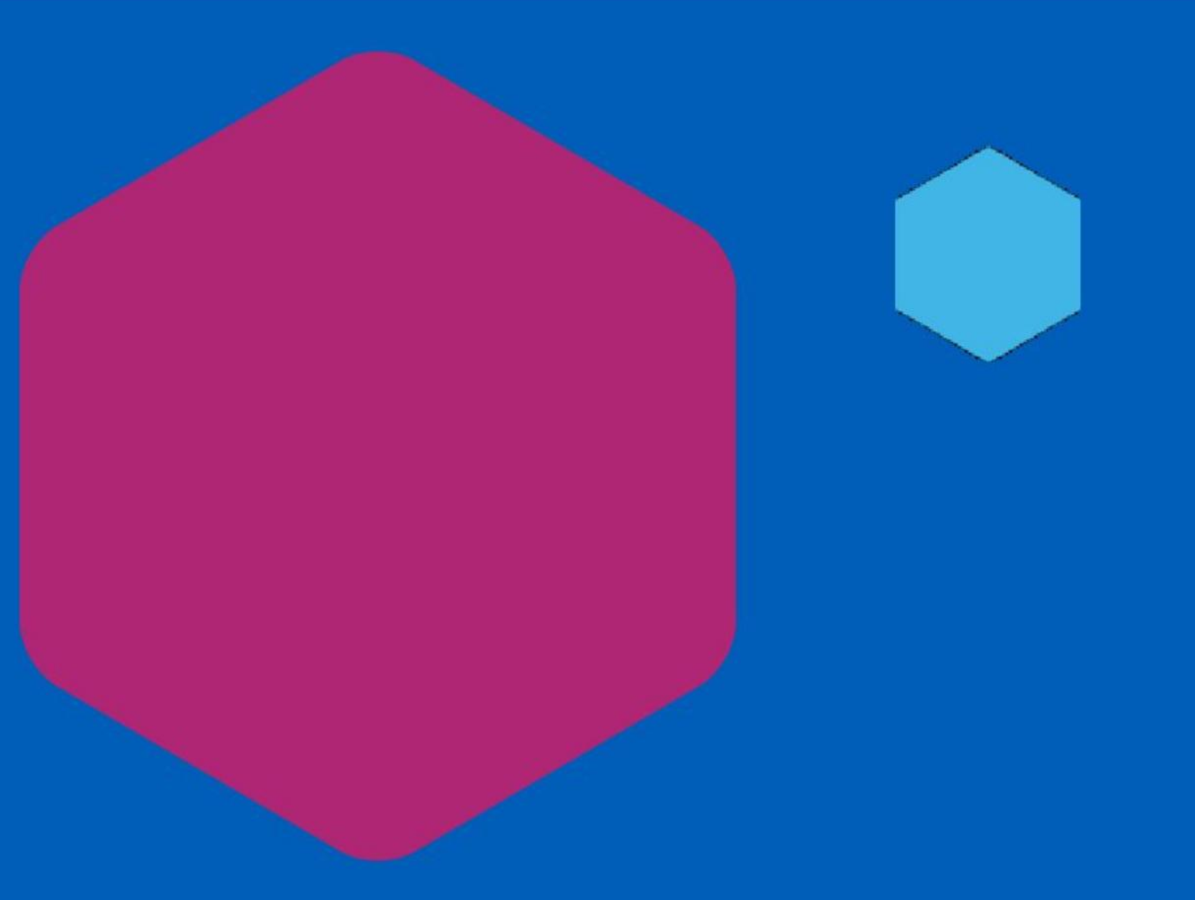
Metric	Variation	Board read-across
Vacancy rate (SFT)	**Concerning***	*Deliberate establishment reset; still meeting target.
Vacancy & turnover (GWH, RUH)	**Improving***	*Masks over-recruitment (RUH 83 WTE) and stagnation risk.

2. Structural alignment to Strategic Planning Framework

The Group is scheduled to publish its strategy by October 2026, this will facilitate the strengthening of the integrated performance report's alignment with the Group's strategic planning framework to ensure clear line-of-sight between strategic objectives, priorities, and reported outcomes. This alignment will enable the Board to assess progress against agreed goals in a coherent and consistent manner, strengthening strategic oversight and accountability.

BSW Group Integrated Performance Report

June 2026 (April 2026 data)



Interpreting summary icons

These icons provide a summary view of the important messages from SPC charts.

	Variation / performance Icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
MSSA	Group			Apr-26	8				Common Cause Variation
MSSA	GWH			Apr-26	5				Common Cause Variation
MSSA	RUH			Apr-26	3				Common Cause Variation
MSSA	SFT			Apr-26	0				Common Cause Variation
MRSA	Group			Apr-26	0				Common Cause Variation
MRSA	GWH			Apr-26	0				Common Cause Variation
MRSA	RUH			Apr-26	0				Special Cause Improving - Below Lower Control Limit
MRSA	SFT			Apr-26	0				Common Cause Variation
Ecoli	Group			Apr-26	20				Common Cause Variation
Ecoli	GWH			Apr-26	9				Common Cause Variation
Ecoli	RUH			Apr-26	10				Common Cause Variation
Ecoli	SFT			Apr-26	1				Common Cause Variation
Cdiff	Group			Apr-26	19				Common Cause Variation
Cdiff	GWH			Apr-26	6				Common Cause Variation
Cdiff	RUH			Apr-26	11				Common Cause Variation
Cdiff	SFT			Apr-26	2				Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
ED 4 Hour Performance	Group	All Types		Apr-26	66.4%				Common Cause Variation
ED 4 Hour Performance	GWH	All Types	78.0%	Apr-26	67.6%	X			Special Cause Concerning - Two Out of Three Low
ED 4 Hour Performance	RUH	All Types	72.0%	Apr-26	61.0%	X			Common Cause Variation
ED 4 Hour Performance	SFT	All Types	76.1%	Apr-26	71.2%	X			Common Cause Variation
ED 12 Hour Performance	Group	Type 1 and Type 2 attendances		Apr-26	10.3%				Special Cause Concerning - Run Above Mean
ED 12 Hour Performance	GWH	Type 1 and Type 2 attendances	13.0%	Apr-26	12.9%	✓			Common Cause Variation
ED 12 Hour Performance	RUH	Type 1 and Type 2 attendances	0.0%	Apr-26	8.0%	X			Common Cause Variation
ED 12 Hour Performance	SFT	Type 1 and Type 2 attendances	5.7%	Apr-26	10.9%	X			Common Cause Variation
Cancer 62 Day Performance	Group			Mar-26	67.9%				Special Cause Concerning - Run Below Mean
Cancer 62 Day Performance	GWH		76.0%	Mar-26	72.0%	X			Common Cause Variation
Cancer 62 Day Performance	RUH		75.0%	Mar-26	68.6%	X			Common Cause Variation
Cancer 62 Day Performance	SFT		78.9%	Mar-26	61.7%	X			Special Cause Concerning - Run Below Mean
Cancer 28 Day Performance	Group			Mar-26	80.4%				Special Cause Improving - Above Upper Control Limit
Cancer 28 Day Performance	GWH		81.0%	Mar-26	80.6%	X			Common Cause Variation
Cancer 28 Day Performance	RUH		75.0%	Mar-26	80.6%	✓			Special Cause Improving - Two Out of Three High
Cancer 28 Day Performance	SFT		80.0%	Mar-26	79.8%	X			Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
RTT wait times top versus bottom quintile of social deprivation	GWH			Apr-26	-1.0%				Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	RUH		0.0%	Apr-26	-2.4%	X	?		Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	SFT		0.0%	Apr-26	0.1%	✓	?		Common Cause Variation
RTT 18 week %	Group			Apr-26	65.3%			H	Special Cause Improving - Above Upper Control Limit
RTT 18 week %	GWH		60.0%	Apr-26	56.7%	X	?	L	Special Cause Concerning - Below Lower Control Limit
RTT 18 week %	RUH		67.7%	Apr-26	70.3%	✓	F	H	Special Cause Improving - Above Upper Control Limit
RTT 18 week %	SFT		65.0%	Apr-26	71.5%	✓	P	H	Special Cause Improving - Above Upper Control Limit
RTT % Over 52 Weeks	Group			Apr-26	1.1%			L	Special Cause Improving - Two Out of Three Low
RTT % Over 52 Weeks	GWH		1.0%	Apr-26	2.3%	X	F	H	Special Cause Concerning - Increasing Run
RTT % Over 52 Weeks	RUH		1.0%	Apr-26	0.5%	✓	?	L	Special Cause Improving - Decreasing Run
RTT % Over 52 Weeks	SFT		0.0%	Apr-26	0.1%	X	F	L	Special Cause Improving - Below Lower Control Limit
DM01 Performance	Group			Apr-26	86.4%			H	Special Cause Improving - Above Upper Control Limit
DM01 Performance	GWH		99.0%	Apr-26	88.8%	X	F	H	Special Cause Improving - Run Above Mean
DM01 Performance	RUH		99.0%	Apr-26	85.3%	X	F	H	Special Cause Improving - Above Upper Control Limit
DM01 Performance	SFT		87.0%	Apr-26	84.7%	X	?		Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
% of NCTR	Group			Apr-26	19.8%				Common Cause Variation
% of NCTR	GWH			Apr-26	20.7%				Special Cause Concerning - Run Above Mean
% of NCTR	RUH			Apr-26	19.1%				Common Cause Variation
% of NCTR	SFT			Apr-26	19.5%				Common Cause Variation
Average days between discharge ready date and discharge date	Group			Apr-26	1.5				Special Cause Concerning - Above Upper Control Limit
Average days between discharge ready date and discharge date	GWH			Apr-26	2.8				Special Cause Concerning - Run Above Mean
Average days between discharge ready date and discharge date	RUH			Apr-26	2.8				Common Cause Variation
Average days between discharge ready date and discharge date	SFT			Apr-26	1.0				Special Cause Concerning - Above Upper Control Limit
Average handover time	Group	Minutes		Apr-26	33				Special Cause Improving - Run Below Mean
Average handover time	GWH	Minutes		Apr-26	38				Special Cause Improving - Run Below Mean
Average handover time	RUH	Minutes	30	Apr-26	33	X			Special Cause Improving - Below Lower Control Limit
Average handover time	SFT	Minutes	20	Apr-26	22	X			Common Cause Variation
Average LoS	Group			Apr-26	7.5				Common Cause Variation
Average LoS	GWH			Apr-26	7.1				Common Cause Variation
Average LoS	RUH			Apr-26	8.6				Common Cause Variation
Average LoS	SFT			Apr-26	6.9				Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
SHMI	GWH	Summary Hospital-level Mortality Indicator		Dec-25	99.5%				Special Cause Improving - Run Below Mean
SHMI	RUH	Summary Hospital-level Mortality Indicator		Apr-26	98.4%				Common Cause Variation
SHMI	SFT	Summary Hospital-level Mortality Indicator		Dec-25	91.5%				Special Cause Improving - Two Out of Three Low
Pressure Ulcers per 1000 beddays	Group	Category 2/3/4, excluding specialist areas		Apr-26	1.3				Common Cause Variation
Pressure Ulcers per 1000 beddays	GWH	Category 2/3/4, excluding specialist areas		Apr-26	0.5				Common Cause Variation
Pressure Ulcers per 1000 beddays	RUH	Category 2/3/4, excluding specialist areas		Apr-26	1.1				Special Cause Concerning - Above Upper Control Limit
Pressure Ulcers per 1000 beddays	SFT	Category 2/3/4, excluding specialist areas		Apr-26	2.7				Common Cause Variation
Care Hours per Patient Day (CHPPD)	Group			Apr-26	9.3				Special Cause Improving - Two Out of Three High
Care Hours per Patient Day (CHPPD)	GWH			Apr-26	10.1				Special Cause Improving - Above Upper Control Limit
Care Hours per Patient Day (CHPPD)	RUH			Apr-26	8.5				Common Cause Variation
Care Hours per Patient Day (CHPPD)	SFT			Apr-26	7.7				Special Cause Concerning - Run Below Mean
Falls per 1000 bed days	Group			Apr-26	5.4				Common Cause Variation
Falls per 1000 bed days	GWH			Apr-26	4.3				Common Cause Variation
Falls per 1000 bed days	RUH			Apr-26	6.4				Common Cause Variation
Falls per 1000 bed days	SFT		7.0	Apr-26	5.9	✓			Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Vacancy Rate	Group			Apr-26					
Vacancy Rate	GWH		7.0%	Apr-26	-4.8%	✓			Special Cause Improving - Decreasing Run
Vacancy Rate	RUH		4.0%	Apr-26	-1.5%	✓			Special Cause Improving - Below Lower Control Limit
Vacancy Rate	SFT		5.0%	Apr-26	0.8%	✓			Special Cause Concerning - Above Upper Control Limit
% Voluntary Turnover	Group			Mar-26	6.99%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	GWH		13.00%	Mar-26	6.79%	✓			Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	RUH			Mar-26	4.91%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	SFT			Mar-26	10.03%				Special Cause Improving - Below Lower Control Limit
% Sickness	Group			Mar-26					
% Sickness	GWH		4.00%	Mar-26	3.97%	✓			Common Cause Variation
% Sickness	RUH		4.70%	Mar-26	5.63%	X			Special Cause Concerning - Run Above Mean
% Sickness	SFT		3.00%	Mar-26	4.00%	X			Special Cause Concerning - Run Above Mean

Note: The vacancy rate for GWH in April is 5.0% rather than –4.8% This is still meeting month end targets

BSW Group Scorecard

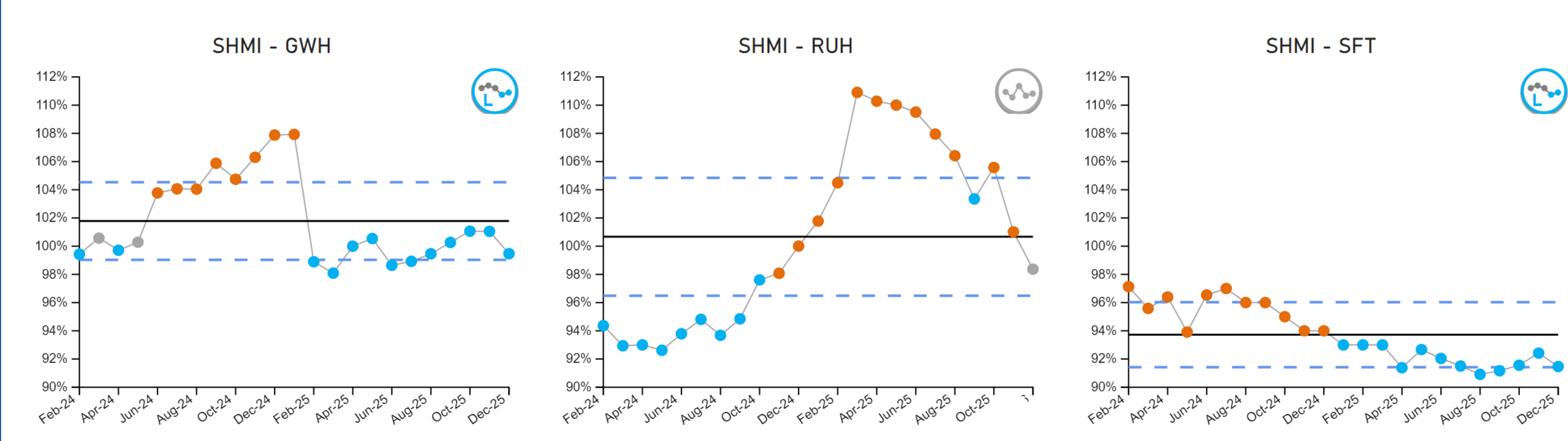
Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Neonatal Deaths per 1000 Births	Group			Apr-26	0.0				Common Cause Variation
Neonatal Deaths per 1000 Births	GWH			Apr-26	0.0				Special Cause Improving - Below Lower Control Limit
Neonatal Deaths per 1000 Births	RUH			Apr-26	0.0				Special Cause Improving - Run Below Mean
Neonatal Deaths per 1000 Births	SFT			Apr-26	0.0				Special Cause Improving - Below Lower Control Limit
Stillbirths per 1000 Births	Group			Apr-26	2.6				Common Cause Variation
Stillbirths per 1000 Births	GWH			Apr-26	0.0				Common Cause Variation
Stillbirths per 1000 Births	RUH			Apr-26	3.0				Common Cause Variation
Stillbirths per 1000 Births	SFT			Apr-26	6.1				Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	Group			Apr-26	9.46				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	GWH			Apr-26	4.43				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	RUH			Apr-26	0.00				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	SFT			Apr-26	5.03				
Average Daily Number of Patients in Corridor Care within ED	Group			Apr-26	56.29				
Average Daily Number of Patients in Corridor Care within ED	GWH			Apr-26	28.73				
Average Daily Number of Patients in Corridor Care within ED	RUH			Apr-26	18.87				
Average Daily Number of Patients in Corridor Care within ED	SFT			Apr-26	8.69				

SHMI

Please note that the SHMI metric cannot be aggregated across multiple trusts



SHMI

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
SHMI	GWH	Summary Hospital-level Mortality Indicator		Dec-25	99.5%				Special Cause Improving - Run Below Mean
SHMI	RUH	Summary Hospital-level Mortality Indicator		Dec-25	98.4%				Common Cause Variation
SHMI	SFT	Summary Hospital-level Mortality Indicator		Dec-25	91.5%				Special Cause Improving - Two Out of Three Low

Understanding Performance

Each of the 3 Acute Trust's SHMI remain statistically within the expected range according to data published by NHSE.

RUH – There continues to be improvement in the SHMI position. There have been consistent and sustained improvements seen in the data over the last 6 months and progress continues to be made due to the improved clinical coding which was considered to be a contributing factor to the adverse SHMI position. No concerns have been identified through other mortality surveillance processes. The SHMI is 'As Expected.'

GWH - The latest SHMI data publication covers the period Jan 2025 to Dec 2025. This shows the Trust to be 'As Expected'.

SFT – The SHMI is also statistically 'As Expected,' and is below the mean average. There have been a consistent downward (positive) trajectory over the past 12-18 months.

Countermeasures

Collectively, a series of development sessions to review current Power-Bi capabilities and opportunities were recently established to help align internal data reporting and methodologies.

The ICB are considering how they might be able to improve our system reporting by bringing together learning from both community/acute deaths in relation to medical examiner reviews.

The importance of coding for accurate reporting of national mortality figures (SHMI) has been a recent theme of discussion across the three acutes. The system mortality group plans to invite coding representatives to a future meeting to try and initiate joint discussions about this, and to understand opportunities to share resources and learning. Representation at the BSW system mortality meeting is to be reviewed in line with the ICB geography footprint.

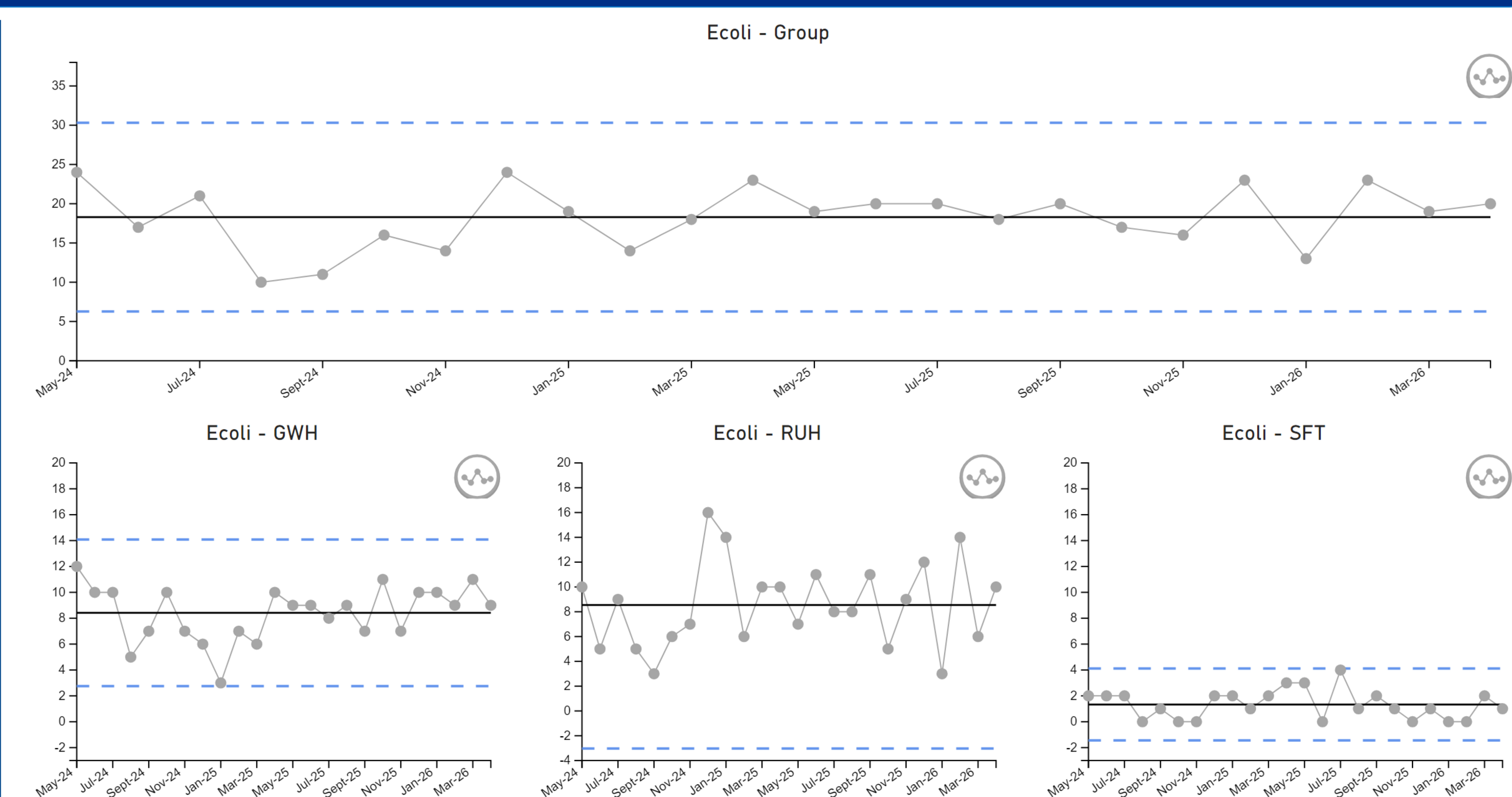
RUH are continuing in their planning to adopt the same mortality IT system used at SFT for recording mortality reviews electronically (MaMR module in AMAT) the 2 trusts continue to work together to support the implementation and launch this through sharing learning and experience

Risks and Mitigation

There is a BSW system mortality group (Chaired by the ICB) which meets monthly, and there is representation from each of the 3-acutes at this meeting. The SHMI data and mortality insights are shared and discussed for learning purposes at these meetings. The ICB are beginning to consider how 3 separate mortality groups might transition into a single cluster mortality group as BSW ICB are now in a cluster with Somerset and Dorset. Local mortality leads are to be consulted on this.

The SHMI data published by NHS Digital will continue to be reviewed regularly by each of the hospital mortality teams, and this will help to mitigate the withdraw from our reporting of HSMR+ (which was previously generated by Dr Foster). The combination of improving our internal reporting, development of the Power-BI toolkit, use of the NHS Digital SHMI dashboard, and adherence to each acute Trust's internal learning from death processes, collectively ensures that learning is identified at the earliest opportunity.

Ecoli



Ecoli

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Ecoli	Group			Apr-26	20				Common Cause Variation
Ecoli	GWH			Apr-26	9				Common Cause Variation
Ecoli	RUH			Apr-26	10				Common Cause Variation
Ecoli	SFT			Apr-26	1				Common Cause Variation

Understanding Performance

Group: E. coli bloodstream infections remain above trajectory and the South West average across the group, with performance driven primarily by higher rates in GWH and RUH, although variation continues to be largely consistent with common cause.

GWH: The number of harms reduced in month however, E. coli rates remain consistent overall, with routine variation and no clear signal of concern.

SFT: There has been one Hospital Onset Healthcare Associated (HOHA) reportable *E.coli* bloodstream infection (BSIs), compared to two last month.

RUH: Urinary tract sources remain the leading contributor to E coli infections.

Countermeasures

Group: BSW Hospital Group IPC Leads will work collaboratively to review catheter management practices, reduce variation, and implement best practice to support a reduction in E. coli rates across the Group.

GWH: Past reviews have indicated that infections are largely associated with urinary tract infection.

SFT: Catheter care remains a key focus for IPC and urology nurse specialists

RUH: Targeted quality improvement workstreams are in place focussed on preventing urinary tract infections and increasing hydration.

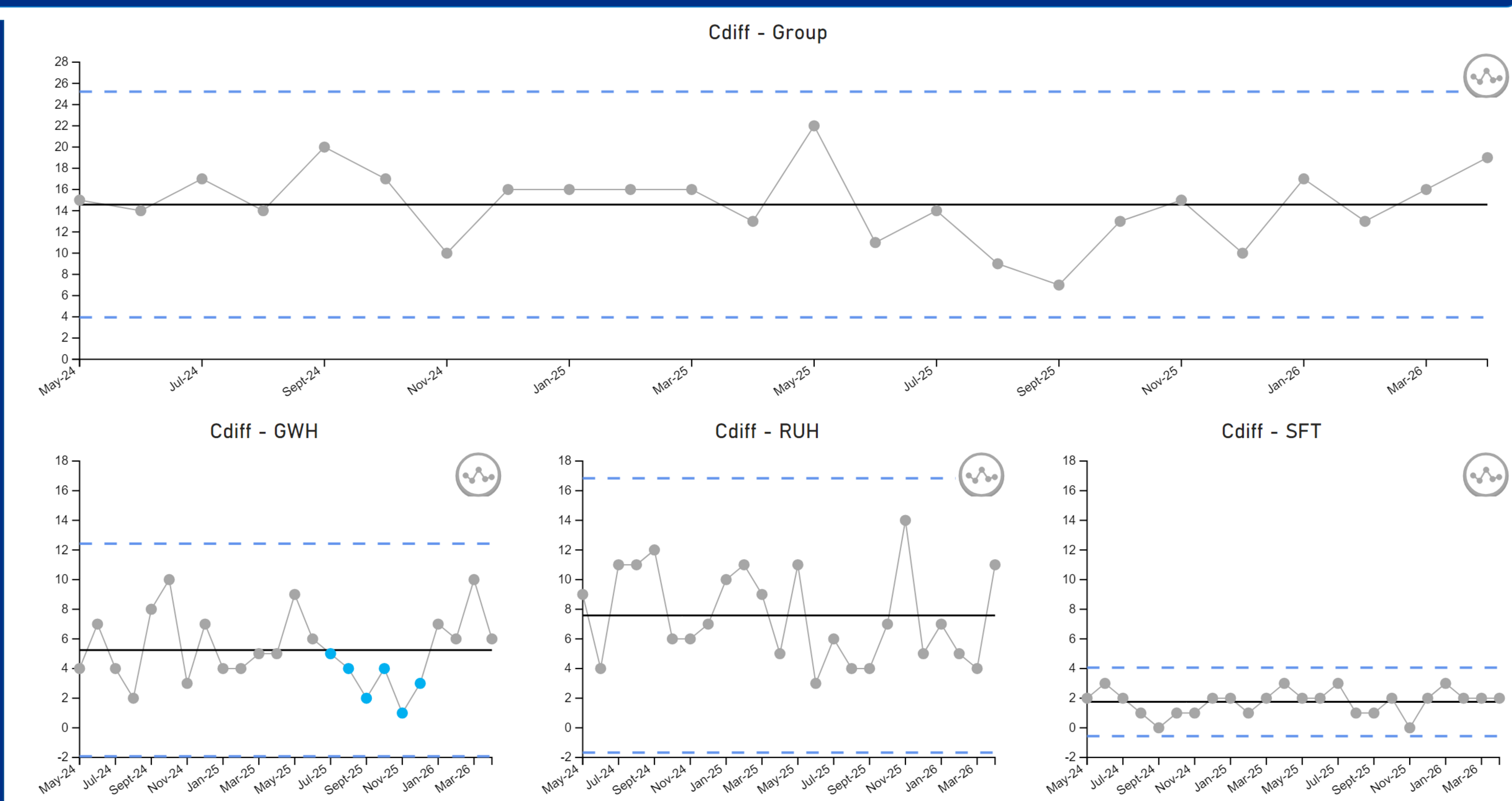
Risks and Mitigation

GWH: While a seasonal rise is anticipated during the summer months, actions are focused on reinforcing good hydration, alongside established infection prevention workstreams. These include catheter care, decontamination of patient care equipment, and early identification. Ongoing assurance is supported through antimicrobial stewardship and continued monitoring to ensure timely intervention and sustained control.

SFT: Catheter management audits continue with timely interventions to reduce any gaps in care provision.

RUH: There is a risk E. coli numbers continue to rise. The workstream is monitored regularly at the Quality & Safety Improvement Group and the Infection Prevention and Control Committee. Work continues to ensure alignment, minimise duplication, and maintain momentum across all improvement activities.

Cdiff



Cdiff

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Cdiff	Group			Apr-26	19				Common Cause Variation
Cdiff	GWH			Apr-26	6				Common Cause Variation
Cdiff	RUH			Apr-26	11				Common Cause Variation
Cdiff	SFT			Apr-26	2				Common Cause Variation

Understanding Performance

Group: C. difficile performance shows ongoing month-to-month variation across the Group, with higher rates at the start of the reporting year, particularly at RUH and to a lesser extent GWH, while overall variation remains consistent with common cause.

GWH: C. difficile numbers show month-to-month variation but remain broadly stable overall, with numbers slightly decreasing. The Trust remains below the South-West regional average.

SFT: For Hospital Onset Healthcare Associated (HOHA)reportable C. difficile, there have been two cases this month, consistent with the previous month and remaining within expected common cause variation.

RUH: There has been a notable increase in infection rates, with no clear underlying cause identified at this stage. Further analysis is underway to understand causation.

Countermeasures

Group: BSW-wide antimicrobial stewardship and IPC workstreams continue, focusing on prescribing optimisation, environmental cleanliness and shared learning across organisations.

GWH: Equipment cleaning and prescribing of Proton Pump Inhibitors (PPI) remain a focus for the Infection Control (IPC) team.

SFT: Recommencement of C. difficile 'virtual' rounds with Infection Control Doctor from April. Anti-microbial ward rounds continue x 2 weekly

RUH: Continuous monitoring of antimicrobial prescribing is undertaken, supporting by quarterly reporting.

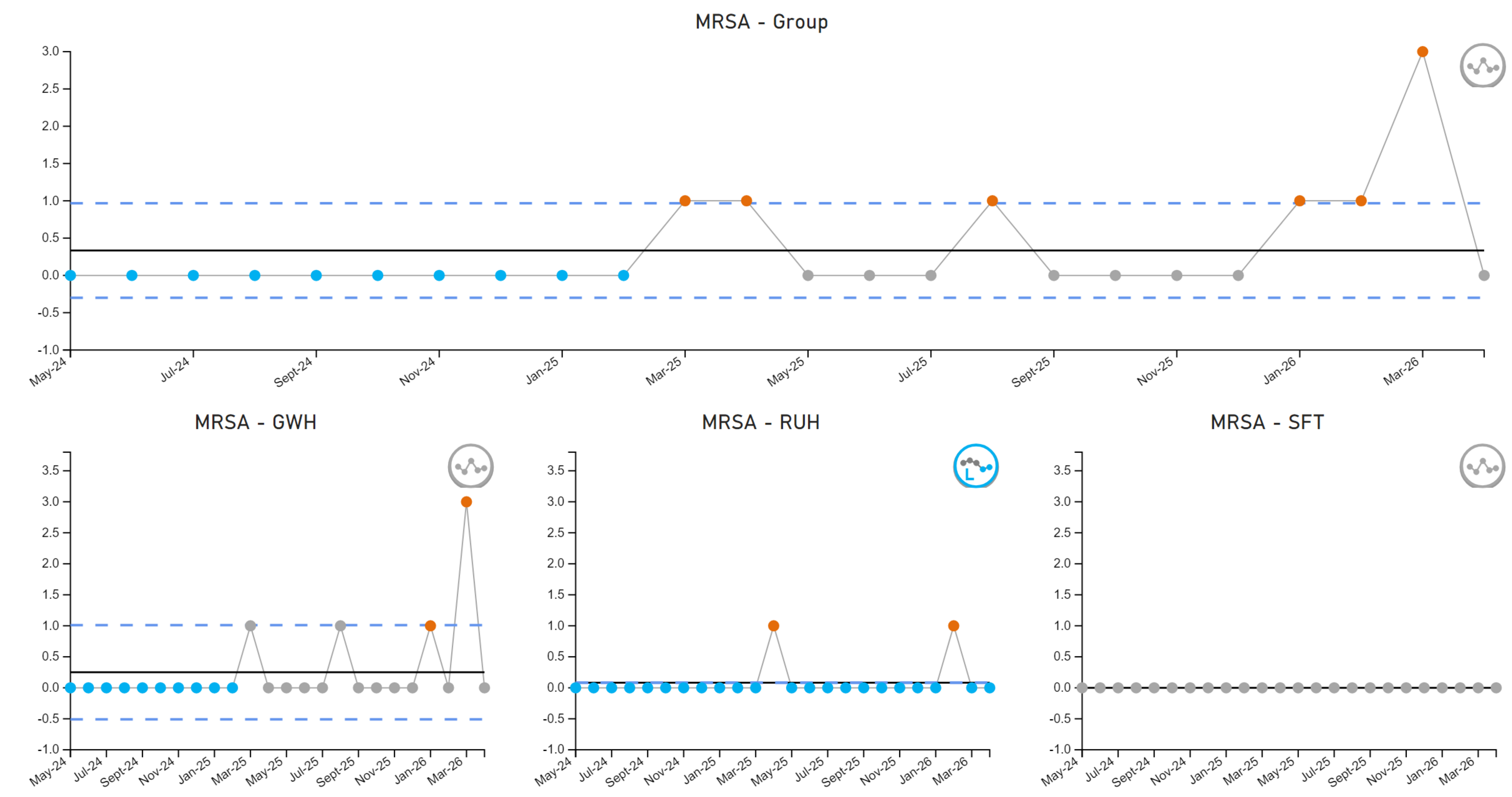
Risks and Mitigation

GWH: Training and education continues to be supported.

SFT: Robust monitoring of trends and identification of linked cases is in place, led by the Infection Prevention and Control (IPC) team. Divisions undertake regular reviews, implement targeted action plans, and report progress to the Infection Prevention and Control Working Group (IP&CWG). In parallel, the Trust-wide *Learning from Incidents Forum* continues to support the systematic sharing of good practice and organisational learning.

RUH: The high number of C.diff cases at the start of the reporting year is of concern. Cases have been distributed across the wards, clinical risk factors are being reviewed, cleaning requesting had been standardised and vapour cleaning implemented.

MRSA



MRSA

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
MRSA	Group			Apr-26	0				Common Cause Variation
MRSA	GWH			Apr-26	0				Common Cause Variation
MRSA	RUH			Apr-26	0				Special Cause Improving - Below Lower Control Limit
MRSA	SFT			Apr-26	0				Common Cause Variation

Understanding Performance

Group: No MRSA cases reported across the Group at the beginning of the reporting year.

GWH: There was no healthcare associated methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia reported during April.

SFT: There was no healthcare associated methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia reported during April. 26.

RUH: There was no healthcare associated MRSAB reported during April 2026 .

Countermeasures

Group: System-wide work continues to strengthen prevention through improved line care; early identification of skin breaks and consistent review of cases across all organisations.

GWH: Targeted improvement work is focused on strengthening early identification and management of skin breaks and maintaining skin integrity. Continued monitoring and case reviews when required.

SFT: Continued monitoring and escalation of cases.

RUH: Workstreams continue to focus on increasing patient hand hygiene compliance, reducing the inappropriate use of gloves and empower clinical staff in departments to select the correct PPE

Risks and Mitigation

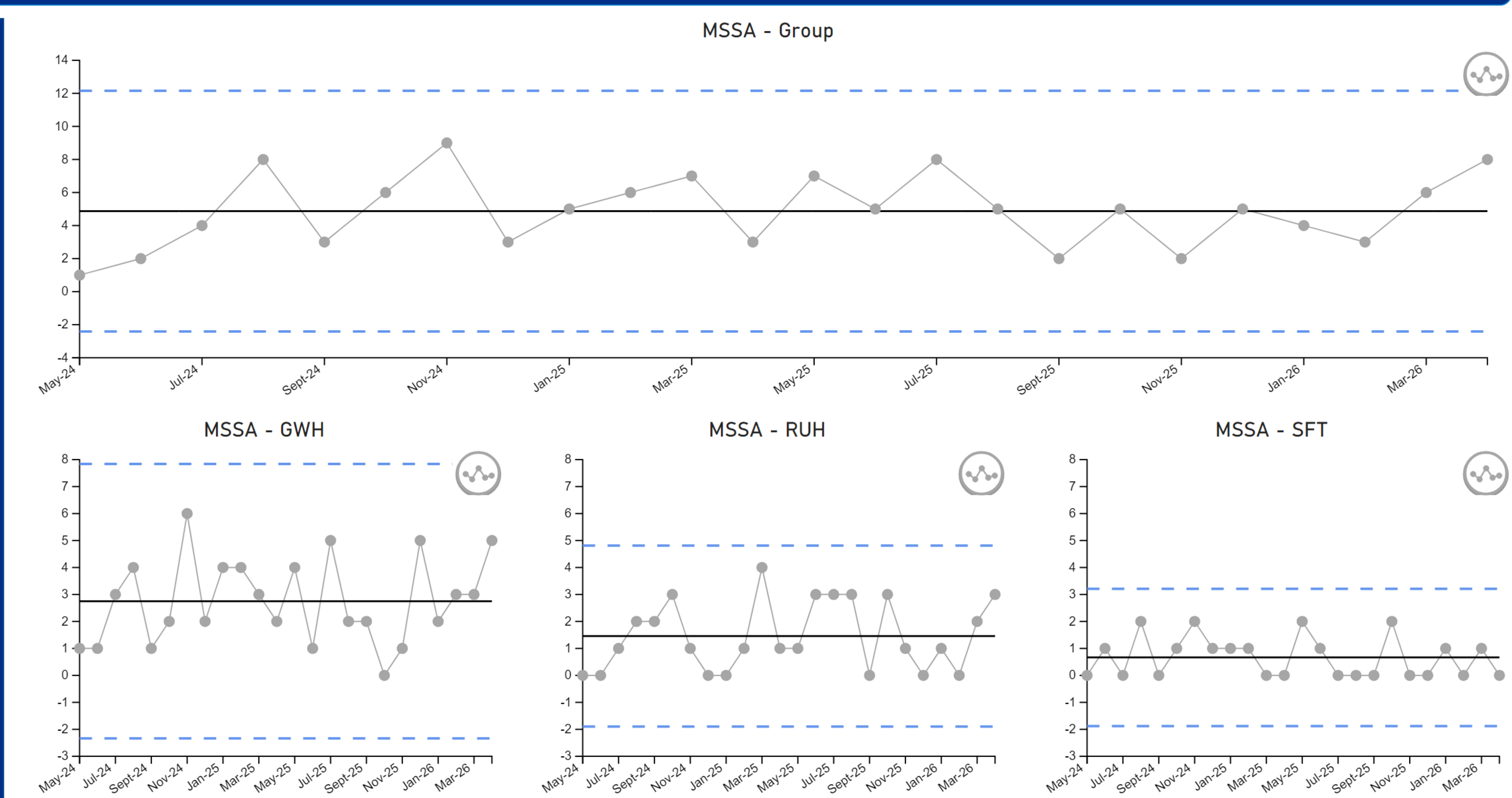
Group: Targeted education and training in infection prevention, hand hygiene and line care are being reinforced across all three Trusts to reduce the risk of further cases.

GWH: Targeted infection prevention training is being reinforced across the Trust.

SFT: Targeted education and surveillance continues

RUH: IPC & the QI team are jointly leading the delivery of six core quality standards, designed to provide a holistic and system-wide impact on patient outcomes.

MSSA



MSSA

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
MSSA	Group			Apr-26	8				Common Cause Variation
MSSA	GWH			Apr-26	5				Common Cause Variation
MSSA	RUH			Apr-26	3				Common Cause Variation
MSSA	SFT			Apr-26	0				Common Cause Variation

Understanding Performance

Group: MSSA bacteraemia rates show ongoing variation across the group, with higher case numbers at GWH and RUH at the start of the reporting period, while SFT reported no cases, with overall variation remaining within expected ranges.

GWH: MSSA numbers have increased slightly, with 5 cases reported in April

SFT: There was 0 MSSA reported in April 2026.

RUH: There were 3 MSSA infections during April 2026 with different identified causation.

Countermeasures

GWH: Learning from recent cases has identified common themes, consistent with those seen in Methicillin-Resistant Staphylococcus aureus (MRSA), particularly in relation to the management of intravascular devices and skin integrity.

SFT: To continue to monitor and report. All cases reviewed with ward teams and IPC for learning opportunities.

RUH: Focussed improvement work is underway to understand the points and risk of contamination. A quality improvement project has commenced looking at central and intravenous access device management. This will also include work which will contribute to the reduction of infections.

Risks and Mitigation

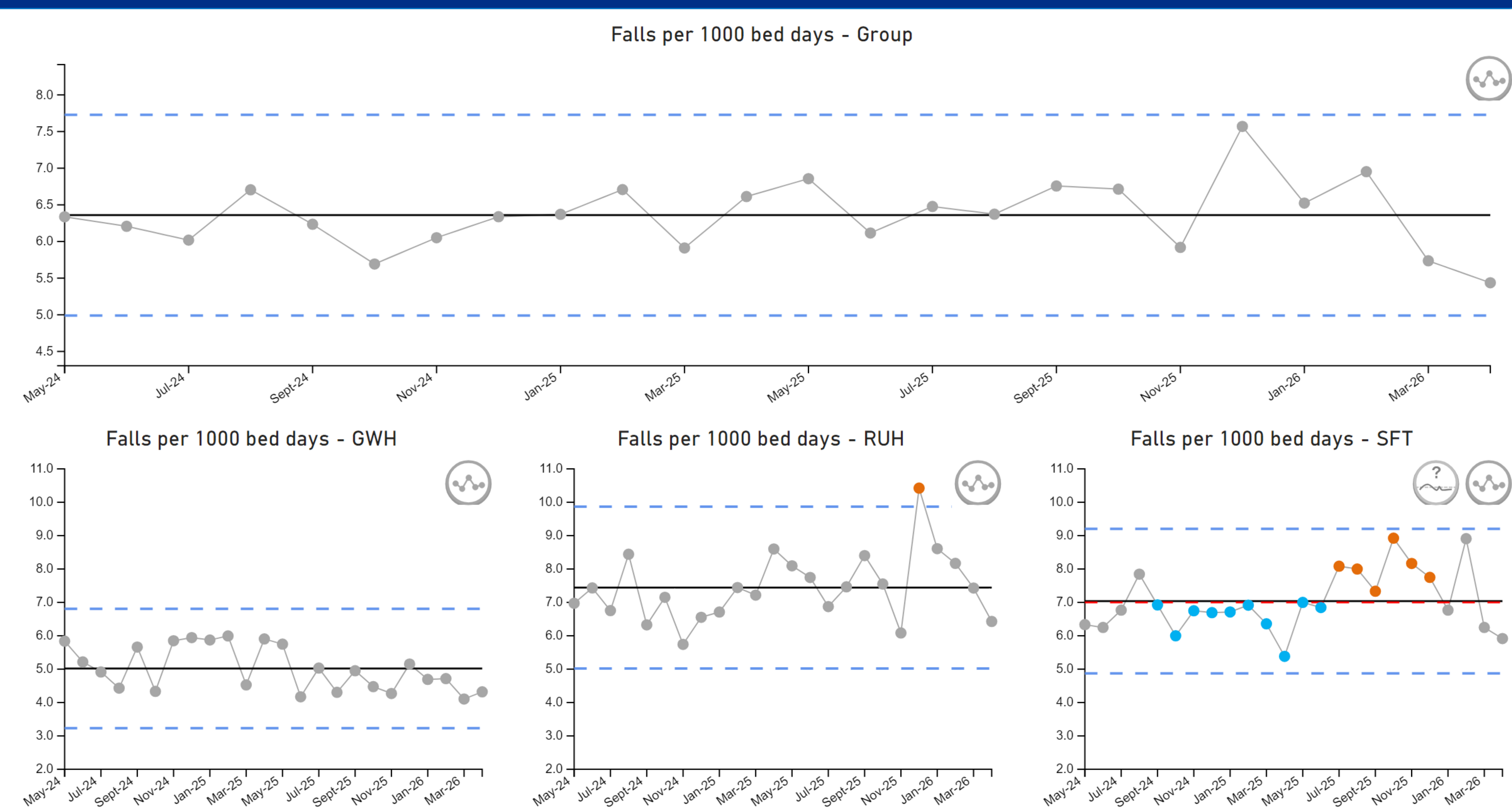
Group: Education and training remain a key focus across IPC teams, supporting improved compliance with infection prevention practices and sustained reduction in MSSA rates.

GWH: Ongoing mitigations include compliance audits, strengthened hand hygiene, and regular IPC assurance processes, with continued monitoring of MSSA rates to assess impact and drive further improvement.

SFT: Targeted education and surveillance continues

RUH: A programme of ongoing mitigation is in place which includes compliance audits and monitoring to support improvement.

Falls per 1000 bed days



Falls per 1000 bed days

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Falls per 1000 bed days	Group			Apr-26	5.4				Common Cause Variation
Falls per 1000 bed days	GWH			Apr-26	4.3				Common Cause Variation
Falls per 1000 bed days	RUH			Apr-26	6.4				Common Cause Variation
Falls per 1000 bed days	SFT		7.0	Apr-26	5.9	✓			Common Cause Variation

Understanding Performance

Group: Falls performance remains better than the national average across the Group, with overall variation consistent with common cause. However, there is a higher rate observed at RUH, which is being monitored to understand local drivers and opportunities for improvement.

GWH: Falls performance at GWH continues to improve, with a sustained reduction over time indicating a positive and embedded improvement trajectory. 76 falls were reported in April compared to 77 falls reported in March 2026.

SFT: Falls rose slightly in April to 5.9 / 1000 bed days but remains below the Trust target of 7/1000 bed days.

RUH: 98% of inpatients did not fall during April 26. All falls are reviewed multi-professionally to identify opportunities for learning. Falls per 1,000 bed days in April were below the National Audit for inpatient falls (NAIF) benchmark of 6.6.

Countermeasures

GWH: Falls incidents continue to be reviewed through a weekly multidisciplinary panel, enabling learning to be identified and shared across teams to prevent recurrence and improve patient safety. There is focus on increasing meaningful activity for enhanced care patients and improving handover processes to ensure staff are clear on individual patients' mobility needs.

SFT: All wards have reviewed falls reduction A3 countermeasures. Performance had declined slightly during periods of escalation, high occupancy and acuity, but has improvement is noted following targeted interventions.

RUH: Compliance with recording lying and standing blood pressure to reduce postural hypotension, a common contributor to falls increased during April. Themes from a trust wide PSII are now included in the Fall's prevention and improvement group workplan.

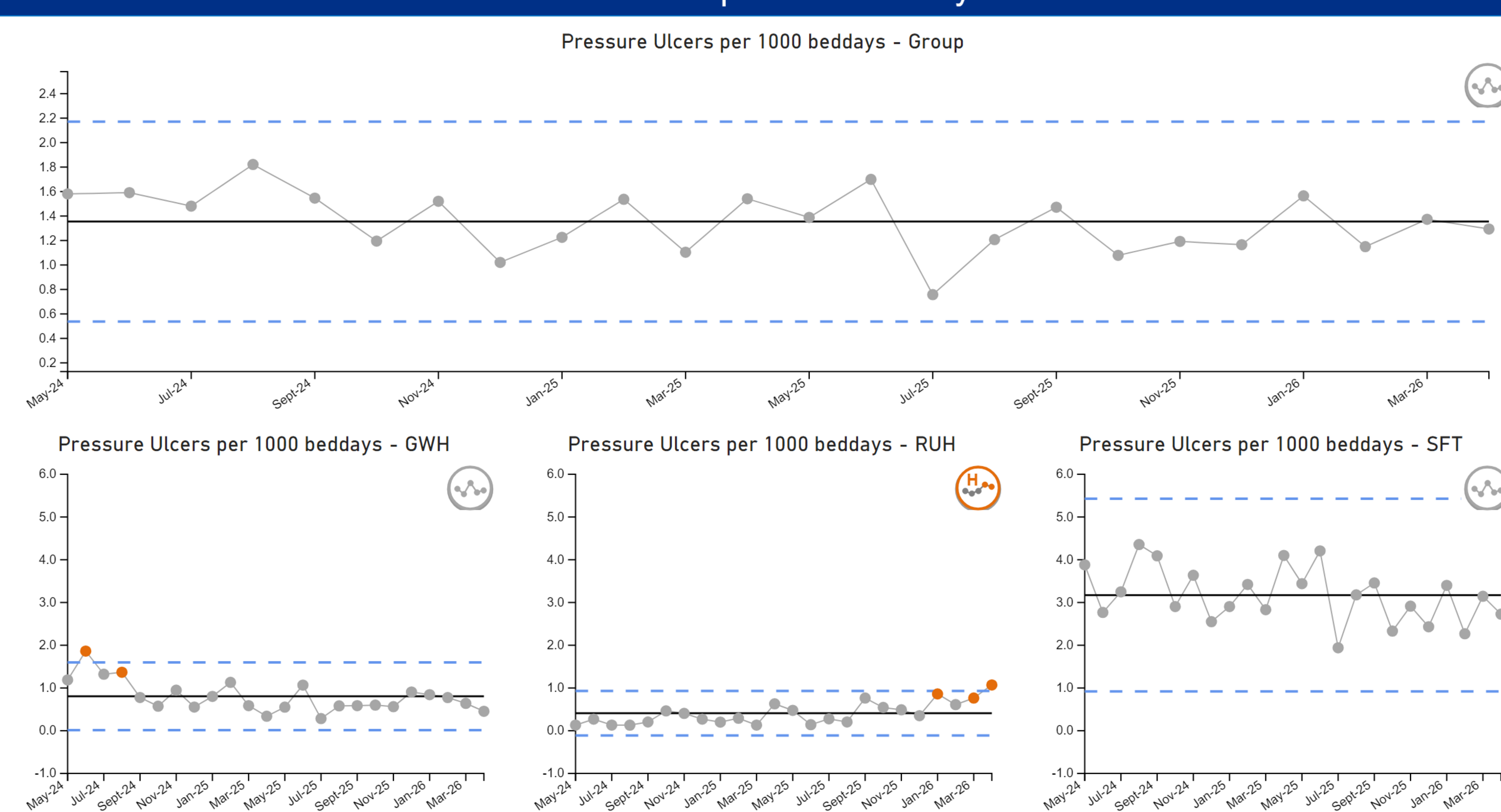
Risks and Mitigation

GWH: Continuing to embed the "Call – Don't Fall" and "Listen and Loiter" initiatives to reduce falls risk and improve proactive patient monitoring. Work is progressing with the Deconditioning programme to reduce risk of falls.

SFT: Staffing and patient safety are reviewed three times daily, with countermeasures refreshed. Use of escalation, areas and high acuity, along with a focus on reducing deconditioning / promoting mobility may be contributing to increased falls; however, incidents resulting in moderate or greater harm remain low.

RUH: Lying and standing blood pressure compliance had been reducing, but the past 4 months has shown a steady increase. Focused work is being completed in several wards

Pressure Ulcers per 1000 beddays



Pressure Ulcers per 1000 beddays

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Pressure Ulcers per 1000 beddays	Group	Category 2/3/4, excluding specialist areas		Apr-26	1.3				Common Cause Variation
Pressure Ulcers per 1000 beddays	GWH	Category 2/3/4, excluding specialist areas		Apr-26	0.5				Common Cause Variation
Pressure Ulcers per 1000 beddays	RUH	Category 2/3/4, excluding specialist areas		Apr-26	1.1			H	Special Cause Concerning - Above Upper Control Limit
Pressure Ulcers per 1000 beddays	SFT	Category 2/3/4, excluding specialist areas		Apr-26	2.7				Common Cause Variation

Understanding Performance

Group: Pressure harm rates remain low across all 3 Care Organisations in April 2026.

GWH: Pressure harm has remained stable with 8 hospital acquired pressure harms in month. A rate of 0.5 per 1000 bed days.

SFT: The Trust has recorded a reduction in overall Category Pressure Ulcers (PUs) in April, decreasing from3.1 to 2.7 per 1,000 Occupied Bed Days (OBDs). This includes a reduction in Category 2 PUs and Category 3PUs while no Category 4 PUs have been reported for five consecutive months.

RUH: For April 2026, the RUH reported 1.1 pressure ulcers per 1,000 bed days (19 pressure ulcers).

Countermeasures

Group: A standardised BSW-wide approach continues to be developed, focusing on early identification of at-risk patients, consistent reporting and shared learning to reduce variation.

GWH: Teams are strengthening how to identify and manage Moisture-Associated Skin Damage (MASD), while improving the quality and timeliness of risk assessments for pressure ulcers.

SFT: Trust wide PU steering group in place with multi-professional representation. MASD trolley dash sessions to continue throughout the year to sustain momentum. A Rapid Improvement Event is commencing to reduce MASD incidence, alongside ongoing work to enhance PU data collection and improve ward-level access to timely, actionable data.

RUH: Targeted countermeasures are in place, led by the Tissue Viability Improvement Group. The Pressure Ulcer task and finish group are using quality improvement methodologies including listening exercises with staff to understand the barriers for providing preventative measures.

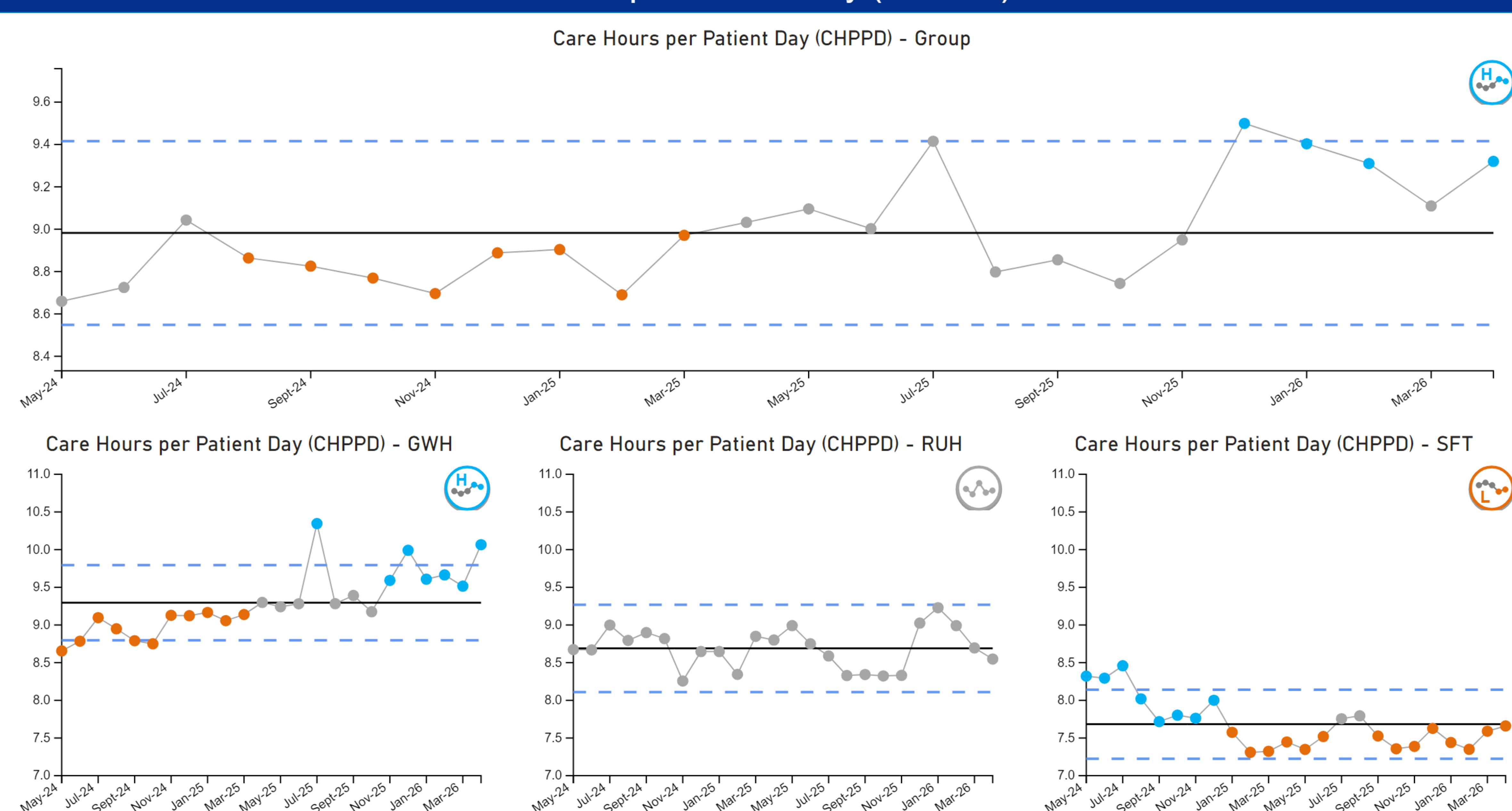
Risks and Mitigation

GWH: Focus on ensuring consistent, accurate assessments so patients receive the right care as early as possible. This is being supported through enhanced staff training, including a planned specialist masterclass in May, with further sessions booked to sustain and build on this progress.

SFT: Increased ED waits, high bed occupancy, and patient ward transfers are elevating pressure ulcer risk. High levels of MASD continue to increase the risk of skin breakdown, targeted education from the Tissue Viability team is ongoing to mitigate impact.

RUH: There is a risk that the lack of timely skin bundle assessments will impact on the ability to reduce avoidable pressure ulcers. The Tissue Viability Improvement Group monitors compliance with the matrons who work with the clinical area to implement improvements.

Care Hours per Patient Day (CHPPD)



Care Hours per Patient Day (CHPPD)

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Care Hours per Patient Day (CHPPD)	Group			Apr-26	9.3				Special Cause Improving - Two Out of Three High
Care Hours per Patient Day (CHPPD)	GWH			Apr-26	10.1				Special Cause Improving - Above Upper Control Limit
Care Hours per Patient Day (CHPPD)	RUH			Apr-26	8.5				Common Cause Variation
Care Hours per Patient Day (CHPPD)	SFT			Apr-26	7.7				Special Cause Concerning - Run Below Mean

Understanding Performance

GWH: CHPPD hours and reporting at GWH continue under review to provide assurance that data extracted from HealthRoster and Power BI is accurate, following the identification of discrepancies. However, it is recognised that the increased in CHPPD is linked to increased ETOC requirements and use of escalation areas.

SFT: CHPPD increased for a second consecutive month to 7.7, with a 2.5% improvement in fill rate supporting higher staffing presence. ETOC demand remains high, with 2,077 registered 1:1 hours delivered, predominantly via RMN agency.

RUH: In April CHPPD is 8.5. Since December 2025 we have seen an overall decrease in the total CHPPD. The CHPPD variance corresponds with the reduced fill rates below 90% on day shifts and additional escalation capacity open within inpatient units. When reviewed on Model Hospital (latest data available March 2026) we remain in quartile 3 and benchmark just below the provider median of 8.8

Countermeasures

GWH: A targeted reconciliation exercise is underway to validate CHPPD data flows from HealthRoster through to Power BI, including parameter checks, roster assumptions, and alignment with national CHPPD definitions.

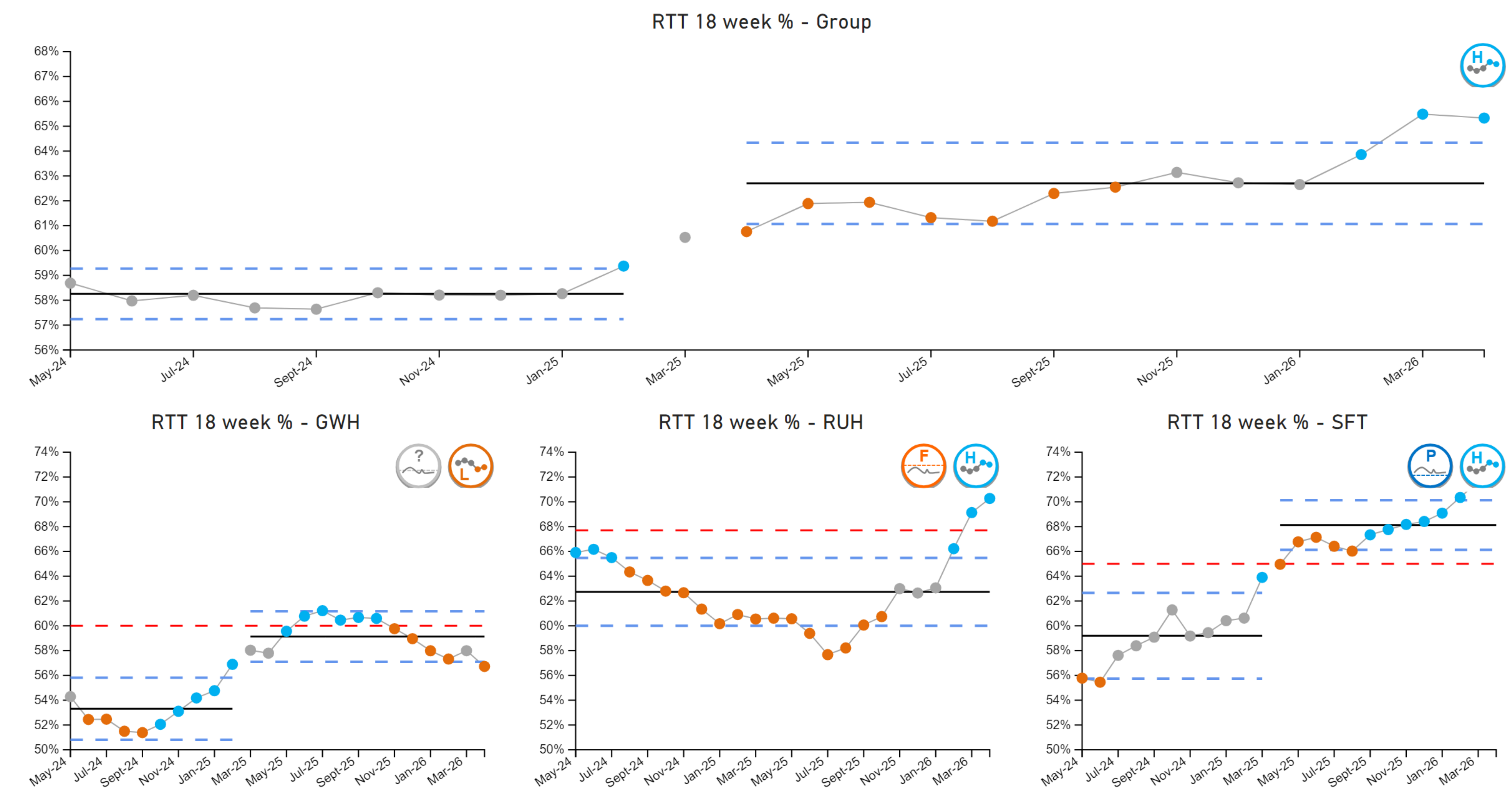
SFT: Assurance and scrutiny for above-establishment shifts (including ETOC requests) sits with Divisional Directors of Nursing, ensuring all options are considered prior to use. Weekly staffing reviews provide ongoing assurance of safe staffing, appropriate temporary staff use and effective absence management.

RUH: Twice daily safer staffing reviews in conjunction with monthly retrospective and prospective roster reviews. Alignment of temporary staffing usage, professional judgement and safer staffing assurance.
Active recruitment to Health Care Support Worker and registrant vacancies continues.

Risks and Mitigation

Group: Work is commencing with the regional workforce lead to benchmark staffing and “staff available” metrics, addressing risks associated with data accuracy, workforce resilience and sustained temporary staffing reliance.
GWH: Recognition that inaccurate CHPPD reporting may lead to misleading internal or system-level assurance. Use triangulated sources (professional judgement, safer staffing reviews, quality indicators) to inform decisions while the review is completed, rather than CHPPD in isolation.
SFT: Sickness absence remains high, impacting staffing and requiring enhanced oversight, with risks escalated via the Quality Hotspot framework. Reliance on agency RMNs for ETOC continues to drive financial pressure and reduce continuity of care; improvement work is underway with NHSE to strengthen oversight and reduce dependency
RUH: The risks identified from SafeCare in April show a sustained increase in levels of short-term absence, alongside existing vacancy and the operational need for additional escalation capacity, which is reviewed at the twice daily safer staffing meetings chaired by a senior nurse.

RTT 18 week %



RTT 18 week %

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
RTT 18 week %	Group			Apr-26	65.3%				Special Cause Improving - Above Upper Control Limit
RTT 18 week %	GWH		60.0%	Apr-26	56.7%	✗			Special Cause Concerning - Below Lower Control Limit
RTT 18 week %	RUH		67.7%	Apr-26	70.3%	✓			Special Cause Improving - Above Upper Control Limit
RTT 18 week %	SFT		65.0%	Apr-26	71.5%	✓			Special Cause Improving - Above Upper Control Limit

Understanding this metric... Variation and Assurance icons are not shown on the scorecard because the metric was re-based from Mar-25 and we have not yet collected the minimum of 12 data points. In this edition of the IPR we are trialling rebasing the SPCs which show significant statistical change over 6 months or more. This is explained further in the narrative.

Understanding Performance

Group

Group 18-week performance improved steeply due to the impact of the Q4 RTT sprint. April saw a slight drop in performance largely due to a deterioration in the GWH position.

GWH performance dropped from 58% to 56.7% largely due to the impact of extended validation on the March position improving it which then dropped again in April.

RUH performance continued to improve by a further 1.2% month-on-month due to ongoing recovery plans and increased focus on high volume specialties.

SFT performance continued its strong performance improvement that has been seen in 25/26.

Countermeasures

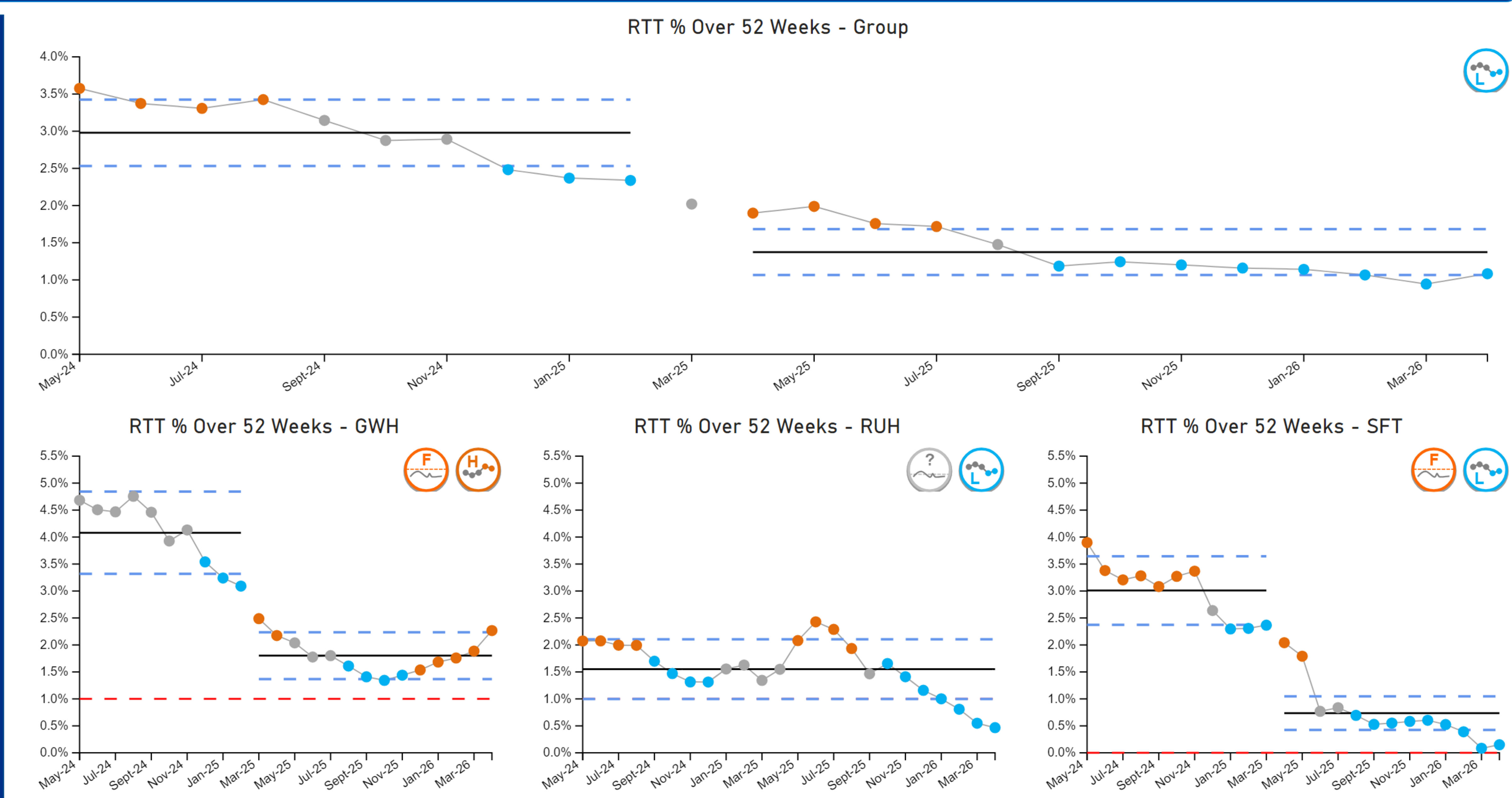
System

- Performance improvement has been strong at both RUH and SFT and so the countermeasures currently in place in those organisations will continue. Risks exist in both organisations linked to rising demand and delivery of the waiting list plan.
- GWH performance remains challenged due to a combination of lack of capacity, incorrect waiting list data, and the impact of winter pressures. A recovery plan has now been drafted setting out five key programmes of work to sustain this improvement in 26/27. This includes: further validation of the waiting list, bottom-up trajectories, improvements to outpatient processes, specialty-owned recovery plans and revised governance. An Elective Recovery Director has been appointed to support this work.

Risks and Mitigation

- Risk: demand increases due to Referral Support Service closure in Q1. Mitigation: size of risk clearly quantified, monitor any demand increase seen in Q1, work with ICB to review mitigations to ensure demand not increased.
- Risk: adoption of 100% advice and refer for next year will support demand reduction but will require extensive redesign. Mitigation: BSW A+R group in place to coordinate approach. Each CO has strong leadership and programme of redesign.
- Risk: delivery of target waiting list position. Mitigation: position report written for all COs outlining context and mitigating actions. RUH and SFT plan – aim to resubmit given changes in demand and recording.

RTT % Over 52 Weeks



RTT % Over 52 Weeks

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
RTT % Over 52 Weeks	Group			Apr-26	1.1%				Special Cause Improving - Two Out of Three Low
RTT % Over 52 Weeks	GWH		1.0%	Apr-26	2.3%	X			Special Cause Concerning - Increasing Run
RTT % Over 52 Weeks	RUH		1.0%	Apr-26	0.5%	✓			Special Cause Improving - Decreasing Run
RTT % Over 52 Weeks	SFT		0.0%	Apr-26	0.1%	X			Special Cause Improving - Below Lower Control Limit

Understanding this metric... Variation and Assurance icons are not shown on the scorecard because the metric was re-based from Mar-25 and we have not yet collected the minimum of 12 data points. In this edition of the IPR we are trialling rebasing the SPCs which show significant statistical change over 6 months or more. This is explained further in the narrative.

Understanding Performance

Group

Group 52-week performance deteriorated slightly in month due to increases particularly at GWH due to the impact of rising waiting lists during 25/26.

GWH position continued to deteriorate in April. Specialties with the greatest issues are all in the Surgery Division: Urology, General Surgery, Orthopaedics.

RUH performance continues to improve and is monitored weekly via the RUH Elective Delivery Group. Plans aim to clear all 52 week waits by end Q2.

SFT performance deteriorated slightly but is very high performing compared nationally with only 45 patients waiting.

Countermeasures

GWH countermeasures are as per those outlined for 18 weeks including the five priority areas for recovery. Specific capacity/demand work is underway in General Surgery, Orthopaedics and Urology given their significant contribution to Trust performance .

RUH performance is monitored via the weekly exec-led Elective Recovery Group which includes monitoring of 52 weeks. A target of 0 52-week breaches has been set internally for end of September. Specific specialties requiring focus are pain, general surgery, and neurology.

SFT continue their COO-led focus on 52 weeks with a goal of ensuring no waits over 52 weeks.

Risks and Mitigation

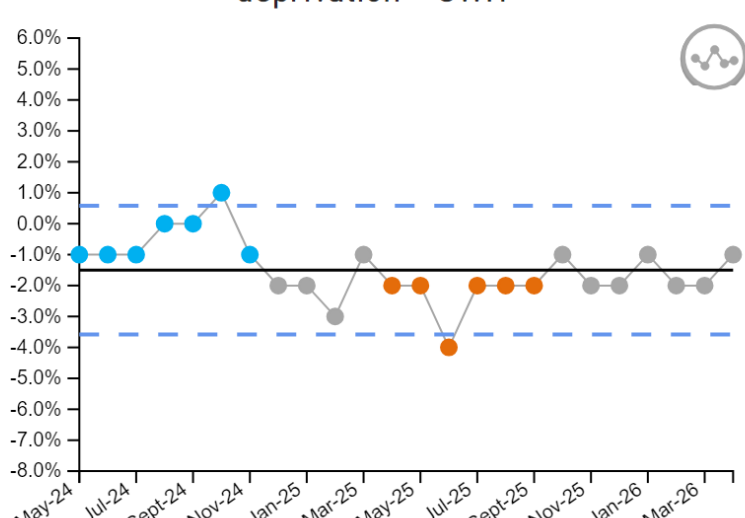
Risks similar to 18-week RTT delivery. However, some specific risks for long waiting patients.

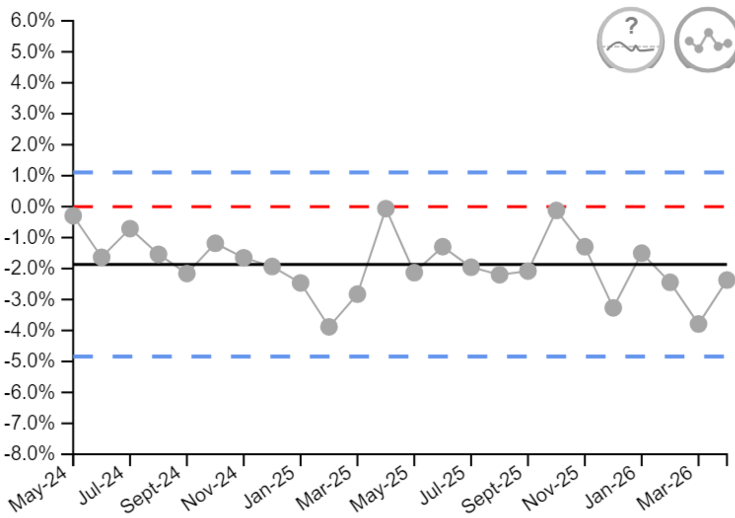
- Risk: high demand for general surgery being seen across Group. Mitigation: specific recovery plans in place at each CO with information being shared on approaches being taken. Risk escalated to ICB.
- Risk: orthopaedics capacity at GWH. Mitigation: identifying clear recovery plans for GWH including internal capacity, outpatient wait reduction, and partnership work with Sulis.

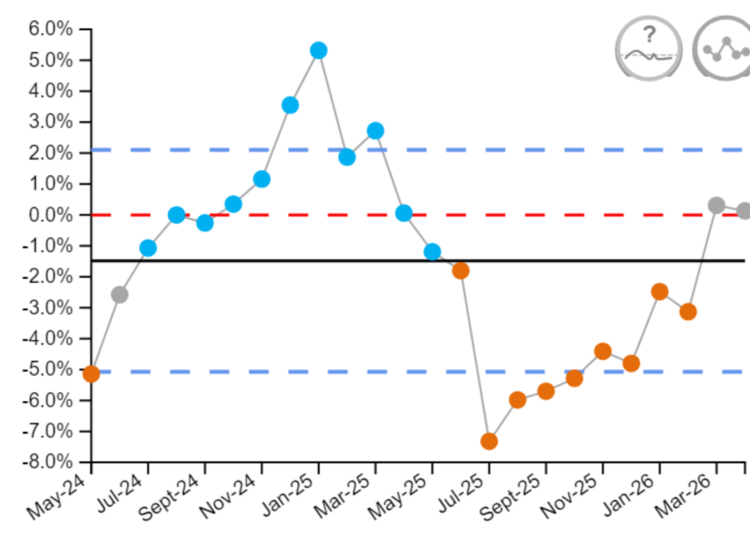
RTT wait times top versus bottom quintile of social deprivation

Please note that the RTT social deprivation metric cannot be aggregated across multiple trusts.

Understanding this metric... A value of 0% indicates that RTT performance was the same for the top and bottom quintiles of social deprivation. A negative value means that RTT performance was poorer for patients in the highest quintile of social deprivation, i.e. the most deprived areas.







RTT wait times top versus bottom quintile of social deprivation

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
RTT wait times top versus bottom quintile of social deprivation	GWH			Apr-26	-1.0%				Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	RUH		0.0%	Apr-26	-2.4%	✗			Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	SFT		0.0%	Apr-26	0.1%	✓			Common Cause Variation

Understanding this metric... A value of 0% indicates that RTT performance was the same for the top and bottom quintiles of social deprivation. A negative value means that RTT performance was poorer for patients in the highest quintile of social deprivation, i.e. the most deprived areas.

Understanding Performance

The data currently shows limited variation in RTT performance between the top and bottom quintiles of social deprivation for each of the 3 acute Trusts. There has been consistent and sustained improvements in the performance data for SFT since July '25, which brings all 3 Trusts close to the mean average, but slightly short of the 0% variation target. Each with common cause variation.

Collectively, we have a good understanding of where our CORE20population is and have established governance meetings in each Trust where health inequalities are regularly being discussed.

The health inequalities leads across the 3 Trusts have regular meetings to discuss our performance data and approach to tackling health inequalities, and to identify shared learning or actions that can be taken collectively to improve patient outcomes. An in-person meeting took place in May focusing on the NHSE statement on health inequalities and our operationalisation of this. Agreed actions have been summarised in the countermeasures section.

Countermeasures

Cross-Trust (SFT, RUH, GWH): Health Inequalities Leads met in May and agreed to work more closely together via 7 shared actions: to align dashboards and CORE20 reporting; review and standardise forms, templates, and governance processes to embed health inequalities considerations more consistently; share best practice (incl. GWH Equity Framework); run a joint awareness campaign (planned for June 2026); develop shared training/resources; and maintain regular joint oversight and annual review.

Other actions being taken:

SFT: Refreshing A3 with Public Health input; 2 BSW-funded paediatrics and cancer projects to reduce inequalities; Wiltshire workshop to focus priorities and partnership working aligned to BSW inequalities strategy.

RUH: Targeted follow-up for missed appointments in deprived groups; pilots on digital exclusion; University of Bath research on urgent and emergency care by deprivation; A3 refresh underway.

GWH: Developing a health inequalities dashboard aligned to NHSE board requirements.

Risks and Mitigation

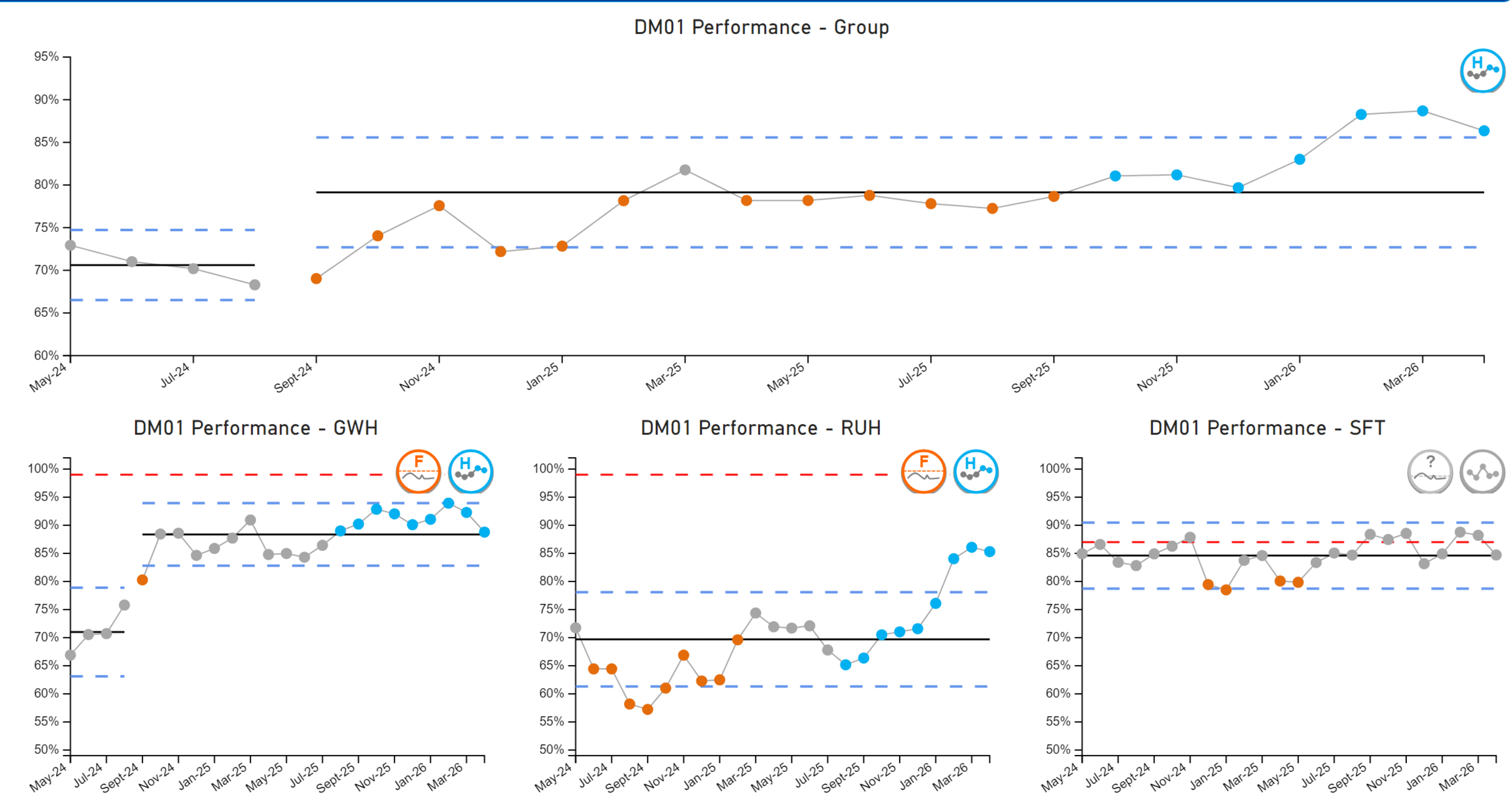
There is a degree of operational complexity in factors that drive the data. The is mitigated through having good oversight of the data and having established governance groups across the group with focus on reducing health inequalities. There is also significant variation in governance structures, reporting arrangements, and priorities across the three Trusts, which may affect alignment and delivery.

SFT: The Ops HI Group feeds into the wider Wiltshire Health Inequalities Group (WHIG). Additional groups operate in BANES (meeting bi-monthly) and Swindon (established summer 2025).
GWH: An internal Inclusion and Health Inequalities Sub-Committee meets bi-monthly. The Health Inequalities Lead also attends the quarterly Performance, Population and Place Committee.
RUH: Re-establishing an internal operations group to support health inequalities work.

Planned mitigations include looking to establish:

- Joint BI and EPR working groups.
- Shared templates, frameworks, and reporting approaches.
- Common education and awareness resources.
- Regular collaborative meetings and Board-level engagement to maintain oversight and accountability.

DM01 Performance



DM01 Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
DM01 Performance	Group			Apr-26	86.4%				Special Cause Improving - Above Upper Control Limit
DM01 Performance	GWH		99.0%	Apr-26	88.8%	X			Special Cause Improving - Run Above Mean
DM01 Performance	RUH		99.0%	Apr-26	85.3%	X			Special Cause Improving - Above Upper Control Limit
DM01 Performance	SFT		87.0%	Apr-26	84.7%	X			Common Cause Variation

Understanding Performance

Group
Group DM01 performance dropped slightly in April due to deteriorations across all three COs driven by some consistent issues in endoscopy, audiology.

GWH performance remains best in group at 88.8% but dropped due to issues in endoscopy linked to CDC mobilisation, and echo.

RUH performance deteriorated slightly partly due to a reduction in the total diagnostic waiting list due to reduced referrals in April.

SFT performance reduced and was impacted by issues in MRI and audiology.

Countermeasures

System
- CDC utilisation reviewed at monthly Diagnostic Delivery Group - M2 plan shows delivery of activity plan across all COs – a significant improvement on 25/26.
- Diagnostic pathway programme to be delivered during 26/27 focussing on gastro, cardiology and Audiology to improve pathways.

GWH. Recovery plan in place and delivering for endoscopy capacity in the CDC with activity above plan. Ultrasound capacity increased to reduce backlog.

RUH. Performance recovery plans continue into 26/27 with capacity aligned in RUH and Sulis CDC. Key areas of focus include endoscopy, DEXA and ultrasound.

SFT. Focus on audiology recovery given recruitment and staffing issues. MRI provision issue now resolved which should improve capacity.

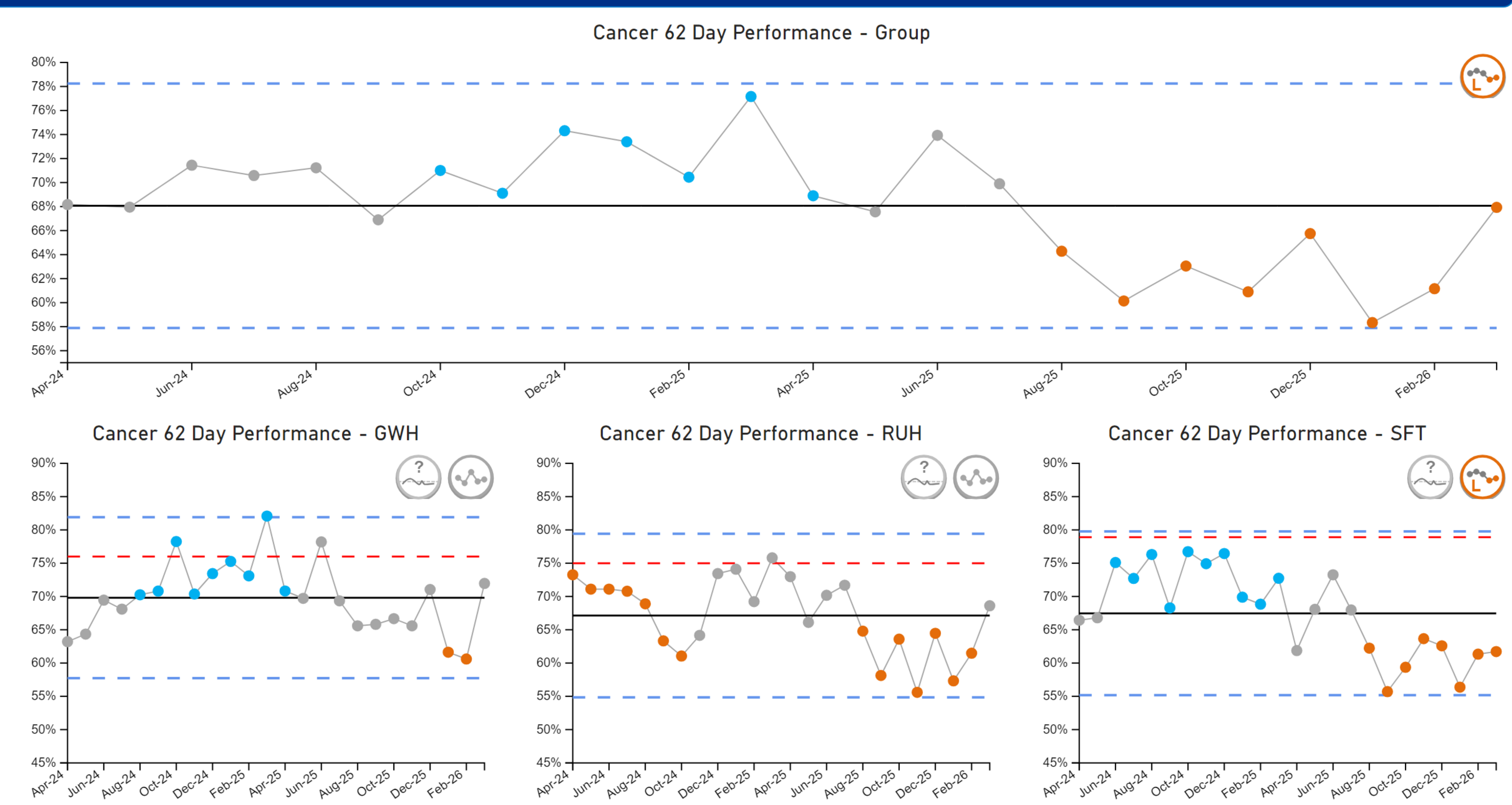
Risks and Mitigation

- Risk: CDC revenue insufficient for planned capacity. Mitigation: risks flagged to region however significant income risk remains especially for Sulis which may need to reduce capacity.

- Risk: SFT activity against CDC plan given capacity issues in radiology. Mitigation: Now resolved - SFT have recovered delivery of plan in M2.

- Risk: system-wide workforce challenged. Mitigation: working group established to develop workforce plan in most challenged modalities starting with Sonography. Proposal coming to July Diagnostic Delivery Group.

Cancer 62 Day Performance



Cancer 62 Day Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Cancer 62 Day Performance	Group			Mar-26	67.9%				Special Cause Concerning - Run Below Mean
Cancer 62 Day Performance	GWH		76.0%	Mar-26	72.0%	X			Common Cause Variation
Cancer 62 Day Performance	RUH		75.0%	Mar-26	68.6%	X			Common Cause Variation
Cancer 62 Day Performance	SFT		78.9%	Mar-26	61.7%	X			Special Cause Concerning - Run Below Mean

Understanding Performance

Group
Group 62 day performance improved significantly to 67.9% due to recovery plans across all sites.

GWH performance improved significantly. Urology remains a particular issue still with 28% of breaches linked to Urology and 26% to Breast.

RUH performance delivered a significant improvement thanks to particular improvements in colorectal. Key challenges remain in skin and urology.

SFT performance improved to 61.7% and the number of patients waiting over 62 days dropped to the lowest point since last summer.

Countermeasures

System
Tele-dermatology project continues roll out strong uptake in Bath and further work to do to improve primary care referrals to Salisbury.

GWH. Radiology recruitment will improve urology pathway delays. Increasing Breast OP clinics to reduce waits. Dermatology in-sourcing to improve capacity.

RUH Specific focus on improving access in colorectal, skin and urology via improved diagnostic access, outpatient waits and PTL rigour.

SFT. Review of booking processes and timed pathways underway. Performance Recovery Plan reviewed by COO to ensure delivery of improvements.

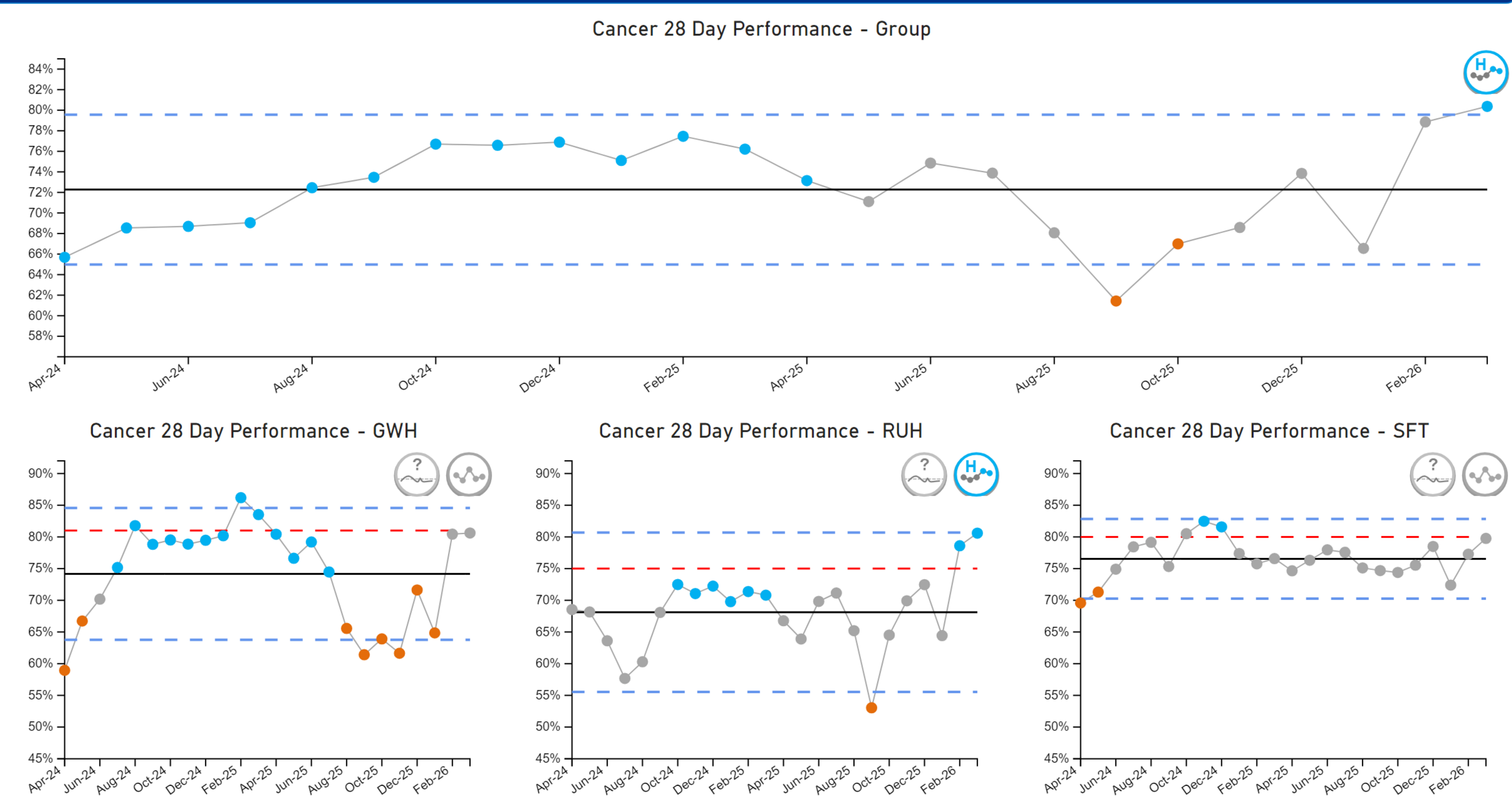
Risks and Mitigation

- Risk: dermatology cancer demand high across system. Mitigation: BSW Dermatology Programme now launched – sprint taking place between July to September to determine new service model for BSW.

- Risk: plastics service at GWH reliant on Oxford outreach model. Mitigation: GWH and SFT reviewing alternative options to deliver improved capacity within system.

- Risk: cancer demand continuing to grow. Mitigation: robust capacity planning required in all Trusts to ensure sufficient capacity especially in diagnostics.

Cancer 28 Day Performance



Cancer 28 Day Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Cancer 28 Day Performance	Group			Mar-26	80.4%				Special Cause Improving - Above Upper Control Limit
Cancer 28 Day Performance	GWH		81.0%	Mar-26	80.6%	✗			Common Cause Variation
Cancer 28 Day Performance	RUH		75.0%	Mar-26	80.6%	✓			Special Cause Improving - Two Out of Three High
Cancer 28 Day Performance	SFT		80.0%	Mar-26	79.8%	✗			Common Cause Variation

Understanding Performance

Group
Group 28-day performance improved significantly due to improvements in all three COs.

GWH performance improved slightly month on month with particular issues remaining for outpatient appointments in colorectal and breast.

RUH performance improved to 80.6% due to improvements in skin particularly.

SFT performance improved and has seen improvements particularly in urology due to improved biopsy capacity. Colorectal remains a challenge.

Countermeasures

System
- Cancer Alliances providing funding to BSW Trusts to support capacity in-year and recovery of standards.
- CDC mobilisation supporting diagnostic capacity in challenged areas including endoscopy.

GWH. Additional capacity required particularly to reduce outpatient waits in breast and colorectal. These are included in Trust recovery plans.

RUH. Continued focus on dermatology, urology, breast and colorectal to drive improvements in timed pathways.

SFT. Continued focus especially in dermatology and plastics is key to improvement performance further this includes outsourcing plus teledermatology roll out.

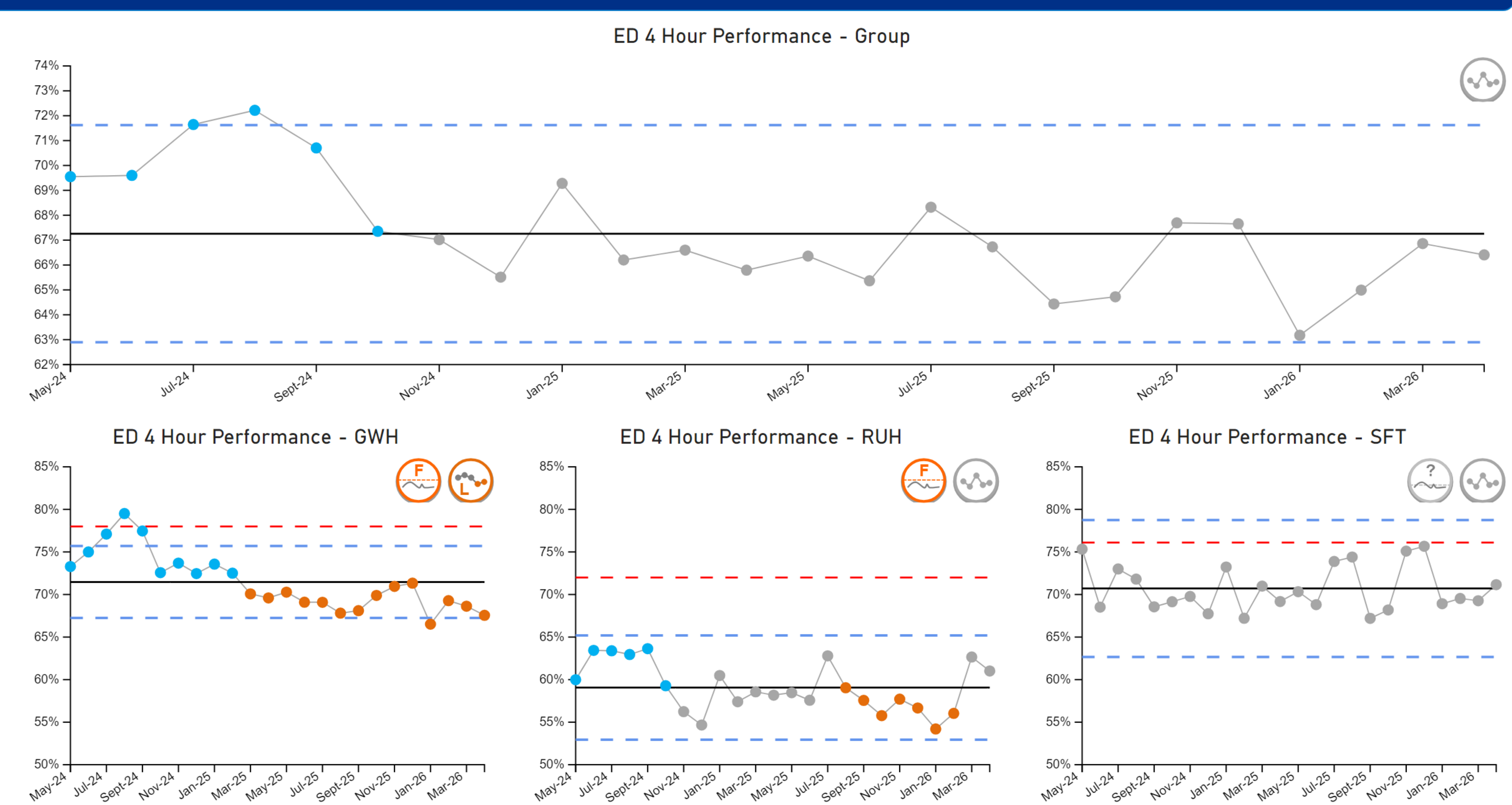
Risks and Mitigation

- Risk: diagnostic demand for cancer exceeds capacity. Mitigation: CDC programme increasing diagnostic capacity across BSW to ensure prompt and local diagnosis.

- Risk: dermatology capacity insufficient for demand. Mitigation: short-term focus on increasing triage of dermatology referrals using tele-derm hubs. Longer-term revised service for BSW to be developed and commissioned including revised roles to deliver care.

- Risk: consistent challenges in similar specialties that are seen nationally: urology, colorectal, dermatology. Mitigation: each CO has recovery plans in these areas, is supported by SWAG to review best practice, and is linked to national work focussed on improving these pathways.

ED 4 Hour Performance



ED 4 Hour Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
ED 4 Hour Performance	Group	All Types		Apr-26	66.4%				Common Cause Variation
ED 4 Hour Performance	GWH	All Types	78.0%	Apr-26	67.6%	X			Special Cause Concerning - Two Out of Three Low
ED 4 Hour Performance	RUH	All Types	72.0%	Apr-26	61.0%	X			Common Cause Variation
ED 4 Hour Performance	SFT	All Types	76.1%	Apr-26	71.2%	X			Common Cause Variation

Understanding Performance

Achievement of 4-hour performance remains challenging and currently the Trusts are not delivering against plan with no overall improvement in the group position . The likelihood of achievement of the 4-hour standard as set out in planning for 25/26 is low due to trajectory that was set at the outset. GWH is the most challenged with the RUH seeing some improvement in month.

4-hour performance is an overall indicator of system flow not just of ED processes and this continues to be a challenge across BSW both in acute trusts and across the system. Whilst there was a tolerance of 2% growth included in the planning for 25/26 there is significant variability in the profile of that demand presenting at EDs and this creates significant challenges in the ability to meet the demand at times of surge. We continue to see increased demand across all but particularly noted for RUH and GWH in terms of ambulance conveyance.

Countermeasures

- Each organisation has an improvement plan that focuses on ED process improvements incorporating actions to increase SDEC capacity to avoid attendance at ED. RUH have a refreshed plan focusing on ED.
- There is a system wide care coordination (Care Co) function that is key to ensuring only appropriate patients conveyed to acute trusts to ensure the right patients present at EDs
- There is refocused UEC reset being planned to support system improvement.
- System wide groups are in place to support delivery of alternatives to ED conveyance
- Ongoing improvements in SWASFT to improve see and treat and hear and treat numbers.
- Front door event with Health Hero and key stakeholders in Care co in May 2026.
- UEC Winter summit July 15th

Risks and Mitigation

R – lack of community capacity leading to delays in discharge

M – ongoing demand profiling across the system to ensure the correct capacity is in place to meet demand

R – the ability for internal and system responses to keep with the pace of change needed

M- trust and system oversight of challenges with escalation processes

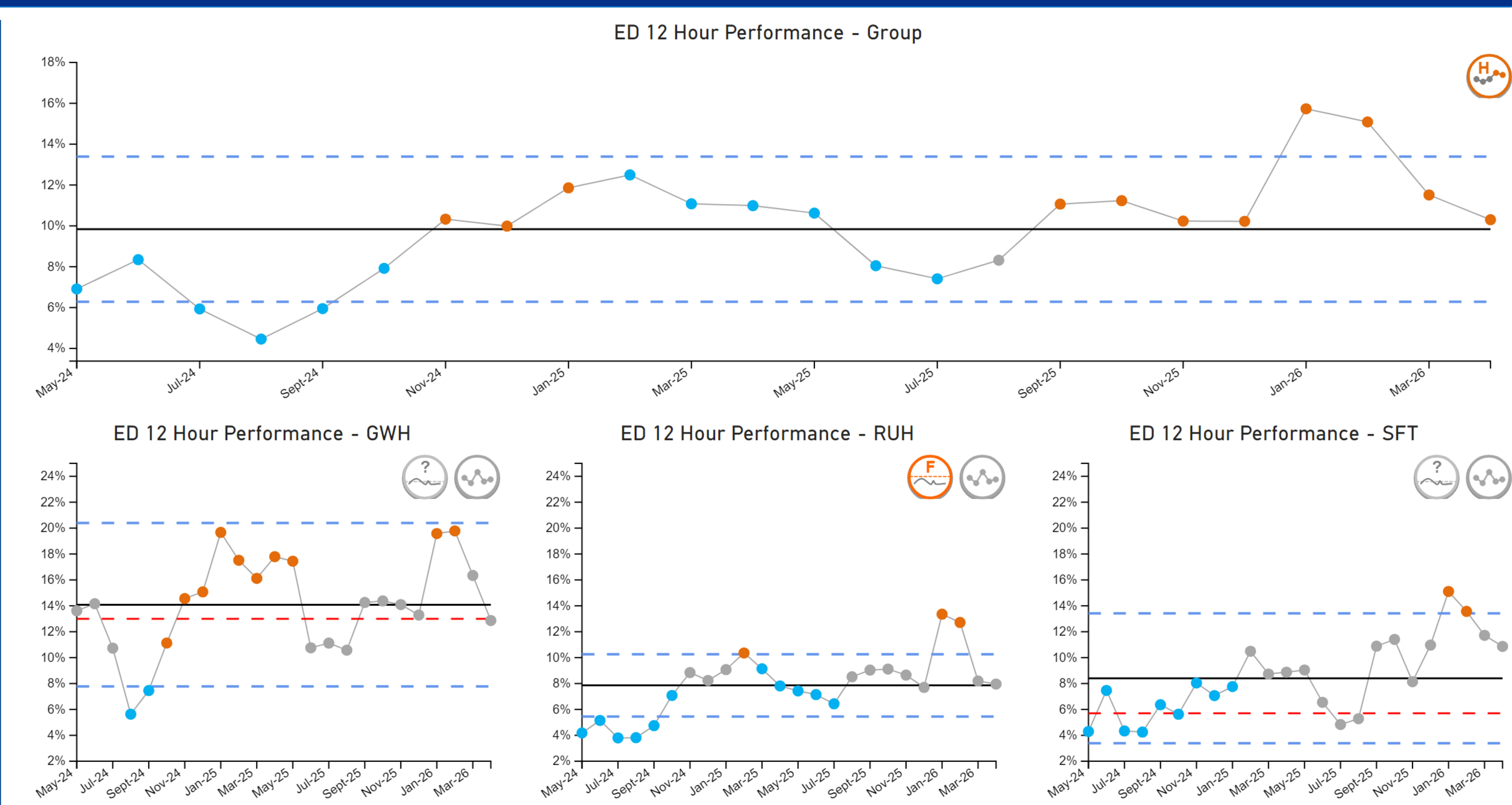
R – we are noting an increase in complexities of patient needs on discharge pathways

M- locality discussions about local issues and actions taken to reduce delays in processes for the P1-3 demand

R - Reporting and recording highlights under reporting

M – pragmatic decision across all acutes to record the relevant information and where the NCTR and DRD are the same report as such

ED 12 Hour Performance



ED 12 Hour Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
ED 12 Hour Performance	Group	Type 1 and Type 2 attendances		Apr-26	10.3%			H	Special Cause Concerning - Run Above Mean
ED 12 Hour Performance	GWH	Type 1 and Type 2 attendances	13.0%	Apr-26	12.9%	✓	?		Common Cause Variation
ED 12 Hour Performance	RUH	Type 1 and Type 2 attendances	0.0%	Apr-26	8.0%	✗	F		Common Cause Variation
ED 12 Hour Performance	SFT	Type 1 and Type 2 attendances	5.7%	Apr-26	10.9%	✗	?		Common Cause Variation

Understanding Performance

- Overall continued improvement in reducing 12hour delays, though above plan.
- Each organisation has an improvement plan that focuses on ED process improvements incorporating actions to increase SDEC capacity to avoid attendance at ED. RUH have a refreshed plan focusing on ED.
- There is a system wide care coordination (Care Co) function that is key to ensuring only appropriate patients conveyed to acute trusts to ensure the right patients present at EDs
- There is refocused UEC reset being planned to support system improvement.
- System wide groups are in place to support delivery of alternatives to ED conveyance
- Ongoing improvements in SWASFT to improve see and treat and hear and treat numbers.
- Front door event with Health Hero and key stakeholders held in Care co in May 2026.

Countermeasures

- Each organisation has an improvement plan that focuses on ED process improvements incorporating actions to increase SDEC capacity to avoid attendance at ED. RUH have a refreshed plan focusing on ED.
- There is a system wide care coordination (Care Co) function that is key to ensuring only appropriate patients conveyed to acute trusts to ensure the right patients present at EDs
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- Winter Debrief held in April with key learning to be shared and actions taken.

Risks and Mitigation

- Each organisation has an improvement plan that focuses on ED process improvements incorporating actions to increase SDEC capacity to avoid attendance at ED. RUH have a refreshed plan focusing on ED.
- There is a system wide care coordination (Care Co) function that is key to ensuring only appropriate patients conveyed to acute trusts to ensure the right patients present at EDs
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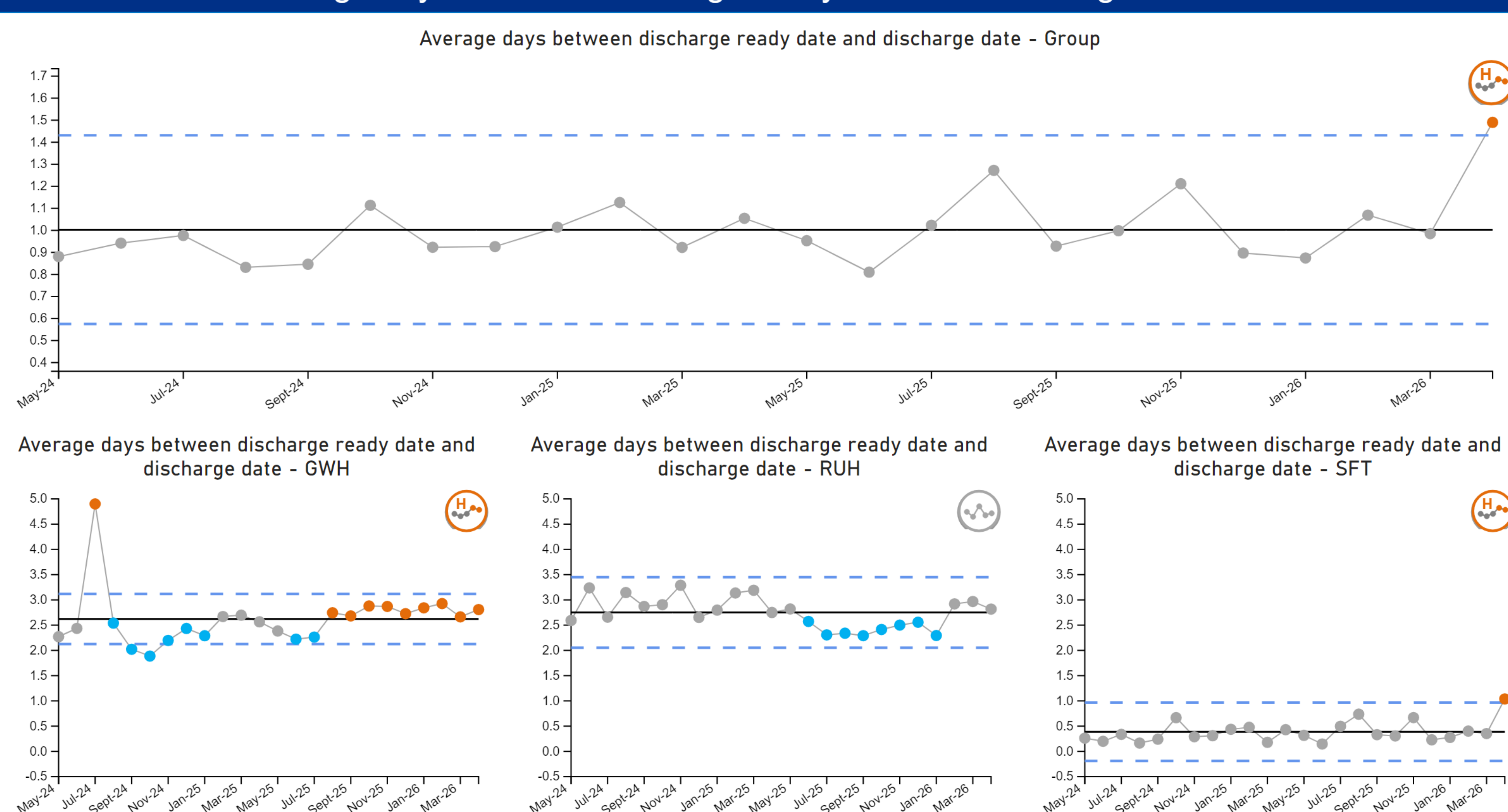
- Front door event with Health Hero and key stakeholders in Care co in May 2026.
- Winter Debrief held in April with key learning to be shared and actions taken.

Average days between discharge ready date and discharge date



Average days between discharge ready date and discharge date

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average days between discharge ready date and discharge date	Group			Apr-26	1.5				Special Cause Concerning - Above Upper Control Limit
Average days between discharge ready date and discharge date	GWH			Apr-26	2.8				Special Cause Concerning - Run Above Mean
Average days between discharge ready date and discharge date	RUH			Apr-26	2.8				Common Cause Variation
Average days between discharge ready date and discharge date	SFT			Apr-26	1.0				Special Cause Concerning - Above Upper Control Limit

Understanding Performance

There is no significant change to this indicator, other than deterioration in SFT. Continued focus on internal reporting and actions needed to reduce delays.
SFT continue to see the longest delays for P1-3 though data correction will see some change going forward.
Whilst it is recognised that there is some value in the recording of this as it is the same as the NCTR date, which is the measure currently used across the system to identify patients that are discharged on complex P1 to 3 pathways. P0 delays are reducing with internal focus across all three.
There are still some reporting challenges for this indicator as those patients that leave on the day that they become NCTR (mainly P0s) do not have a recorded DRD as it is assumed that this is the same as the NCTR date. This results in non-recording of the indicator.

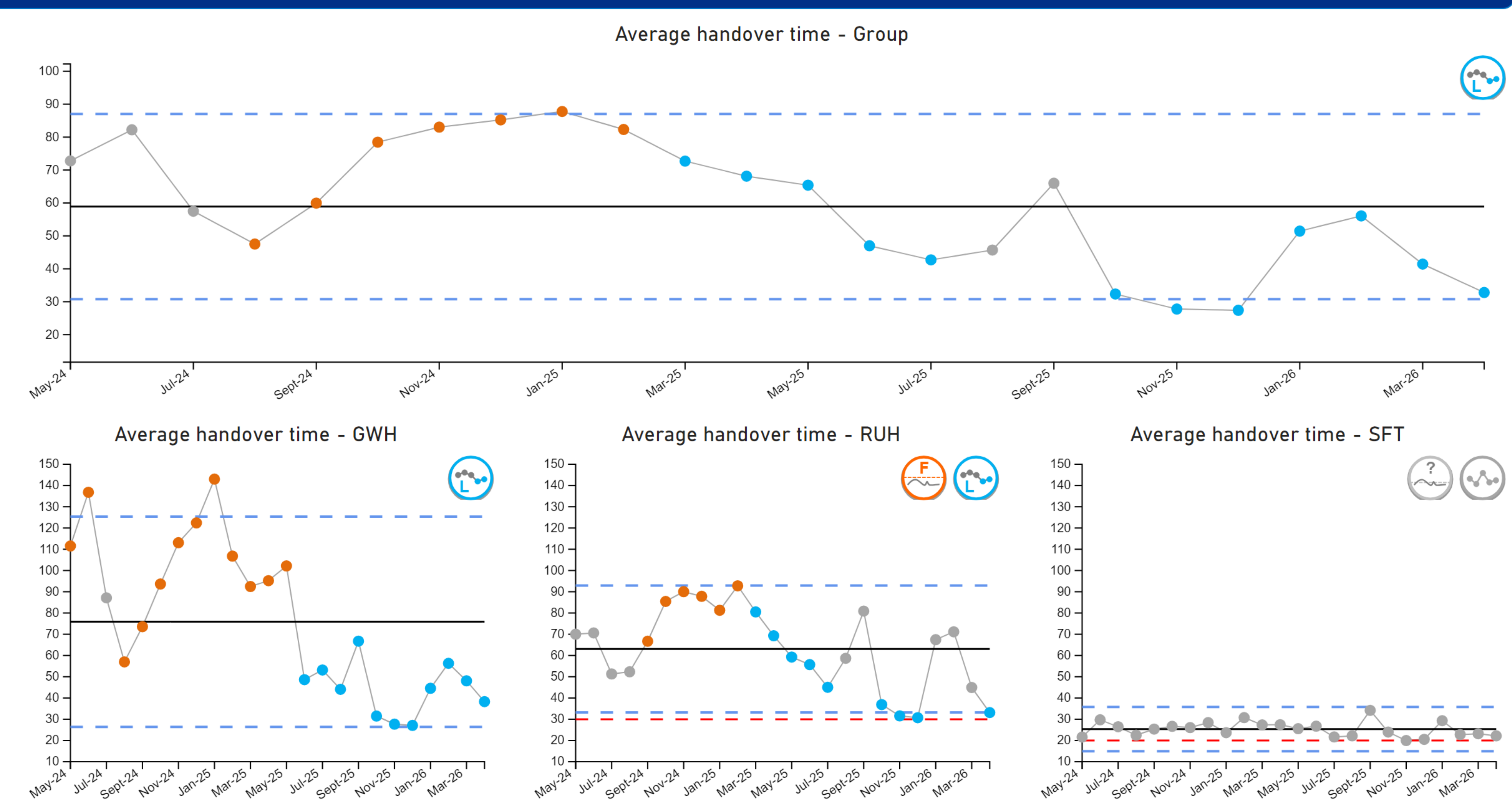
Countermeasures

- There is significant work ongoing in each organisation to reduce delays in discharging patients due to hospital reasons
- Internal improvement plans across all three trusts have actions and activities relating to reducing delays in P0 discharges and those that are more complex that have hospital actions
- Ongoing improvements in each Care Transfer Hub to reduce interface delays due to processes in place
- Shared learning of best practice and improvement through new forums to link operational and tactical discharge leads across the group
- Daily NCTR meetings to agree pathways and monitor progress on discharge planning for P1-3
- Escalation processes in place to ensure delays are unblocked and expedited, when outside of BSW tolerances set by pathway.
- UEC reset focus on NCTR going forward.

Risks and Mitigation

R – lack of community capacity leading to delays in discharge
M – ongoing demand profiling across the system to ensure the correct capacity is in place to meet demand
R – the ability for internal and system responses to keep with the pace of change needed
M- trust and system oversight of challenges with escalation processes
R – we are noting an increase in complexities of patient needs on discharge pathways
M- locality discussions about local issues and actions taken to reduce delays in processes for the P1-3 demand
R - Reporting and recording highlights under reporting
M – pragmatic decision across all acutes to record the relevant information and where the NCTR and DRD are the same report as such

Average handover time



Average handover time

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average handover time	Group	Minutes		Apr-26	33				Special Cause Improving - Run Below Mean
Average handover time	GWH	Minutes		Apr-26	38				Special Cause Improving - Run Below Mean
Average handover time	RUH	Minutes	30	Apr-26	33	X			Special Cause Improving - Below Lower Control Limit
Average handover time	SFT	Minutes	20	Apr-26	22	X			Common Cause Variation

Understanding Performance

Continued improvements in the performance of handover delays across all three acutes.
Significant focus on delivering the trajectory as set out in the plan.

Countermeasures

- One system approach for BSW handover delays taken with SWASFT and acutes collaboratively
- Senior ED teams engaged in local and across group discussions and sharing lessons learnt
- Implementation of W45 has led to different actions internally to support EDs across all acutes.
- Alignment of internal actions to ensure support to ED depts to off load ambulances within the maximum time of 45 minutes

Risks and Mitigation

R: continued system issues with flow M: actions being taken through UEC reset to reduce delays in processes, R: internal flow issues M: each acute has a UEC Improvement plan that is focusing on ED and ward improvements
R: demand increases at the Emergency Depts M: ICB Deep Dive into ambulance activity to understand drivers for the changes since October 2025.
R: ongoing corridor care M: see internal actions plans

Average Daily Number of Patients in Corridor Care within ED

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average Daily Number of Patients in Corridor Care within ED	Group			Apr-26	56.29				
Average Daily Number of Patients in Corridor Care within ED	GWH			Apr-26	28.73				
Average Daily Number of Patients in Corridor Care within ED	RUH			Apr-26	18.87				
Average Daily Number of Patients in Corridor Care within ED	SFT			Apr-26	8.69				

Charts are not provided for this metric because there is not yet enough data to draw a meaningful chart. The metric was newly introduced in March 2026.

Understanding Performance

In March 2026 NHSE published new guidance that outlined the additional actions that are required to eliminate corridor care. This is a system challenge that relates to poor flow out of the back door of the Emergency Depts and can also result in extra beds being placed in wards and other areas that are not designated bed spaces – definition within the document (NHSE March 26). Corridor care is recognised to happen in ED and across ward areas.
Each acute has set out a plan to reduce and eliminate corridor care however a system response is required.
A Group plan has been submitted to national and regional team with each acute having a plan for delivery of the improvement.
Increased system demand and W45 has impacted on ambulance conveyance to EDs.
Further developments in reporting to be undertaken.

Countermeasures

In March 2026 NHSE published new guidance that outlined the additional actions that are required to eliminate corridor care. This is a system challenge that relates to poor flow out of the back door of the Emergency Depts and can also result in extra beds being placed in wards and other areas that are not designated bed spaces – definition within the document (NHSE March 26). Corridor care is recognised to happen in ED and across ward areas.
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Risks and Mitigation

R: no reduction in system demand **M**: demand andcapacity modelling requested via system to ensure thatthere is adequate capacity to support good flow
R: non delivery of internal actions **M:** ongoing review ofplans and monthly UEC boards in place, oversight viaIPR and executive structures
R: Non delivery of system actions to support reduceddemand and no change in pathways **M:** system reset ofUEC governance and peer provider challenge andsupport to be put in place
R: Lack of oversight of UEC pathways that leads to nochange in the system position **M:** see above
R: No reduction in NCTR **M:** system reset of governance

Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	Group			Apr-26	9.46				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	GWH			Apr-26	4.43				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	RUH			Apr-26	0.00				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	SFT			Apr-26	5.03				

Charts are not provided for this metric because there is not yet enough data to draw a meaningful chart. The metric was newly introduced in March 2026.

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Further developments in reporting to be undertaken.
RUH have very few areas to board in and in March no corridor care outside of the ED.

Countermeasures

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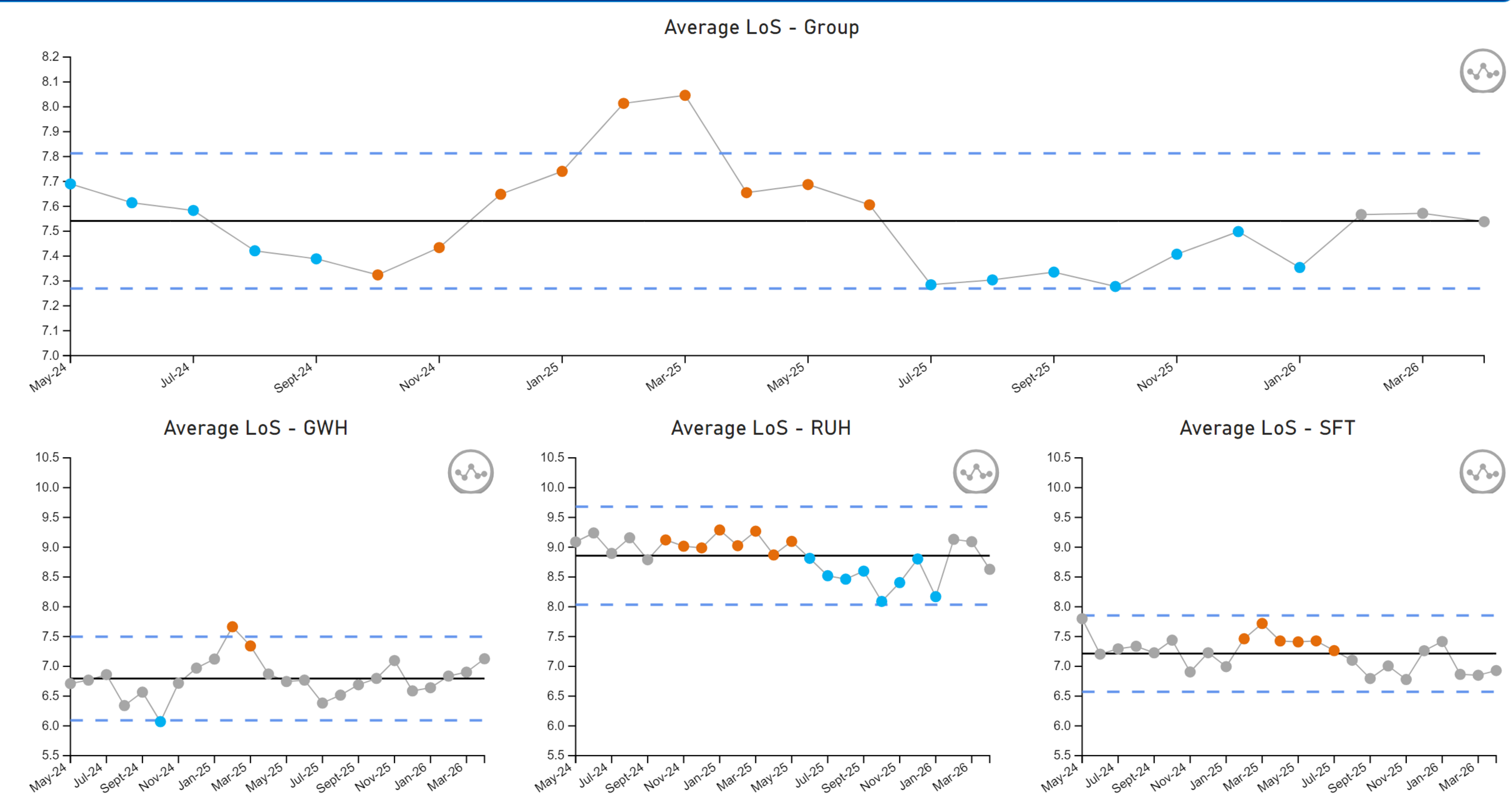
R: Lack of oversight of UEC pathways that leads to no change in the system position **M:** see above
R: No reduction in NCTR **M:** system reset of governance

Average LoS



Average LoS

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average LoS	Group			Apr-26	7.5				Common Cause Variation
Average LoS	GWH			Apr-26	7.1				Common Cause Variation
Average LoS	RUH			Apr-26	8.6				Common Cause Variation
Average LoS	SFT			Apr-26	6.9				Common Cause Variation

Understanding Performance

All the initiatives across the acute trusts will result in reductions in LOS.
No significant changes noted from previous months.
RUH continue to see improvements in LOS whilst GWH note a slight increase though both all normal variation limits.
SFT slight reduction noted on last month.
GWH continue to have this as a key breakthrough objective.
GWH and RUH benchmark reasonably well in LOS with SFT having more challenges due to the high numbers of NCTR and the significant delays – approx. 9 days from referral to discharge though this is reducing from previous months .

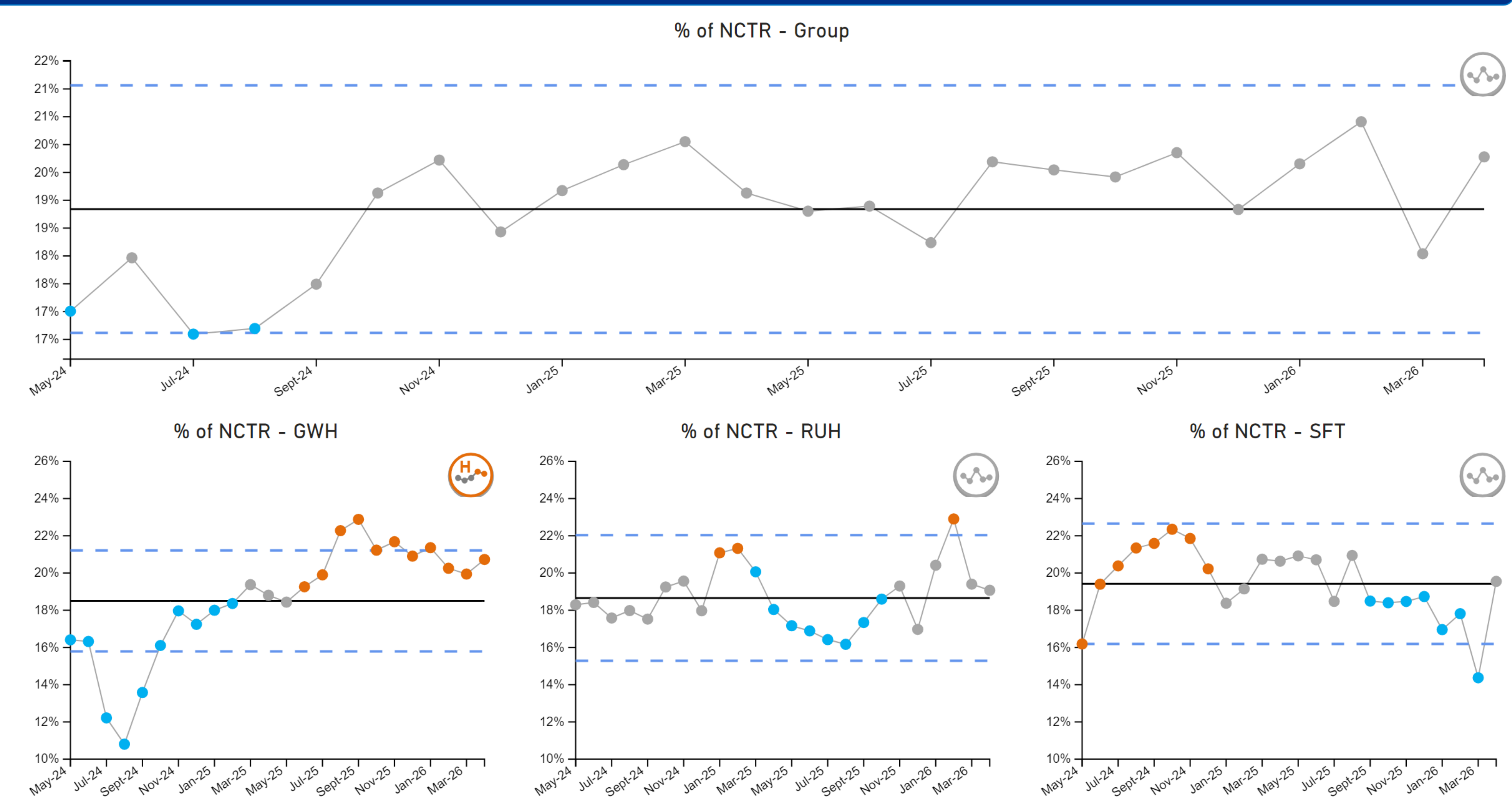
Countermeasures

- Internal flow improvements across all three trusts as part of UEC improvement plans– including ward process improvements and referral process improvements to reduce delays across all internal elements of the pathways
- Engagement with clinicians across specialties across all three acutes to improve flow
- Benchmarking tools used to identify areas for improvement and managed through internal groups
- System work to understand capacity provision to reduce delays
- Multiple system discussions to improve pathway processes

Risks and Mitigation

- R - Inability to deliver improvement programmes at the pace required to see improvement
- M - oversight at trust and Delivery group in place to identify where there are challenges to delivery and unblock any issues, ongoing go and see approach by execs at trust level to support delivery, clear objectives for each workstream, ongoing risk assessment of delivery
- R - Poor patient experience and harm due to delays in hospital beds
- M – oversight of quality impacts through various fora including the systemwide quality oversight group , clear escalation policies in place, monitoring of live performance position
- R- system delivery of community capacity to ensure good flow out of acute trusts
- M – daily oversight calls in place to monitor and escalate when delays begin to occur

% of NCTR



% of NCTR

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
% of NCTR	Group			Apr-26	19.8%				Common Cause Variation
% of NCTR	GWH			Apr-26	20.7%			H	Special Cause Concerning - Run Above Mean
% of NCTR	RUH			Apr-26	19.1%				Common Cause Variation
% of NCTR	SFT			Apr-26	19.5%				Common Cause Variation

Understanding Performance

NCTR remains the most significant challenge across BSW across all three acutes. SFT continues to see improvements, but the challenge remains with delays in discharge pathways. Significant internal focus on pathway 1-3 delays and the ESD service expansion supporting improvement.

This is a system wide measure that requires whole system actions to improve. Whilst there are some weeks that there is improvement there are not sustained actions to see consistent improvement.

There are aspects of the NCTR that are within the acute trusts ability to improve (P0) , the main challenge is for those patients that are waiting for P1 to P3 ongoing care in the community. There are some capacity challenges, and they are varied across BSW though interface delays is an area that is of concern.

There are system thresholds set for discharge of P1 – 3 to enable measurement of delays and identify areas of focus, though these are not consistently met and no way of capturing the data has been found.

Countermeasures

- Each acute trust has an improvement plan that is designed to address the reduction in NCTR that are actions to be taken within acutes
- There is a focus on P0 discharges that don't require any interventions from other providers
- Various improvements and changes to ways of working of care transfer hubs – reviews and changes in practices
- Changes to discharge teams
- Improving ward processes is a key countermeasure to improving internal flow
- Several system initiatives in place to reduce community delays as presented at Recovery Board.
- Requires more a more robust system response going forward to reduce delays in pathways and improve numbers of discharges daily to align to demand.

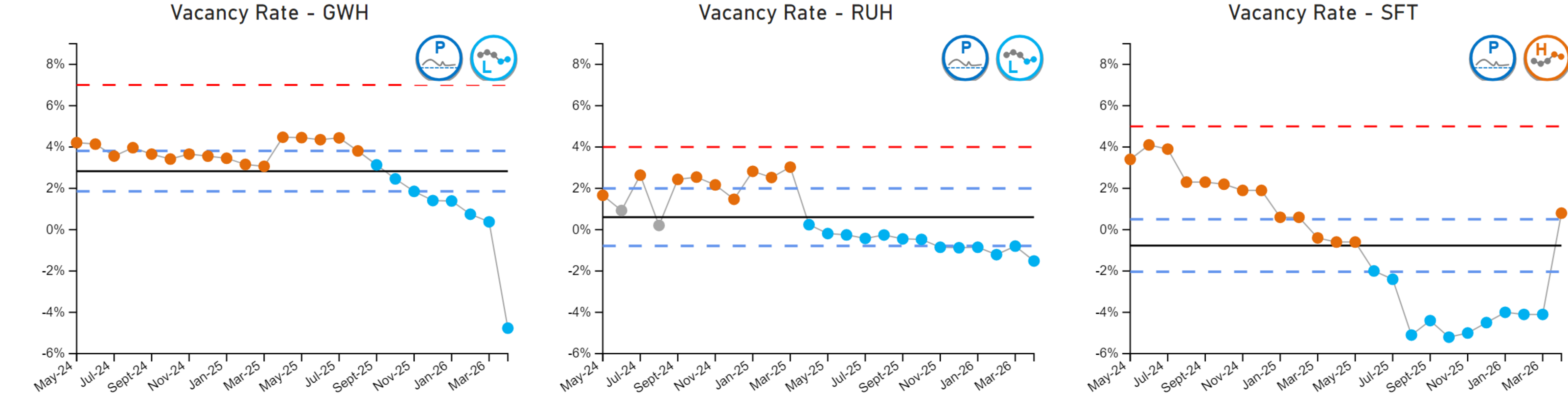
Risks and Mitigation

R – lack of capacity to discharge patients into the community
M – various schemes under consideration by acutes to support discharge from hospital
R – system ways of working not able to transform in a timely way to support reduction in NCTR
M – actions being taken across the system with various workstreams in place, locality meetings been reinstated
R- due to non-reduction in NCTR acute trusts will be unable to reduce beds in line with recovery plan
M – additionality in acute trusts being identified to support winter through winter plans

Vacancy Rate

Please note that workforce information colleagues have advised against aggregating vacancy rate across multiple trusts until the metrics used at each trust have been aligned.

Note that the vacancy rate at GWH is 5% rather than –4.8%



Vacancy Rate

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Vacancy Rate	Group			Apr-26					
Vacancy Rate	GWH		7.0%	Apr-26	-4.8%	✓	P	L	Special Cause Improving - Decreasing Run
Vacancy Rate	RUH		4.0%	Apr-26	-1.5%	✓	P	L	Special Cause Improving - Below Lower Control Limit
Vacancy Rate	SFT		5.0%	Apr-26	0.8%	✓	P	H	Special Cause Concerning - Above Upper Control Limit

Understanding Performance

(GWH): Date not accurate. April vacancy position is 248 WTE (budget/ledger basis). This figure is likely overstated due to unidentified CIP savings and CIP adjustments that have not yet been removed from the establishment baseline.

(SFT): Vacancy position is 30 WTE, representing a significant change since M12. This is primarily due to a reset of establishments, moving from a previously over-recruited position to a vacancy position.

(RUH): The trend line remains in an over-recruited position (83 WTE), with the over-recruitment continuing to increase.

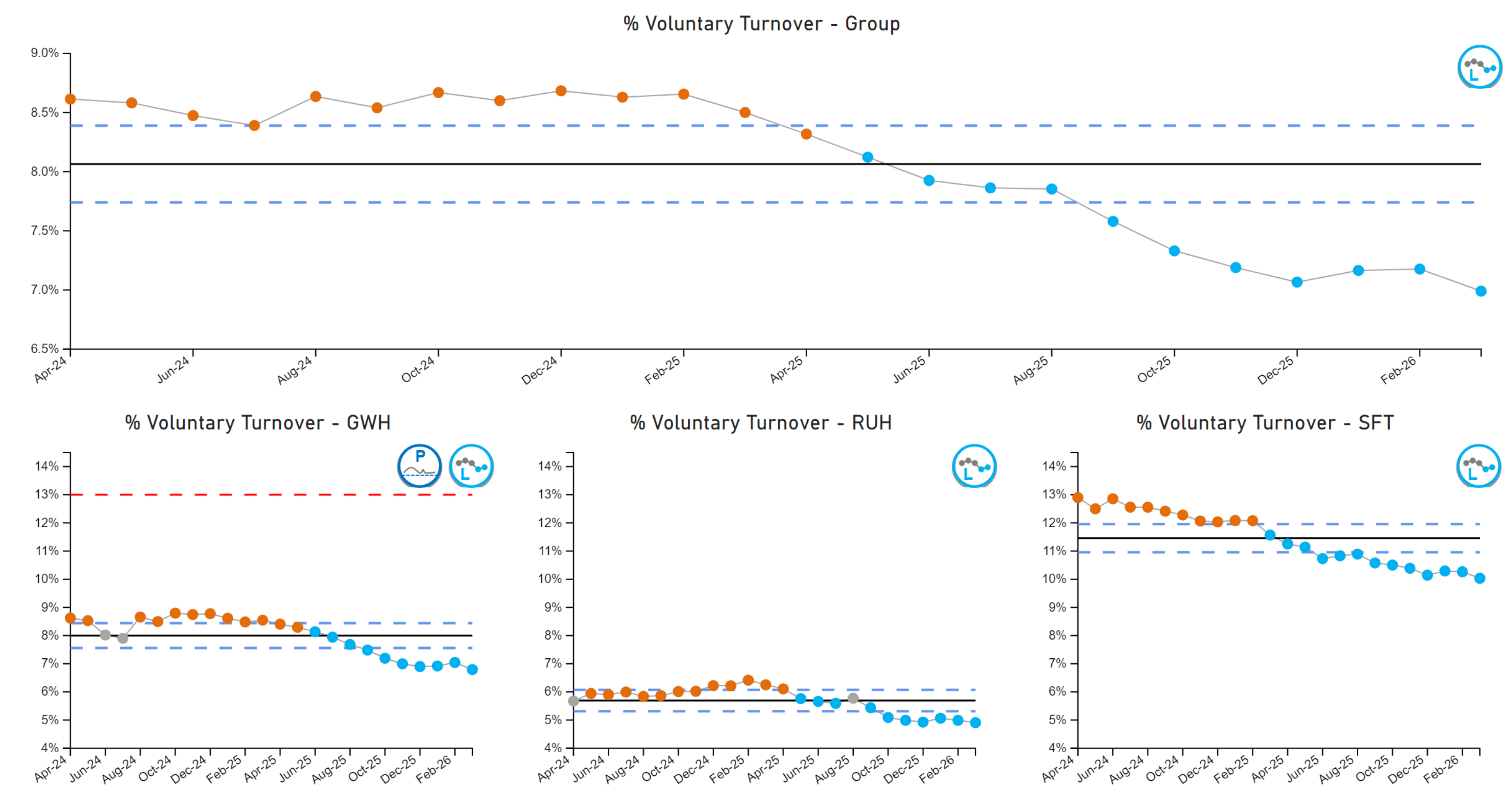
Countermeasures

Standardise vacancy and establishment reporting methodology across all Trusts for consideration at GLT.

Improve monthly triangulation between HR ESR data, roster, and finance ledgers.

Risks and Mitigation

% Voluntary Turnover



% Voluntary Turnover

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
% Voluntary Turnover	Group			Mar-26	6.99%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	GWH		13.00%	Mar-26	6.79%	✓			Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	RUH			Mar-26	4.91%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	SFT			Mar-26	10.03%				Special Cause Improving - Below Lower Control Limit

Understanding Performance

Significantly low level of voluntary turnover as a group and in RUH

Trend in all 3 Trust demonstrate an improving trend

Countermeasures

At present, voluntary turnover has not been recognised by the Trust as a driver metric. As a result, no targeted countermeasures have been initiated to address potential risks associated with staff attrition.

Significantly low staff turnover at RUH could hinder the delivery of workforce reduction and transformation if changes are not achieved through natural turnover

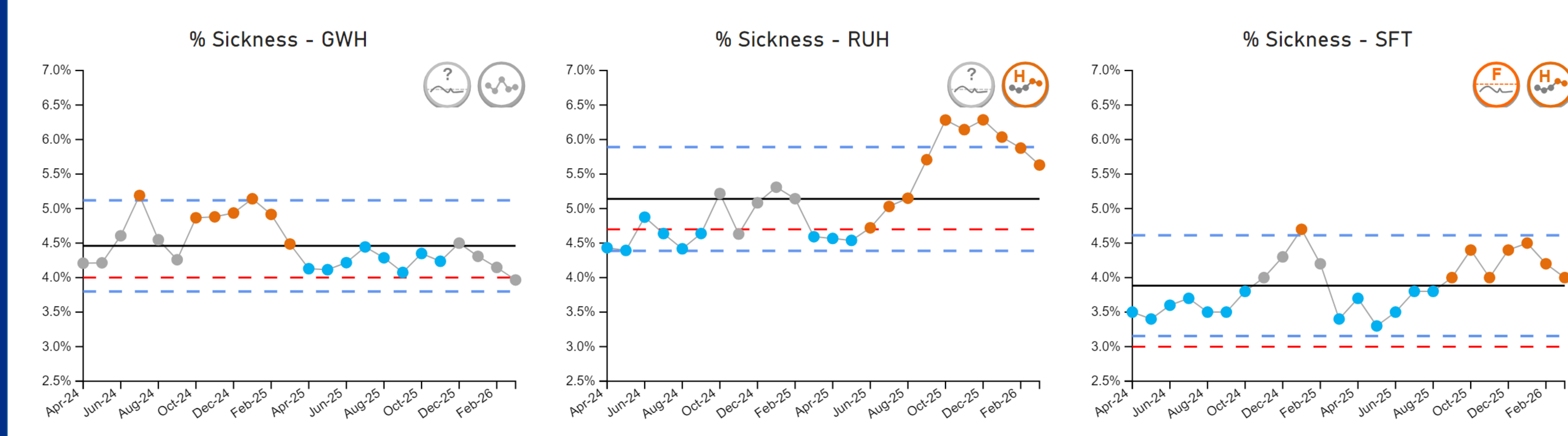
Risks and Mitigation

As identified across all turnover metrics, low levels of turnover can negatively impact Trust performance.

A persistently stagnant workforce may limit innovation, reduce adaptability, and hinder the Trust’s ability to respond effectively to emerging challenges.

% Sickness

% Sickness - Group



% Sickness

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
% Sickness	Group			Mar-26					
% Sickness	GWH		4.00%	Mar-26	3.97%	✓			Common Cause Variation
% Sickness	RUH		4.70%	Mar-26	5.63%	✗			Special Cause Concerning - Run Above Mean
% Sickness	SFT		3.00%	Mar-26	4.00%	✗			Special Cause Concerning - Run Above Mean

Understanding Performance

Sickness Absence Rates – March

RUH reports the highest sickness absence rate at 5.6%, significantly above the group average however improvement over the last 4 months.

GWH has the lowest rate at 3.97%, while SFT is currently at 4.%.

.

Countermeasures

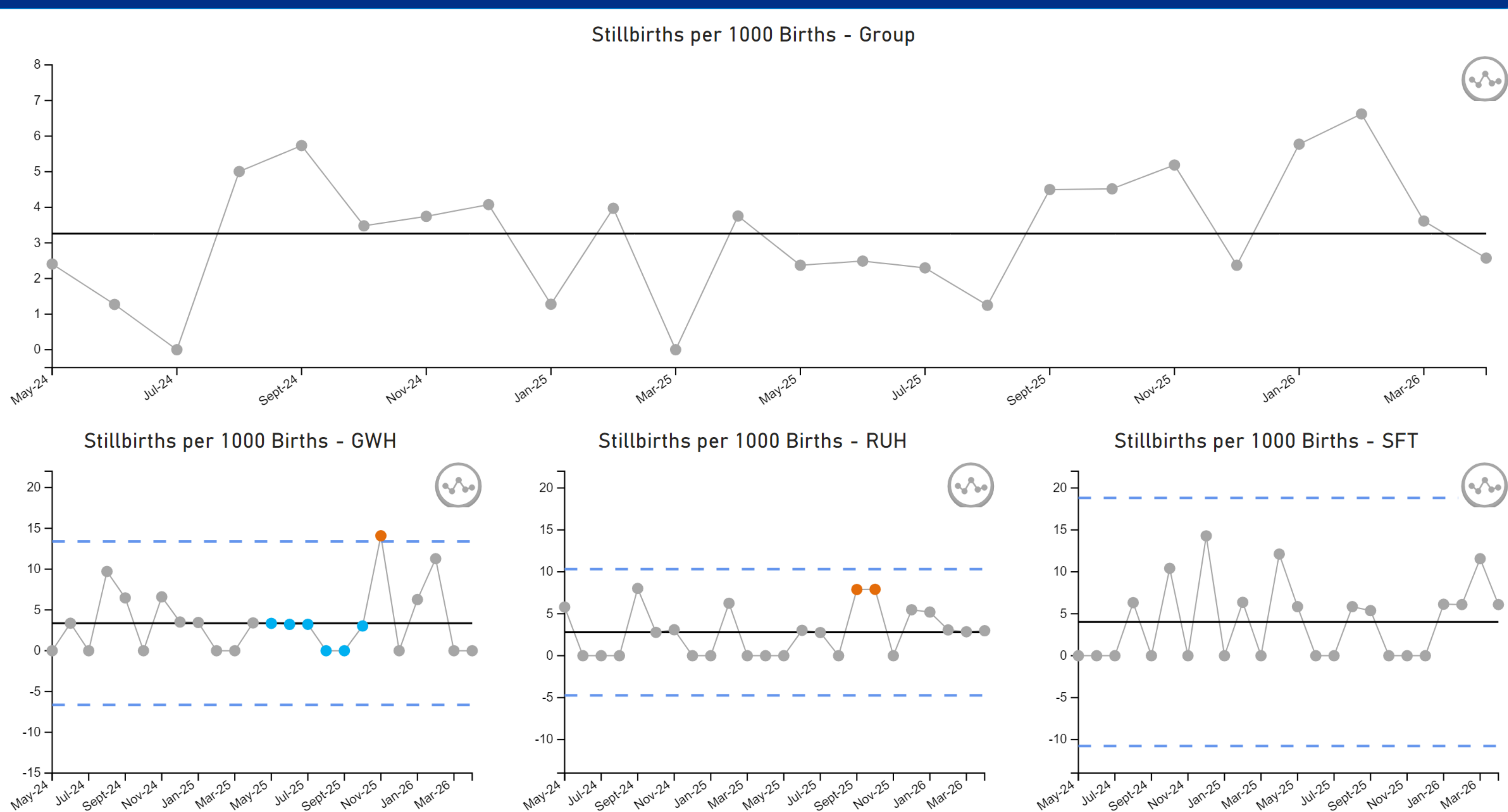
Work underway to improve sickness absence through the Well at Work campaign at RUH is beginning to deliver positive impact, which should help reduce temporary staffing pressure and improve workforce availability.

Continued focus on attendance management, wellbeing interventions, and targeted recruitment controls will be important to stabilise the workforce position.

Risks and Mitigation

Corporate Transformation is likely to impact sickness levels in corporate areas, which have traditionally remained.

Stillbirths per 1000 Births



Stillbirths per 1000 Births

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Stillbirths per 1000 Births	Group			Apr-26	2.6				Common Cause Variation
Stillbirths per 1000 Births	GWH			Apr-26	0.0				Common Cause Variation
Stillbirths per 1000 Births	RUH			Apr-26	3.0				Common Cause Variation
Stillbirths per 1000 Births	SFT			Apr-26	6.1				Common Cause Variation

Understanding Performance

GWH: All stillbirth cases are subject to a review to understand underlying drivers and identify any immediate learning.

RUH: Performance remains within expected limits with common cause variation and is lower than the Group average.

SFT: All stillbirth cases are subject to a review to understand underlying drivers and identify potential themes.

Countermeasures

GWH: All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT) since 2018. PMRT reporting is Safety Action Three of the NHSR Maternity Incentive
Scheme (CNST) year 8. An update is shared with the board via the Quarterly Safety Report.

RUH: All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT) since 2018–A retrospective review of all deaths in 2025 has been undertaken and is due to report in June 2026.

SFT: Continuing to review all Stillbirths in line with Maternity Governance processes and monitor any trends. No themes identified to date.

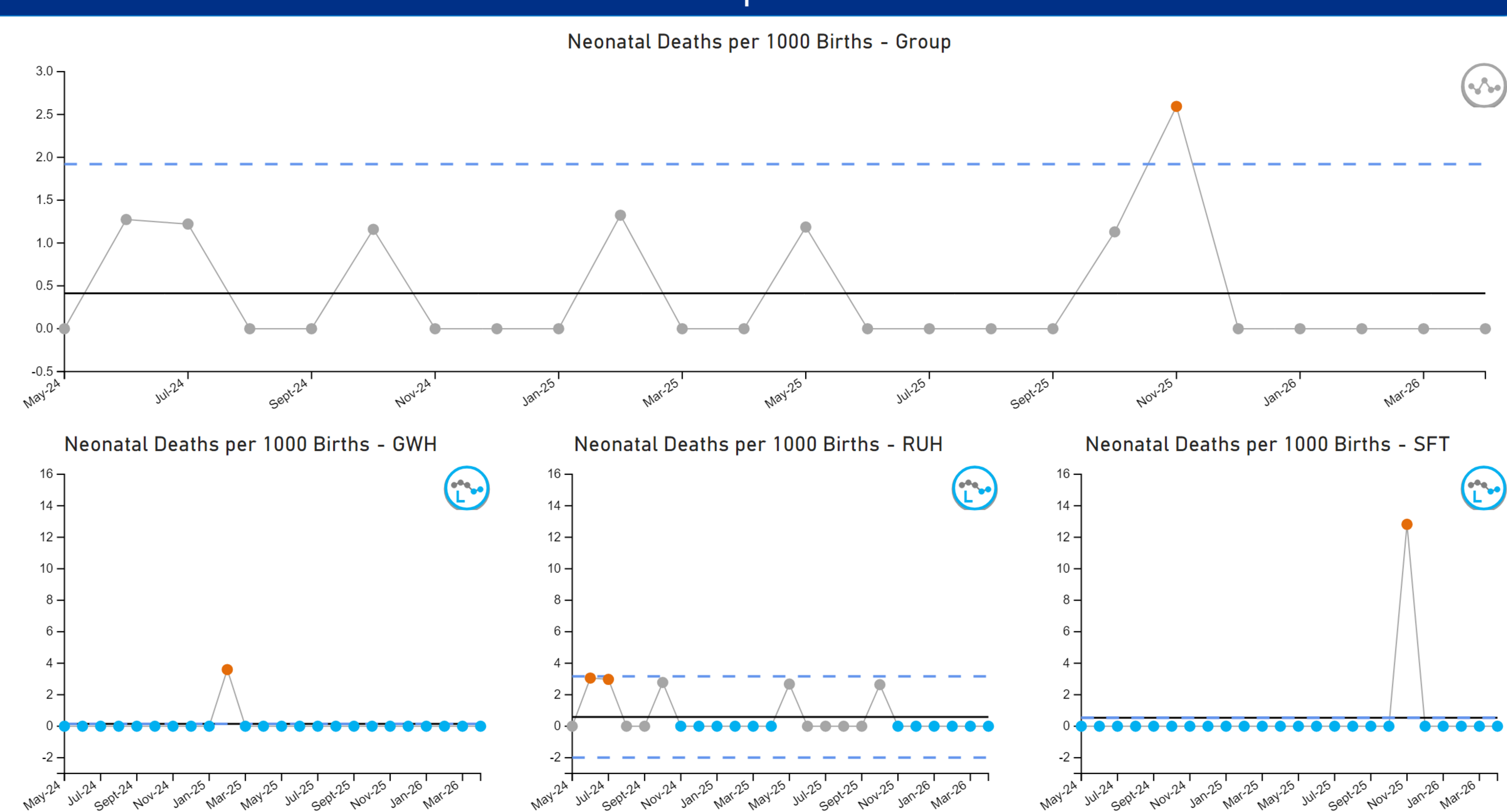
Risks and Mitigation

GWH: Robust systems are in place to review all stillbirths and ensure learning is shared.

RUH: Robust monitoring systems in place to review all stillbirths .

SFT: Continue to review all stillbirths as per governance and PSIRF framework, and review (including external review) via PMRT in addition.

Neonatal Deaths per 1000 Births



Neonatal Deaths per 1000 Births

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Neonatal Deaths per 1000 Births	Group			Apr-26	0.0				Common Cause Variation
Neonatal Deaths per 1000 Births	GWH			Apr-26	0.0				Special Cause Improving - Below Lower Control Limit
Neonatal Deaths per 1000 Births	RUH			Apr-26	0.0				Special Cause Improving - Run Below Mean
Neonatal Deaths per 1000 Births	SFT			Apr-26	0.0				Special Cause Improving - Below Lower Control Limit

Understanding Performance

GWH: Neonatal data for the reporting month indicates no reported deaths at GWH.

RUH: no neonatal deaths in April 2026.

SFT: no neonatal deaths in April 2026.

Countermeasures

Group: There continues to be robust governance processes in place to review all neonatal deaths.

Risks and Mitigation

Group: There continues to be robust governance processes in place across the Group to review all neonatal deaths.

BSW Hospitals Group Board

Agenda item	4.2
Report title	Month 2 Group Finance Report
Date of meeting	2nd July 2026
Sponsor	Simon Wade, Group Chief Financial Officer
Prepared by	Simon Wade, Group Chief Financial Officer
Approval Process: (where has this paper been reviewed and approved)	Paper produced directly for Board.

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

1) **Month 2 is materially off plan** — YTD deficit is £17.1m, £6.7m adverse to plan, driven by positions at GWH (£4.0m) and RUH (£2.6m).
2) **Income shortfalls are activity-led resulting from operational pressures** — reduced elective activity has created over £2.0m of lost income across GWH and RUH.
3) **Pay remains the biggest pressure** — Group pay is £5.2m overspent YTD, linked to escalation capacity, increased demand and delayed delivery of efficiencies.
4) **Efficiency delivery is improving but still high risk** — the £117.2m programme is 94% identified, with risk reducing, but pace of delivery remains critical to recovery.
5) **Recovery within Q1 is challenging** — operational pressures are easing slightly and turnaround work is showing early positive signs.

RECOMMENDATION

The Group Board is asked to:

[State clearly what is being asked, using Receive / Note / Approve / Endorse.]

1. Note the financial position at Month 2 and the emerging risks

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

BSW Hospitals Group Month 2 financial update

Month 2 Financial Position

	Monthly Plan £'000	Monthly Actual £'000	Monthly Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
Clinical Income	111,280	110,234	**(1,046)**	223,030	221,266	**(1,764)**
Other Clincial Income	7,075	8,183	**1,108**	13,065	14,716	**1,651**
Operating Income	8,150	6,833	**(1,317)**	16,215	13,738	**(2,477)**
Total Income	**126,505**	**125,250**	**(1,255)**	**252,310**	**249,720**	**(2,590)**
Pay	81,658	84,373	**(2,715)**	162,930	168,158	**(5,228)**
Non Pay	41,130	42,059	**(929)**	82,114	83,125	**(1,011)**
Other Operating Costs	829	717	**112**	1,658	1,433	**225**
Finance costs	8,141	7,201	**941**	16,015	14,153	**1,862**
Total Expenditure	**131,758**	**134,350**	**(2,591)**	**262,717**	**266,869**	**(4,152)**
Bottom line position	**(5,253)**	**(9,100)**	**(3,847)**	**(10,407)**	**(17,149)**	**(6,742)**

Month 2 position headlines

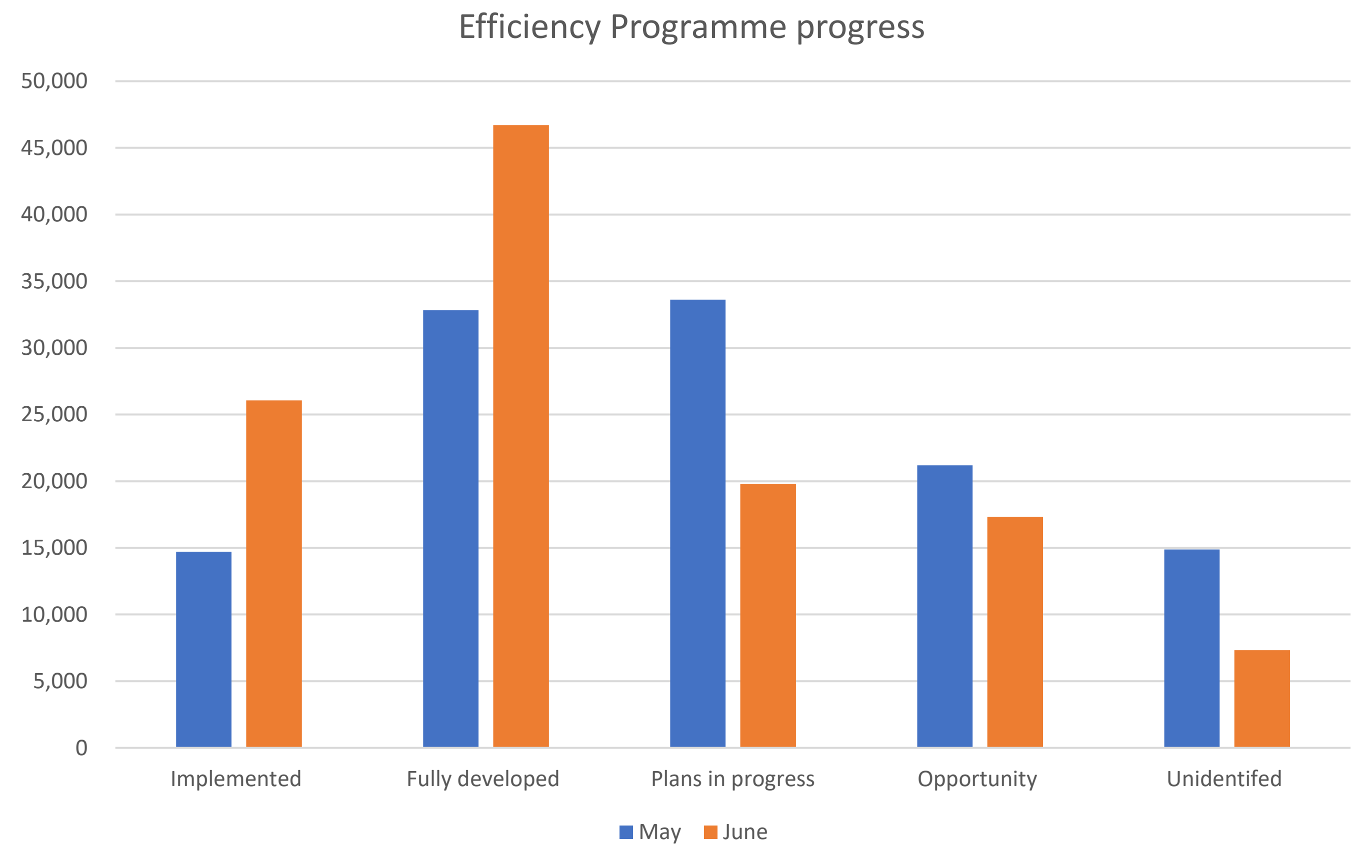
The Hospitals Group position at M2 is an overspend of £6.7m, driven by adverse variances at GWH (£4.7m) and RUH (£2.6m), the Salisbury position remains in line with plan. There are a number of key elements driving the adverse variance year to date and these include:

- Shortfalls in activity delivery resulting in reduced Elective income totalling over £2.0m at GWH and RUH, which are partially offset by an overperformance at SFT
- Efficiency programmes have under delivered at GWH (£3.1m) and RUH (£1.6m). Key drivers of this have included escalation capacity open due to a series of critical incidents and increasing volumes at the front door. The impact of system wide demand management plans has not met the planned levels as plans are still in the development and only partial implementation phase.
- Pay has continued to overspend at RUH and GWH as a result of the inability to deliver efficiency programmes due to the operating position. Total pay across the Group is overspent by £5.2m.
- Whilst overspent against plan, the pay run rate is lower than the 25/26 average in real terms.
- Temporary staffing was £0.5m lower than the prior month, but the filling of Medical vacancies and the impact of the escalation position remains a concern across all sites
- The £117.2m efficiency programme is now 94% identified, with an increase in the delivery confidence

Whilst the position has not been the start required for the first two months, there have been positive signs of improvement arising from the work of transformation and turnaround teams across all sites.

Meeting Q1 will still be a significant challenge following the M2 results but with operational factors slightly easing and the increased identification of the schemes for the efficiency programmes, there is a degree of confidence positive movements can progress to greater delivery.

Group wide efficiency update



Progress since May update:

- £24m increase in high degree of confidence schemes
- Higher risk element of programme now at 21% of overall programme from 31%
- New opportunities of c£8m have been identified to derisk the programme in latter part of year

Month 2 Capital update

	Month 2 Plan £'000	Month 2 Actual £'000	Month 2 Variance £'000	Annual Plan £'000	Forecast Outturn £'000
GWH PDC Schemes	836	94	742	**5,819**	**6,033**
RUH PDC Schemes	1,475	598	877	**9,474**	**9,782**
SFT PDC Schemes	550	39	511	**12,406**	**12,406**
Group wide PDC Schemes	**2,861**	**731**	**2,130**	**27,699**	**28,221**
GWH Internal Schemes	1,397	1,407	(10)	**9,167**	**12,568**
RUH Internal Schemes	1,246	1,041	205	**13,934**	**13,934**
SFT Internal Schemes	1,499	1,466	33	**9,450**	**9,450**
Group wide Internal Schemes	**4,142**	**3,914**	**228**	**32,551**	**35,952**
Total Capital position	**7,003**	**4,645**	**2,358**	**60,250**	**64,173**

BSW Group Board

Agenda item	Item 4.3
Report title	Group CPO Report
Date of meeting	2 July 2026
Sponsor	Jude Gray, Group CPO
Prepared by	Jude Gray, Group CPO
Approval Process: (where has this paper been reviewed and approved)	

☐ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

The July CPO Report comprises:

1. Group and Care Organisation Staff Survey 2025 results and actions and 2026 Staff Survey Planning - refer separate paper 4.3a for details.

2. Group response to Lord Mann Review recommendations to address antisemitism and islamophobia – refer separate paper 4.3b for details.

3. Summary of June 2026 Resident Doctor Pay Offer. The offer has five main components:

   1) improved pay progression linked to training competencies and associated work delivered

   2) reimbursing Royal College membership, portfolio, and exam fees

   3) up to 4,500 additional training places over the next three years

   4) further action on the 10 Point Plan to improve resident doctors' working lives

   5) a new, improved contract for Locally Employed Doctors (LEDs)

   The ballot on the offer runs from 18 June to 26 June 26.

4. Confirmation that the People services team continues to provide expert support the Corporate Services Transformation Programme – separate paper under item 7.2 for details

RECOMMENDATION

The Group Board is asked to:

1. Note the Group and Care Organisation Staff Survey 2025 results and actions and 2026 Staff Survey Planning - see paper 4.3a for details

2. Note the Lord Mann Review recommendations and plans to address antisemitism and islamophobia – refer paper 4.3b.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

BSW Hospitals Group Board

Agenda item	Item 4.3a
Report title	Update on Care Organisation and Group Staff Survey Actions
Date of meeting	7th July 2026
Sponsor	Jude Gray – Chief People Officer
Prepared by	Matthew Foxon – Site HR Director
Approval Process: (where has this paper been reviewed and approved)	

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☒ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*	
☒ Developing an engaged workforce	☒ Making our teams diverse and inclusive
☐ Making our services safer	☐ Improving timely access to our services
☐ Improving the experience of those who use our services	☐ Improving our financial sustainability
☐ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

Across all three Care Organisations (RUH Bath, Great Western Hospital, and Salisbury Foundation Trust), the overall picture is consistent:

- Staff remain highly committed to patient care and generally score at or above comparator averages on many measures.
- Survey results have been affected by a difficult financial, operational and workforce environment.
- The biggest areas of decline are centered on career development, feeling valued, staffing capacity, workload pressures, leadership visibility, and confidence that concerns lead to action.
- All three organisations are responding with similar improvement priorities: stronger engagement, speaking-up culture, well-being support, better feedback loops, leadership development, and improved learning/development opportunities.

More detail at a care organisation level, are found in appendices A, B and C.

Collectively, these themes and opportunities position the group to move from understanding staff experience to delivering coherent, evidence-based improvements at scale, with particular focus on:

- Reducing inequalities
- Strengthening development and career progression
- Improving staff confidence in leadership and organisational responsiveness
- Building on the strong foundation of staff engagement to drive sustainable improvement

RECOMMENDATION

The Group Board is asked to:

1. Note the focused work underway at each care organisation
2. Note the actions under development at a group level

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
A	GWH Staff Survey Presentation
B	RUH Staff Survey Presentation
C	SFT Staff Survey Presentation

Update on Care Organisation and Group Staff Survey Actions

Across the Care Organisations, a consistent set of themes has emerged, highlighting both areas requiring improvement and opportunities for coordinated, group-wide action.

Key Areas for Improvement

Development – "We Are Always Learning"

Across all three trusts, staff reported declining perceptions of:

- Career progression.
- Learning opportunities.
- Development support and access to training.
- Appraisal value.

Declining perceptions of access to learning, career development, and progression opportunities are evident across all organisations. This remains the most consistent area of concern and is being addressed through a group-wide learning and education review, focused on the offer, impact, and sharing of best practice across organisations.

- Compassionate and Inclusive Culture – "We Are Compassionate and Inclusive"
  While this remains a relative strength, there are increasing pressures in relation to feeling valued, leadership visibility, and day-to-day experience. There is an opportunity to strengthen compassionate leadership behaviours and consistency of experience across teams.

- Inequalities in Staff Experience (WRES and WDES)
  Staff survey metrics continue to highlight disparities in experience for Global Majority and disabled colleagues across all three Care Organisations.
  A key opportunity is continued alignment and shared learning across EDI, ensuring that impactful interventions are replicated at scale. For example, work undertaken at GWH to address discrimination has already demonstrated measurable improvements in survey outcomes.

- Decline in Recommendation as a Place to Work
  All Care Organisations have seen a reduction in advocacy scores. This represents a significant early warning indicator of workforce dissatisfaction and potential retention risk, reinforcing the need for visible, coordinated action. Staff are reporting a decline in well-being, not lined to well-being offers but due to staffing levels, workloads, support and development.

- Positive Engagement with Improvement
  A consistent strength across the group is that staff feel able to contribute ideas, suggestions, and improvements. This provides a strong foundation to build on an

"improving together" culture, ensuring that staff feedback leads to meaningful and visible change.

Group-Level Opportunities and Actions

The alignment of themes provides a clear opportunity to take a more coordinated, systematic approach at a BSW Group level:

- Understanding Root Causes (A3 Approach)
  Applying an A3 methodology across the group will support deeper analysis of survey feedback, enabling Care Organisations to move beyond symptoms and identify the underlying drivers of decline, particularly in development, workload, and staff experience.
- Strengthening EDI Impact Through Shared Learning
  Continued collaboration across Care Organisations will ensure that successful approaches—such as GWH's work on reducing discrimination—are spread, adapted, and embedded consistently across the group. A BSW Group meeting is in place looking at impact of schemes across the three organisations and shared learning.
- Transforming Learning and Development Provision
  The ongoing group-wide learning/education review will:
  - Assess current provision and impact
  - Identify gaps and duplication
  - Enable scaling of best practice
  - Recommend proposed models of delivery
- Improving Insight Through Data and Triangulation
  For the 2026 Staff Survey, there is a clear ambition to strengthen insight through:
  - Triangulated data available via Power BI, combining survey results with workforce and operational data
  - More timely, accessible reporting to inform local and group decision-making
  - Greater consistency in how data is interpreted and acted upon
- Coordinated Governance and Delivery
  A more joined-up approach will be supported through a Group Staff Experience and Engagement Forum, involving Care Organisation People Partners. This will:
  - Provide oversight of progress against shared priorities
  - Enable cross-organisational learning
  - Ensure alignment while allowing for local delivery

- Maintain focus on measurable improvement in staff experience

BSW Hospitals Group Board

Agenda item	Item 4.3b
Report title	Board Response to Lord Mann Review: Summary of Findings and Proposed Actions
Date of meeting	
Sponsor	Jude Gray, BSW Group Chief People Officer
Prepared by	Helen Back, BSW Group Associate Director of Culture
Approval Process: (where has this paper been reviewed and approved)	Lord Mann Review released June 2026, details around approach will be taken through Care Organisation and Group leadership governance.

☒ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

Lord Mann published his review into tackling racism and other forms of racism within the NHS and wider healthcare regulatory system on the 4th June 2026.

The review found evidence that racism, including antisemitism, continues to affect both NHS staff and patients, undermining confidence in services, workplace culture and the experience of care. The review concluded that incidents are not always identified, reported, investigated or addressed

consistently across the NHS and that stronger accountability, clearer standards and improved organisational capability are required.

The Government has accepted all recommendations directed at the Department of Health and Social Care and NHS England and has committed to implementing measures aimed at strengthening accountability, improving incident reporting and management, enhancing leadership capability, and ensuring a consistent approach to tackling racism in all its forms. (GOV.UK)

The Board are asked to welcome this review and support its overarching objective of ensuring that all patients, staff and service users are treated with dignity, respect and fairness. The Board are asked to recognise that antisemitism, Islamophobia and all forms of racism are unacceptable and have no place within the NHS. The Board are asked therefore to accept the direction of travel set out within the review and is committed to implementing relevant recommendations locally.

Key Findings of the Review

Lord Mann's review identified several significant themes:

- Evidence that antisemitism and other forms of racism continue to be experienced by NHS staff and patients.
- Inconsistency in how incidents are recognised, reported, investigated and resolved across organisations.
- A need for clearer accountability and stronger leadership at all levels of the NHS.
- Variability in understanding of antisemitism and other forms of racism among managers and staff.
- The importance of creating safe reporting mechanisms and ensuring confidence in organisational responses.
- The need for stronger regulatory oversight and greater transparency regarding actions taken in response to discriminatory behaviour.

A series of asks for immediate action were set out in a letter on the 4th June 2026 from Sir Jim Mackey, Chief Executive NHS England and Danny Mortimer, Director General for People, NHS England.

NHS England Immediate Actions

1) **Sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles.**

   BSW Group will sign up to these principles and pledges to integrate the seven principles into workforce strategy, data collection and patient care. The Royal United Hospitals Bath made this pledge in 2024 as part of the Race Equity Programme; this was supported by an anti-racist statement developed in partnership with the workforce.

   Within the BSW Group Equality, Diversity and Inclusion portfolio, work is taking place to align to create an anti-racist statement which will align to the anti-racist principles as outlined and the actions suggest by NHS England. An action plan is also being developed to ensure these principles are adopted within BSW Group and impact can be monitored.

2) **Implementation of Violence Prevention and Reduction Standard**

BSW Group have implemented the Violence Prevention and Reduction Standard, audited its procedures against the standard for each of the past three years, and implemented several actions to support compliance. This reports to the Health and Safety Committee.

BSW group reports at a care organisation level on various types of violence and aggression, including incidents that are racially motivated. There is not consistent ability across BSW Group to analyse types of racist abuse experienced by staff, which we will commit to improving.

3) **Adopt the new government definition of anti-Muslim hostility.**

Definition: Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.

It is proposed to incorporate the commitment to adopt the above definition within the BSW Group anti-racist statement.

4) **Ensure all staff have completed the NHS Core Skills Framework on Equality, Diversity and Human Rights, which includes content on Islamophobia**

All Care Orgnisations are aligned to the NHS Core Skills Framework and have a compliance level above 85%. This content does not include Islamophobia, at the point of writing this paper.

BSW Group is represented in the above programmes and will update learning material upon release and commit to communicating the requirement to complete and provide data on progress.

5) **Prepare to Implement the forthcoming NHS Staff Standards.**

BSW Group will implement the NHS Staff Standards when released, in support of the Fit for the Future: 10 Year Health Plan for England and publish data when requested.

6) **Ensure board agreement to undertake new anti-racism training when it becomes available**

   Training not yet available, commitment to board and senior leadership to undertake.

7) **Ensure colleagues, staff representatives, patients and communities are aware of actions through internal and external communications channels and are appropriately engaged in further developments.**

   There is a commitment to address this as part of the programme to adopt and further embed the NHS Race and Health Observatory Seven Anti-Racism principles across the Group.

8) **Ensure Board and relevant committees fully understand staff survey data on experience of racism and are taking appropriate action and monitoring progress.**

   Information from Staff Survey and Workforce Race Equality Standard (WRES) are routinely shared at a care organisation and group level.

   Initial review of data shows that across BSW group – an ability to see the experience of colleague whose religious belief is Judaism or Sikhism, is hampered due to low numbers. Our staff record (ESR) shows declaration levels of 0.07% and 0.26% respectively across group. This is lower than census information (2021) for the three care organisations shows, with Judaism being between 0.1 and 0.2% and Sikhism (0.1 to 0.6%).

   Further work is required to understand the root cause the under-reporting or under completion of staff survey by colleagues who hold these beliefs.

Each organisation to confirm whether they have adopted the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility by 31st July 2026.

A recommendation to be taken through care organisations management forums in advance of 31st July 2026 and information submitted.

To support the embedding of actions linked to the Lord Mann Review, NHS EDI duties, WRES, the Equality Delivery System (EDS) 2022, the NHS EDI Improvement Plan six High Impact Actions and the themes raised in the NHS Staff Survey there is a commitment to work together with colleagues, patients and communities and learn from each other.

As an BSW Group EDI team there is commitment to the following:

Governance and Accountability

- Review existing equality, diversity and inclusion governance arrangements.
- Strengthen Board oversight of racism, discrimination and hate-related incidents.
- Share regular reports on workforce and patient experience indicators relating to discrimination and inclusion quarterly.

Policy and Reporting

- Review policies relating to bullying, harassment, discrimination and freedom to speak up.
- Ensure staff have accessible and trusted routes for reporting concerns.

- Strengthen monitoring of incident reporting and organisational responses.

Training and Awareness

- Implement any nationally mandated training requirements arising from the review.
- Enhance leadership development and management training focused on recognising and responding to racism and antisemitism.
- Promote awareness of expected standards of behaviour across the organisation.

Workforce and Culture

- Engage with staff networks and representative groups to understand lived experiences.
- Support initiatives that foster inclusion, belonging and psychological safety.
- Ensure appropriate support is available to staff affected by discrimination.

Assurance

- Undertake a gap analysis against national recommendations once implementation guidance is published.
- Develop a local implementation plan with timescales and measurable outcomes.
- Report on progress to the Board on a regular basis.

Conclusion

Lord Mann's review shows the need for continued action to tackle antisemitism and all forms of racism within the NHS.

The Board is asked to commit to ensuring that the organisation remains a place where staff, patients and communities are treated fairly, feel safe, and have confidence that discriminatory behaviour will be addressed promptly and effectively.

RECOMMENDATION

The Group Board is asked to:

[State clearly what is being asked, using Receive / Note / Approve / Endorse.]

1. Note the findings of the Lord Mann Review.
2. Support the Government's acceptance of the review recommendations.
3. Reaffirm its commitment to maintaining an inclusive, respectful and safe environment for all staff, patients and visitors.
4. Recognise the importance of addressing antisemitism specifically while ensuring action benefits all groups affected by racism and discrimination.
5. Agree that local arrangements should align with emerging national guidance and requirements.
6. Adopt the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility and confirm this to NHS E by 31st July 2026.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

BSW Hospitals Group Board

Agenda item	4.4
Report title	Group Quality and Safety Report
Date of meeting	2nd July 2026
Sponsor	CNOs/ CMOs
Prepared by	Luisa Goddard Chief Nursing Officer
Approval Process: (where has this paper been reviewed and approved)	

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R8	Reducing Avoidable Harm

KEY MESSAGES

The report highlights the Immediate and Essential Actions from the recent Ockenden Report (Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust, June 2026) and ongoing work to address these. It also highlights the quality concern associated with corridor care and stroke services.

RECOMMENDATION

The Group Board is asked to:

1. To the updates from Quality Safety Committees across the Group and progress with establishing shared learning and insights to quality matters.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

This report highlights the strategic oversight and initiatives relating to Quality and Safety across the Group. This report will continue to develop and strengthen to present outcomes from thematic reviews and/ or new /emerging quality concerns. Detailed quality metrics are discussed in detail in each Care Organisations Quality and Safety Committee with escalation in the Managing Directors report. The Group and each Care Organisations IPR provides detailed oversight of key metrics and mitigations.

1. Alert, Advise, Assure

1.1 Alert

This month there was publication of the Ockenden Report, (Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust, June 2026).

The report identified 444 maternity cases and 76 neonatal cases where different care might have or would be expected to have made a difference to the outcome. The report identifies 8 key headings for Immediate and Essential Actions (IEAs) for Trusts to address:

1. Listening to Women & Families
2. Workforce Planning & Safe Staffing
3. Training & Multi-Professional Learning
4. Risk Assessment Throughout Pregnancy
5. Incident Investigation & Family Involvement
6. Governance & Board Accountability
7. Culture, Teamwork & Psychological Safety
8. Mothers Who Have Died and Post Death Care

The leadership team in Perinatal Services, supported by the Maternity and Neonatal Safety Champions are reviewing the report in detail and actions will be taken through Care Organisation Quality and Safety Committees in due course.

Corridor Care

The impact of overcrowding/ corridor care on quality, outcomes and experience is well documented. Recently published national data demonstrates the challenge across the 3 Care Organisations with between 3 and 11% of all ED attendances experiencing corridor care and a significant number of patients experiencing corridor care in hospital at GWH and SFT.

Whilst mitigations remain in place to ensure care is as safe as possible, there is strong published evidence linking overcrowding to increased mortality.

Each Care Organisation has processes in place to;

- Report episodes of corridor care in line with national reporting.
- Have existing flow / UEC programs of work to reduce length of stay and overcrowding.
- Have risk assessments, SOPs and strengthened mitigations in place to ensure if corridor care is in use it provides as safe care and experience as possible.
- Safe staffing processes
- On going monitoring and triangulation of quality and outcomes in relation to corridor care.

These actions are scrutinised within each Care Organisation Quality and Safety committee and remain under constant review.

Stroke Care

High quality Stroke Care across the group remains challenging across the group. due to workforce and capacity constraints. This is reported through the SSNAP data, RUHB 'D' rating, SFT and GWH 'E' rating. Work is ongoing to support improvements to deliver safe effective stroke care in Care Organisation and at Group.

1.2 Advise

Infection Control

Gram negative blood stream infections remain of concern with RUHB and GWH benchmarking highest in the region for E.Coli blood stream infections.

The Associate Directors of Infection Control Prevention / Infection leads in each Care Organisation are collaborating closely on improvement initiatives with a focus on catheter care and ensuring hydration.

1.3 Assure

The Patient Safety Incident Framework (PSIF) continues to be embedded into the Care Organisations with greater sharing of learning across the Group which will be strengthened with the Group level Safety and Learning.

Close.

BSW Hospitals Group Board

Agenda item	Managing Directors Report – Salisbury NHS FT – Item 5.1
Report title	Managing Directors Report – Salisbury NHS FT
Date of meeting	2nd July 2026
Sponsor	Cara Charles-Barks, CEO
Prepared by	Nick Johnson – Managing Director SFT
Approval Process: (where has this paper been reviewed and approved)	

☐ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

STRATEGIC ALIGNMENT *(Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

The organisation continues to deliver safe, high-quality care with sustained improvement in elective and an improving cancer performance. However, operational delivery remains finely balanced due to persistent constraints in urgent care flow, workforce availability and financial recovery. Delivery focus has now shifted from programme design to execution, with strengthened grip and significant Group and system-based interventions required in order to deliver.

RECOMMENDATION
The Group Board is asked to: 1. Note the report

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

1.1 Alert | Advise | Assure

ALERT

- **Financial performance remains fragile**
  - Month 1 and 2 the Trust were on plan.
  - Cash position remains precarious and requires active management
  - **Actions underway:**
    - CIP Delivery Cell mobilised with scheme-level ownership and fortnightly escalation
    - Strengthened financial controls and purchasing discipline
    - Turnaround resource deployed to support delivery across 39 programme lines

- **CIP delivery remains the principal organisational risk**
  - £32.5m programme fully identified but remains high-risk and dependency laden in delivery against NHSE conditions
  - Non- delivery of Group schemes – specifically Clinical Transformation and Corporate Service Transformation savings are now the biggest risk to CIP delivery
  - **Actions underway:**
    - Risk-weighted maturity tracking now embedded and trajectory improving
    - Formal governance through Delivery Cell, Finance & Performance Committee and Group structures
    - Workforce and financial plans being actively retriangulated to ensure deliverability

- **Urgent care flow remains constrained by system factors**
    - NCTR increased to average 81 (target 45), occupancy ~97%, and continued use of escalation areas
    - **Actions underway:**
        - Implementation of Discharge Assessment and Action model across site
        - Strengthened system working with HCRG, Wiltshire Council and ICB
        - Daily executive oversight of flow through bed meetings and escalation SOPs

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- **Workforce availability continues to limit delivery**
    - Staff unavailability remains ~23% (target 16%), sickness ~4%
    - **Actions underway:**
        - Breakthrough objective focused on staff unavailability
        - Detailed data stratification to target high-impact absence cohorts
        - Expansion of team-based rostering and divisional workforce controls

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ADVISE

- Workforce interventions are increasingly targeted, with a shift toward **availability, productivity and retention**, supported by divisional action plans following staff survey results.
- Financial recovery is transitioning into delivery phase, with **stronger governance, milestone tracking and escalation discipline**, supported by internal turnaround capacity.
- Flow improvement remains dependent on system outcomes; actions are now extending beyond the Trust through **discharge redesign, community partnership and front-door pathway development**.
- Group transition is progressing at pace, with governance frameworks now agreed; focus is moving to **embedding new arrangements while protecting delivery capacity**.
- National Oversight Framework for Quarter 4 position remained in segment 3 due to financial override, with a 0.01 reduction in aggregate score.
- Business cases for South Newton, DASH, and KWA approved by SFT Trust Board
- Stroke Business Case approved at TMC
- Key worker accommodation deal which will deliver CIP position and cash boost in M3/4 has been delayed by NHSE, undisclosed assessment of Novel, Contentious and Repercussive guidance.
- CQC Surgery Report still awaited
- Deanery Report Plastics still awaiting publication

ASSURE

- Elective recovery remains strong and stable:
    - RTT 71.5% (ahead of plan), zero 65-week waits maintained

    - Supported through OPERA programme, validation processes and focused specialty delivery
- Cancer pathways continue to improve:
    - 28-day FDS achieved (80.1%), backlog reducing
    - Delivery supported through Cancer Improvement Group oversight and targeted pathway actions
- Quality improvement is demonstrable:
    - Reduction in pressure injuries
    - Improvement in NEWS2 compliance
    - Embedded improvement methodology (PSIRF, huddles, daily management systems)
- Governance and control frameworks remain effective and continue to provide **robust oversight during transition to Group model**

1.2 Key Achievements and Good News

- Sustained **top-quartile elective performance**, driven by structured operational delivery and outpatient transformation
- Cancer recovery delivering national standard through **targeted diagnostic and pathway capacity interventions**
- Improving ED performance despite pressure, supported by **CDU optimisation, single queue processes and discharge focus**
- Improving Together programme delivering measurable improvements in:
    - waiting times
    - productivity
- Group transition progressing into implementation with:
    - Partnership Agreement signed
    - Governance structures in place
    - EPR deployment agreed and mobilisation underway

Patient and staff voice:
Staff remain committed and engaged in delivery, but continue to report pressure associated with sustained demand and organisational change.

Section 2: Performance Triangulation

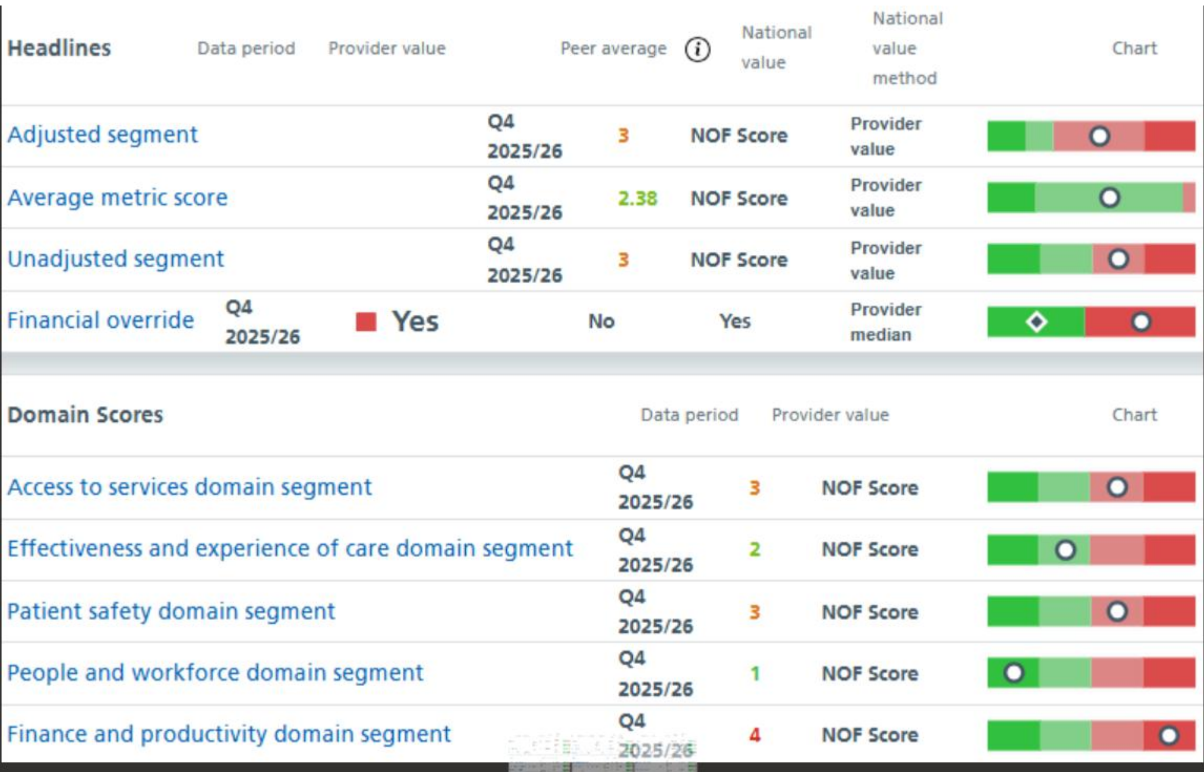
2.1 SPC Variation

- **Sustained improvement:**
    - RTT performance
    - Cancer pathways
    - ED and ambulance handover metrics

- **Adverse variation:**
    - Staff unavailability
    - NCTR and discharge delays
    - Escalation bed utilisation

So what:
Where interventions are well established (elective, cancer), performance is stable and improving. Where dependencies are system-wide (flow, workforce), improvement remains slower and less controllable.

Q4 NOF Position



Headlines	Data period	Provider value	Peer average	National value	National value method	Chart
Adjusted segment	Q4 2025/26	3		NOF Score	Provider value	
Average metric score	Q4 2025/26	2.38		NOF Score	Provider value	
Unadjusted segment	Q4 2025/26	3		NOF Score	Provider value	
Financial override	Q4 2025/26	Yes	No	Yes	Provider median	

Domain Scores	Data period	Provider value	Chart
Access to services domain segment	Q4 2025/26	3 NOF Score	
Effectiveness and experience of care domain segment	Q4 2025/26	2 NOF Score	
Patient safety domain segment	Q4 2025/26	3 NOF Score	
People and workforce domain segment	Q4 2025/26	1 NOF Score	
Finance and productivity domain segment	Q4 2025/26	4 NOF Score	

2.2 Cross-Domain Analysis

Quality & Safety:
Reduction in harm indicators offset by continued risk from escalation areas and high bed occupancy. Mitigation through improvement programmes and strengthened oversight.

Workforce & Finance:
Temporary staffing remains a key enabler of delivery but continues to drive financial pressure. Workforce controls in place but availability remains the primary constraint.

Access & Flow:
Improving front-door performance contrasts with deterioration in discharge, reinforcing that **end-to-end flow remains the key system challenge**.

2.3 Assurance Committee Summary

Committee	Assurance Level	Position
Quality & Safety	Substantial	Improvement programmes effective but challenged by flow
Finance & Performance	Limited	Delivery risk within CIP and financial recovery
People & Culture	Substantial	Workforce controls effective, availability remains risk

Section 3: Deep Dives

1. Financial Recovery and CIP Delivery

The financial position for May 2026. The Trust has recorded a deficit of c£1.7m which is in line with the plan. Year to date the trust is reporting a deficit of £3.8m, in line with plan.

Full year national deficit support funding offsets the planned c£9.4m deficit but is conditional on the delivery of the planned breakeven position. In Month 2, the deficit support funding of c£1.6m has been included within the position. The underlying position excluding deficit support funding is c£2.4m deficit.

Key issues:

Pay costs are £23.1m against a plan of £23.7m – a favourable variance of £0.6m. Pay costs include the Agenda for Change pay award which was paid in April. High unavailability of clinical staff in key activity driving specialties was the main driver of the temporary staffing expenditure increased in month 2 whilst underlying substantive staffing costs increased with the net starters position 6 WTE in month. The pay savings target at month 2 is £1.1m with £1.2m delivered, of which £1.2m was delivered recurrently, a higher proportion of the bed base reduction achieved in month due to the improved NC2R position compared to forecast outturn.

The substantive workforce, including Subsidiaries, has reduced by 60 WTE on contracted levels from March 25 although worked substantive reduced by 78 WTE.

The year to date underspend of £0.2m in Non Pay has resulted from underspends in drugs costs driven by patient activity levels. This is partially offset by pass through payments, clinical supplies in radiology and dermatology, and outsourced healthcare overspends to maintain demand driven activity levels. The position includes a non-pay efficiency target of £0.7m, against which £0.6m has been delivered, driven mainly by clinical services redesign (Hospice) and achievement of planned drugs savings.

The 26-27 efficiency target totals £32.5m, with delivery in Month 2 on plan. 70% of schemes are now finalising detailed plans for an imminent implementation or active delivery. The Trust's bed base targeted reduction is phased throughout the year, however a higher proportion of this was delivered in Month 2 with improved NC2R on the forecast outturn position. The target ramps up over future months where there are likely to be increased operational challenges.

The Clinical income position is driven by Electives, Outpatient Procedures and First attendances above plan, which is offset by underperformance on High cost drugs and devices, and Non Elective activity. There is overperformance across all of the main commissioners with the exception of Specialised commissioning and within Cross Border, Overseas, Local Authorities and Channel Islands.

• Revenue cash requirements from April 26 will be supported by the timing of cash payments from BSW ICB on the 1st of each month. It is anticipated that PDC revenue cash support will be required from September onwards. NHS England have advised there are limited cash resources available and this will need to be managed across the BSW Hospitals group and system.

• Divisional recovery huddles and Delivery Group are ongoing to ensure that productivity improvements and remedial or mitigating actions are taken where appropriate, with a specific focus on Day case and Elective activity and outpatient procedures recording and coding.
• CIP/Transformational cell has been stood up fortnightly to monitor and ensure the maintenance of pace of action and delivery of the programmatic efficiency schemes within the operational plan. CIP cell will monitor performance against trajectory towards the NHS England plan submission criteria.
• Monitoring of staffing availability and rotas to ensure staffing in excess of funded levels are understood and acknowledged with specific focus on medical staffing in conjunction with a review of the agency and bank processes at Divisional level through the recovery huddles.
• Proactive debt recovery and recovery of outstanding contract payments active management of cash payments to suppliers to maximise available cash balances.

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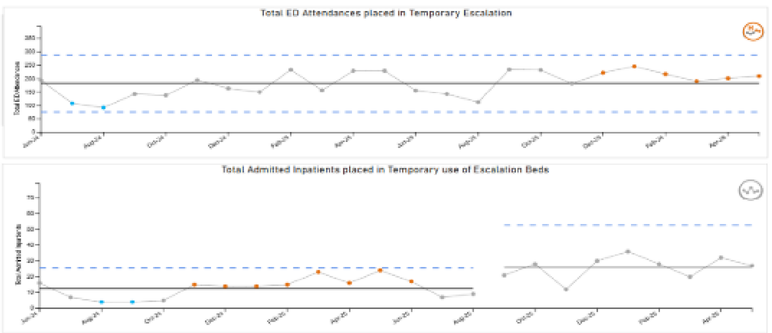
2. Urgent Care Flow and System Dependency

Flow remains the principal operational constraint, driven by delayed discharge and system capacity.

Use of Temporary Escalation Beds & ED Escalation (corridor care)

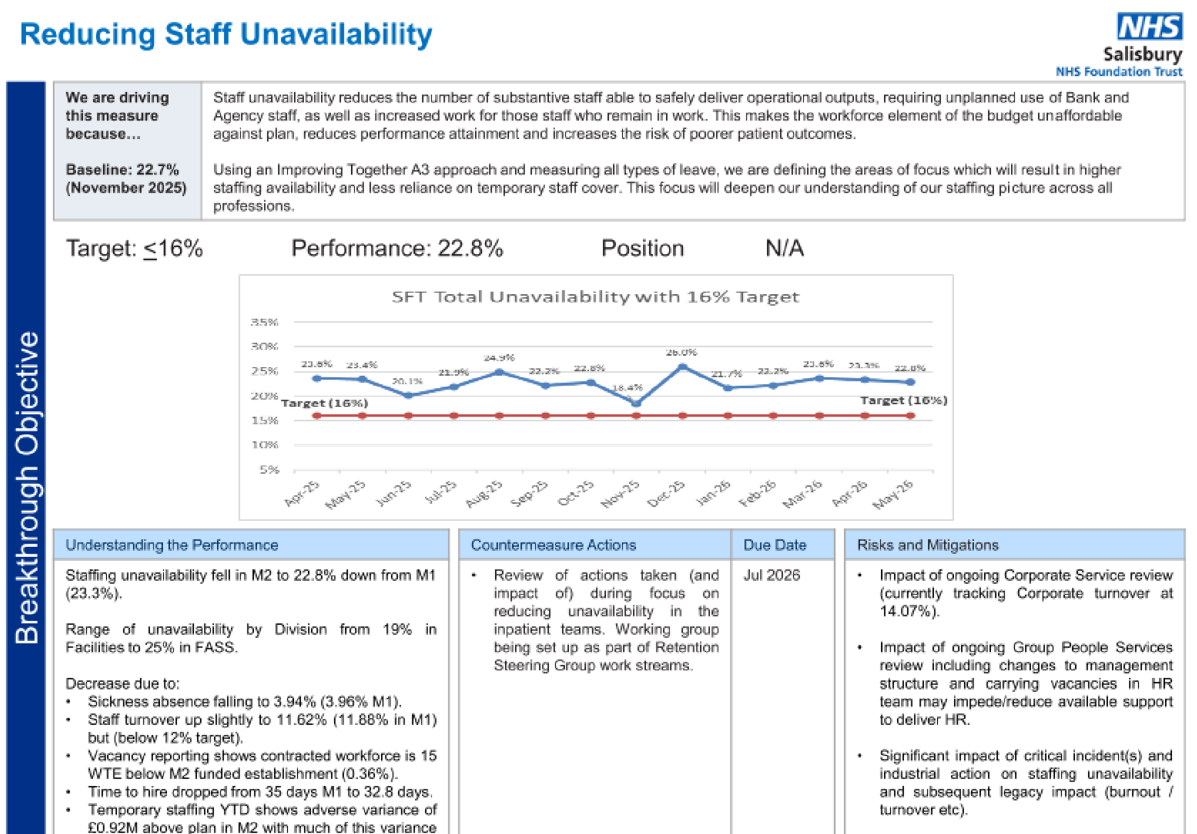


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The Trust continued to face sustained and significant pressure across the unscheduled care pathway throughout May, with growing reliance on escalation beds and ongoing use of Emergency Department (ED) corridor spaces. ED attendances rose to 7,861 in May, up from 7,332 in April, and 210 patients required placement in ED escalation and a further 27 placed in boarding/escalation areas across the Trust. An ambulance cohort area was activated once, in collaboration with SWAST, to release crews back to the road and support safe offloading. During periods of critical incident and extremis, the number of patients in escalation areas increased beyond levels previously seen, reflecting some of the most challenging operational conditions the Trust has faced. Staffing pressures remained considerable, particularly as additional ED escalation areas were opened to manage demand. The use of temporary escalation spaces remained consistently high and significantly above the comparable period last year, supporting patient flow during sustained demand pressures.	• Actions agreed from Critical Incidents to manage flow and capacity • Ongoing review of the escalation policy • Ongoing collaboration with system partners to improve discharge flow and access to community services. • There is continued improving together processes in place to see the reduction in delayed discharges and ward processes to drive earlier discharges to enhance flow and reduce reliance on escalation capacity.	Jun 2026 Jun 2026 Jun 2026 Jun 2026	• Timely escalation into additional escalation spaces has allowed for ambulance offload capacity. • Increased risk for patients cared for in waiting rooms, chairs, and corridors for extended periods of time. • Access to food, drink and toileting facilities have been provided through volunteers. • Reduced flexibility for surge activity during periods of increased demand with all escalation plans exhausted at times. • Daily executive oversight and bed meetings.

3. Workforce Availability

Workforce availability is now a central organising objective.

- Breakthrough objective with targeted interventions
- Data-led approach to sickness and absence
- Divisional accountability for delivery improving



4. Group Transition and Transformation

The transition to BSW Group is progressing at pace and entering operational phase.

- Governance framework implemented
- Corporate Services programme advancing through design and consultation
- EPR programme moving into delivery mobilisation

5. Maternity & Neonatal Services (Summary)

Maternity and Neonatal services continue to demonstrate **strong governance, learning culture and high levels of safety assurance**, despite workforce and compliance challenges.

Quality and Safety

- MOSS Level 1 alert (March) appropriately managed with **critical safety check (GREEN)** and no systemic issues identified

- All perinatal deaths reviewed via PMRT and MNSI, with external scrutiny and family involvement
- No emerging themes identified; current position assessed as a **cluster rather than a trend**

Performance and Outcomes

- Stillbirth rate remains above national average in recent rolling data (≈3.9/1000 vs 3.2), requiring continued vigilance
- Neonatal mortality remains below national average
- Strong compliance with key clinical standards (e.g. triage, CS response times, MDT working)

Workforce and Capacity

- Midwife to birth ratio remains stretched (c.1:26–27 vs 1:24 target)
- BAPM medical staffing compliance remains low (~43%), representing a key ongoing risk
- Neonatal and midwifery workforce gaps being managed through bank, agency and recruitment actions

Governance and Assurance

- Strong Board visibility and oversight including safety champions and regular reporting
- Compliance with CNST standards achieved (10/10 Year 7) and high compliance with national programmes (Saving Babies Lives)

Improvement Actions

- Ongoing work on bladder care, documentation, escalation and communication processes
- PROMPT and training compliance improving with continued focus
- Strengthening of escalation SOPs (including formalisation of MOSS response)

Overall Position:

- **Assurance:** High (process and governance)
- **Outcome risk:** Moderate (driven by workforce and stillbirth rates)
- **Delivery:** Stable with clear actions in place

Section 4: Risk Escalation

4.1 Escalation Gateway

Risk Ref	Risk Title	Control Score (C)	Residual Score (L+I+C)
8102-SFT	Central booking workforce and process instability resulting in risk of patient harm and reduced utilisation across all areas	4	13
6229-SFT	Risk of DSU - Estate Infrastructure failure	4	13
6412-SFT	Harm to women and babies through lack of dedicated 2nd obstetric theatre	4	13
8791-SFT	Financial position 2026/27	4	13
7917-SFT	Fire risk in Main Theatres corridors	4	12
7931-SFT	Lack of appropriate electrical power infrastructure in theatres (Main, DSU and Obstetrics)	4	12
7946-SFT	Transformation programmes and projects are not delivered to time	4	12
8068-SFT	Increase in 2222 calls to Switchboard when lone working, Single operator cover	4	12
7734-SFT	Capital funding	3	12

Not currently included on the risk register but to highlight high scoring risks ahead of next MD report

- Trust Cash position
- Non-delivery of Clinical Transformation efficiencies
- Non-delivery of corporate transformation efficiencies
- Failure to deliver coding improvements

4.2 Risk Narrative

- As the corporate and divisional risk registers are reviewed and transitioned to 5+ model the risks highlighted are subject to change
- Risks remain elevated but are **actively managed through structured mitigation plans**
- Financial, workforce and flow risks remain **interdependent**
- Delivery trajectory dependent on:
  - pace of CIP delivery
  - effectiveness of system flow interventions
  - stabilisation of workforce availability

Section 5: Care Organisation Context

The Trust continues to demonstrate strong clinical leadership, improvement capability and commitment to patient care.

However:

- Operational pressure remains sustained
- Change burden (Group + local) is significant
- Workforce fatigue is evident

Actions underway:

- Divisional response to staff survey findings
- Continued leadership visibility and engagement
- Alignment of improvement and transformation activity to reduce duplication and burden

Sources

- Committee escalation summaries
- IPR extracts
- BAF and risk registers
- NHSE correspondence and conditions

BSW Hospitals Group Board

Agenda item	5.2
Report title	Managing Directors Report - RUH
Date of meeting	2 July 2026
Sponsor	John Palmer, Managing Director
Prepared by	Roxy Milbourne, Interim Head of Corporate Governance Jason Lugg, Chief Nurse Jon Lund, Operational Director of Finance Sarah Hudson, Deputy Chief Operating Officer Urgent and Emergency Care Rhiannon Hills, Director of Transformation Jamie Caulfield, Deputy Director of Estates and Facilities Matt Foxon, Site HR Director
Approval Process: (where has this paper been reviewed and approved)	N/A

☒ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

STRATEGIC ALIGNMENT *(Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

The report highlights a mixed position, with strong continued improvement in elective and diagnostic performance but increasing risk across urgent and emergency care, workforce capacity, financial delivery and EPR readiness. The Board is asked to note the assurance position and maintain active oversight of the key delivery risks.

Performance has improved in elective care and NOF ranking; however, urgent and emergency care performance has deteriorated, with increased corridor care, ambulance delays and sustained demand pressures.

Financial and workforce risks remain material, with a £2.6m adverse position, continued uncertainty around delivery of CIP plans (albeit incrementally improving against the 80% Green CIP target and the 15% actual delivery target for Q1), and ongoing pressures relating to sickness, agency usage and operational capacity.

Implementation of the Care Organisation governance model from July 2026, alongside EPR delivery and critical infrastructure and fire safety risks, requires continued executive grip and Board visibility to support safe and sustainable delivery.

Positive regulatory engagement continues with support for stretched elective activity likely, engagement with our demand management challenges and a recognition (at the time of writing) of a concerted approach to the heatwave and the adverse weather event that struck RUH w/b 22/6.

RECOMMENDATION

The Group Board is asked to:

The Board is asked to note the overall assurance position, the risks requiring active oversight, and the actions being taken to support safe and sustainable delivery.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

Royal United Hospitals Bath NHS Foundation Trust

Managing Director's Report

Report Title:	Royal United Hospitals Bath NHS Foundation Trust Managing Director's Report
Date of meeting:	2 July 2026
MD / Lead:	John Palmer
Purpose:	■ FOR ASSURANCE ☐ FOR DECISION ☐ FOR STRATEGIC STEER

Section 1: Executive Summary

1.1 Alert | Advise | Assure

ALERT: Draw attention to matters requiring the Board's awareness or action.

Care Organisation Governance Transition: The move to the new Care Organisation governance model from July 2026 presents a delivery and transition risk. While the structure provides greater clarity between operational management and assurance, there remains potential for duplication, inconsistency of application across divisions, and reduced clinical engagement due to the requirement to align meeting cycles with Group governance timetables. These risks will require active management during implementation to ensure continuity of oversight and effective decision-making.

Workforce Investment and Capacity: Workforce investment proposals discussed at MEC reflect ongoing pressures in key clinical areas, with associated financial and operational risks if recruitment and retention improvements are not realised at pace. The dependency on workforce stability to support delivery of performance trajectories, including elective recovery and UEC, remains a key risk to delivery.

ADVISE: Provide the context, analysis or recommendation the Board needs to understand the issue.

Governance Model Implementation: MEC supported the introduction of a revised governance structure for the Care Organisation, including the establishment of the Care Organisation Management Committee and three aligned assurance committees. The model is designed to strengthen clarity of accountability, improve triangulation of quality, workforce and financial risks, and support more structured escalation into Group governance. Successful implementation will depend on consistent adoption of the AAA reporting approach, clear ownership across divisions, and well-defined operating arrangements for the refocused operational management forum.

Policy Framework Updates: A number of workforce policies were reviewed and approved, including relocation expenses, fixed term contracts, on-call arrangements, and grievance and resolution. These updates support alignment with current employment practice, improve clarity for managers and staff, and strengthen governance around workforce processes.

Strategic Development – Community Diagnostic Centre (CDC) Trowbridge: MEC received an update on the development of the Trowbridge CDC, confirming continued progress and alignment to elective recovery and diagnostic improvement objectives. The CDC remains a key enabler for improving access, reducing waiting times, and supporting delivery of national diagnostic standards.

ASSURE: Provide evidence (not assertions) that systems and controls are working as intended.

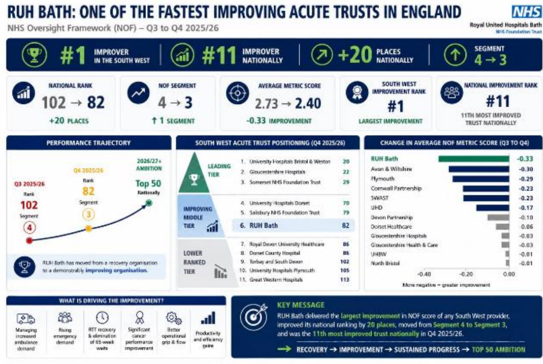
Risk Management and Oversight: The Trust continues to maintain structured oversight of organisational risks through MEC and supporting governance arrangements, with regular review of the corporate risk register and strengthened focus on risk ownership and control effectiveness.

Governance and Decision-Making Framework: The introduction of the revised governance model, alongside continued use of structured Performance Review Meetings and programme boards, provides a clear and consistent framework for operational delivery, assurance, and escalation. This supports improved visibility of risks and performance issues and ensures that decisions are taken at the appropriate level.

Programme and Delivery Assurance: Key strategic programmes, including workforce investment and the development of the Community Diagnostic Centre, are being managed through established governance routes with defined reporting, monitoring, and escalation mechanisms. This provides assurance that delivery is being actively overseen and aligned to Trust priorities.

1.2 Key Achievements and Good News

RUH Bath has demonstrated significant improvement in performance between Q3 and Q4 2025/26, rising 20 places in the national league table and moving from segment 4 to segment 3. This represents the largest improvement of any trust in the South West and positions RUH as the 11th most improved trust nationally. Overall, this reflects a clear trajectory from recovery to sustained improvement, with strengthened operational grip and delivery contributing to measurable gains in national standing.



See full size illustration on page 20.

Section 2: Performance Triangulation

2.1 SPC variation

Figure 1: Performance Alerting Watch Metrics

Alerting Watch Metrics

Watch Metrics - Performance - Alerting

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% Discharged by Midday		45.0%		May-26	21.7%	X			Common Cause Variation
People we care for	% of patients waiting <12hrs in ED		93.7%		May-26	87.5%	X			Special Cause Concerning - Below Lower Control Limit
People we care for	Adult % G&A bed occupancy		92.0%		May-26	96.4%	X			Common Cause Variation
People we care for	Mean time in ED - >75y				May-26	577				Special Cause Concerning - Above Upper Control Limit
People we care for	Mean time in ED - Mental health				May-26	853				Special Cause Concerning - Above Upper Control Limit
People we care for	Mean time in ED - Not Admitted (mins)				May-26	261				Special Cause Concerning - Above Upper Control Limit
People we care for	Non Elective Length of Stay		8.4		May-26	8.8	X			Common Cause Variation

Figure 2: Quality Alerting Watch Metrics

Watch Metrics - Quality - Alerting

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% of ED admissions <60mins from CRtP		80.0%	80.0%	May-26	43.5%	X			Common Cause Variation
People we care for	Early Identification of Deteriorating Patient	NEWS 5+ Screening Completed in 30 - Trust (%)			May-26	22.1%				Special Cause Concerning - Below Lower Control Limit
People we care for	Flu - Healthcare Onset (+3 days)				May-26	42				Special Cause Concerning - Above Upper Control Limit
People we care for	Number of complaints received		30		May-26	31	X			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		May-26	6	X			Common Cause Variation
People we care for	Serious incidents with overdue actions		5		May-26	10	X			Common Cause Variation
People in our community	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD 9-10		0.0%		Apr-26	-11.0%	X			Common Cause Variation
People in our community	% Difference in DNA rates between IMD 1-2 and IMD 9-10		0.0%		May-26	5.2%	X			Common Cause Variation
People in our community	% Difference in RTT performance between IMD 1-2 and IMD 9-10		0.0%		May-26	-2.4%	X			Common Cause Variation

2.2 Cross-Domain Analysis

The Care Organisation delivered the largest improvement in NOF scores across the South West in Quarter 4 and improved its national ranking by 20 places, moving from SOF 4 to SOF 3, making the RUH the 11th most improved trust nationally at the end of 2025/26.

Despite these performance improvements, the Care Organisation continues to operate in a highly pressurised environment with both GP referrals and emergency demand exceeding plan at month 2. Whilst we continue to demonstrate good progress in our elective recovery plans for referral to treatment and diagnostics, cancer wait times for 28 day and 62 day remain below target and there remains significant system demand pressures for emergency care. As a result, we have seen in dip in our 4-hour performance in May and an increase in the number of ambulance handover delays and patients experiencing corridor care.

The focus for quarter 1 remains the sustained improvement in elective operational standards (RTT, Cancer, Diagnostics) and improved partnership working to reduce urgent demand and non-criteria to reside (NC2R) discharge delays with a focus on patients being discharged home (P0) delayed over 24hrs and length of stay of patient discharged to a community setting (P2). The UEC team have launched a UEC 100-day challenge to support improvements across all non-elective pathways as well as planning for the relocation of the Urgent Treatment Centre by quarter 3.

Year-to-date financial performance is £2.6m adverse to plan, driven by savings shortfall, industrial action, and contract funding gaps. Cash balances remain a risk, and system finance performance is adverse overall. Key priorities for Quarter 1 include closing the financial gap and strengthening savings delivery confidence, through the maturity of CIP schemes to achieve 80% Green by the end of June 2026, coupled with the delivery of the quarter 1 CIP target (15%). At end of May, 60% of schemes (£25.1m) are assessed as Green but there remains a risk of achieving 80% by end of June. Productivity improvement is reporting a 3.5% year on year improvement, putting us in the 2nd quartile nationally.

Focused improvement work continues to address the deteriorating pressure injury performance across the Trust and remains a key priority. This includes targeted support in wards that have experienced clusters of pressure injuries, alongside a Trust-wide task and finish group reviewing relevant systems and processes.

Workforce continues to present a degree of risk, with elevated sickness absence (5.5%), increase in use of agency (21.2 WTE v 7.7 plan) and bank (289.3 WTE v 245.8 plan) and appraisal compliance impacting productivity, staff wellbeing and overall organisational resilience. Notwithstanding these pressures, vacancy levels remain low. This reflects the success of targeted recruitment campaigns, particularly within the Emergency Department and across Trust-wide Healthcare Support Worker roles. The Care Organisation continues to demonstrate strong attraction, supported by sustained low levels of turnover.

Work is in progress to develop the Organisation's People Plan supported by a more focused Healthier Workforce Programme, identified as a breakthrough objective for this year in response to high sickness levels. Its purpose is to provide a clear and structured approach to improving the physical, mental, and emotional wellbeing of staff, thereby enabling a healthier, more resilient workforce and supporting the delivery of high-quality patient care.

Figure 3: Business Plan 2026/27 Scorecard

May 2026 — *Performance against trajectory (in year)* — 3 Year Plan Profile

Domain	Metric	26/27 NHSE Instruction	Current Month Trajectory	Apr-26	May-26	Year End 26/27 RUH Plan	Year End 27/28 RUH Plan	Year End 28/29 RUH Plan
UEC	ED Attendance Growth YTD	*Versus 25/26 actual*	1.8%	3.6%	3.0%	-0.5%		
	NEL Admission Growth YTD	*Versus 25/26 actual*	2.4%	12.4%	5.5%	-4.6%		
	Eliminating Corridor Care	*0> 45mins by Nov '26*	0	556 (15%)	683 (15%)	0	0	0
	4-hour ED performance (type 1)	*66.9% by Mar '27*	59.2%	61.2%	56.6%	66.9%	72.9%	79.1%
	4-hour ED performance (all types)	*82% by Mar '27*	69.2%	71.1%	67.0%	75.3%	80.2%	85.0%*
	12-hour ED performance	*96.1%*	92.0%	92.0%	90.1%	93.7%	94.7%	95.0%
	Ambulance handover	*Reduce toward 15 mins*	31	33.1 mins	68.7 mins	30 mins	29 mins	28 mins
Elective & Diagnostic	GP Referral Growth YTD	*Per planning assumption*	0.0%	10.9%	13.0%	0.0%		
	18w RTT Performance	*74.7% for RUH*	69.2%	70.3%	71.1%	74.7%	83.4%	92.0%
	52 Week Waiters	*Reduction towards zero*	331	183	155	198	62	0
	52 Week Waiters %	*Improvement on 1%*	1.0%	0.5%	0.4%	0.8%	0.4%	0%
	Diagnostics 6 week wait	*13.1% for RUH*	13.9%	14.7%	13.1%	12.50%	9.0%	1.0%
Cancer	28 day FDS *	*80% annual ave*	81.1%	79.8%	79.4%	80.0%	80.5%	80.7%
	31 day*	*94%*	92.9%	92.5%	95.0%	94.2%	96.0%	96.1%
	62 day RTT*	*80%*	75.7%	68.5%	70.0%	80.5%	82.7%	85.1%
Workforce	30% Reduction in agency use	*30% improvement from M06*	*tba*	13.3 WTE	21.2 WTE	5 WTE	3 WTE	0
	10% reduction in bank spend	*10% reduction from M06*	*tba*	283.7 WTE	289.2 WTE	237 WTE	-10%	-10%
	Sickness rate (rolling 12 month average)*	*Improvement*	*tba*	5.5%	5.5%	4.8%	4.6%	4.4%
Finance	2% productivity improvement	*(min 2% improvement)*	2.0%	6.5%	3.5%	5.0%	2.7%	1.5%
	Savings Plan	*37.6m (£56.6m over 3 yrs)*	3,766	1,400	2,170	37.6m	10.3m	8.7m
	Balanced or surplus financial position	*Balance or surplus*	((3,304)	((2,886)	((5,935)	0.0m	0.0m	0.0m
Discharge	Non Criteria to Reside (NC2R)	*Number of NC2R*	82	88	100			
	Pathway 0 - Home	*% within 24 hours*	97%	94.5%	93.7%			
	Pathway 1 - Home with support	*% within 48 hours*	100%	43.1%	44.1%			
	Pathway 2 - Community setting	*% within 48 hours*	100%	30.8%	26.8%			
	Pathway 3 - Residential care	*% within 7 days*	100%	42.9%	40.6%			

* one month lag

Summary of performance across the breakthrough objectives and key standards

RUH 4-hour performance in May 2026 was 56.55% on the RUH footprint (unmapped), a decrease of 4.47% from April's performance (61.02%). Non-admitted performance was 67.43%, which is a decrease against April's 71.62%. Admitted performance was 31.92%, which a decrease from 39.45% in April.

Corridor Care - The RUH implemented the use of a corridor in the Emergency Department in October 2025 with launch of W45, to support timely ambulance handover. In May, the number of patients who spent > 45 minutes of their ED visit in the corridor was 683 representing 15% of all ED attendances during that time.

Eliminating corridor care will form part of the 100-day UEC Challenge in June 2026 and we will define countermeasures to address performance improvement.

Elective waits - in May, RTT performance saw an increase in overall performance of 0.8% to 71.1% vs trajectory of 69.2%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 73.9%. The target for over 52-week waiters was achieved with 0.39% of patients on the waiting list being over 52 weeks vs the Trust target of 1%. The Trust continues to sustain the position of having zero patients waiting over 65 weeks.

Diagnostic waits - In May 2026, 86.95% of patients received their diagnostic within the 6-weeks against the 86.10% target (0.85% ahead of trajectory). Performance improved 1.63 % from April 26, with total breaches reducing 165 when compared previous month.

Cancer waits - Cancer performance will now be reported as last month's position, previously reported one month in arrears. In May, 28 Day performance (unvalidated) is currently fractionally under the national standard, achieving 79.5% despite seven specialties improving in month. 31 Day has currently deteriorated to 90.5% but with validation in Breast and Colorectal expected to bring performance close to national standard. 62 Day performance improvement marginally to 70.4% following some improvement in Urology but deterioration in Colorectal.

2.3 Assurance Committee Summary

To be completed once the Group governance structure is in place.

Section 3: Deep Dive / Other Business

The below risks are the three risks that have featured most strongly in the recent governance cycles.

Critical Infrastructure and Fire Safety Risk

Background

The Trust carries a significant and growing backlog maintenance and critical infrastructure risk (CIR) position. The 2025/26 Estates Returns Information Collection (ERIC) return estimates the current CIR cost at £19.7m and the total maintenance backlog at £75.85m, with the full backlog programme estimated at around £120m including fees, VAT and enabling works. The fall in the CIR figure from £33.6m on the 2024/25 return reflects the demolition of most of A Block, not any improvement in the wider estate.

Without a material increase in capital investment, the backlog is projected to reach approximately £87m by 2029/30. The risk is recorded on the Board Assurance Framework as risk 3.4 (Ageing Estate and Backlog Maintenance) and on the operational risk register as Datix 2110, both scored at 20. Following an increase approved at the March 2026 Non-Clinical Governance Committee (NCGC), the matter was escalated to the Board on the basis that the combination of growing infrastructure risk and constrained capital and revenue budgets now exceed what can be managed below Board level.

Fire safety represents the most acute single risk within this position. Compliance gaps include the absence of fire strategies across parts of the site, non-compliant fire compartmentation, and damaged fire doors. The principal fire risks, Datix 1882 (compartmentation and fire doors) and 3280 (fire precautions, evacuation and fire strategies), are each scored at 20.

Update – Fire Safety

A risk-based fire safety prioritisation paper (action MEC019) was approved by the Management Executive Committee on 26 May 2026. It sets out a four-route funding methodology, across national capital, Trust capital, E&F revenue and tolerated risk, to address the highest-priority items from the Authorising Engineer (Fire) Annual Audit Action Plan. Applied in full, fire risks are expected to reduce within the transformational scheme footprints, with limited improvement across the residual estate; Datix scores will decrease but not reach target within the five-year envelope.

A supplier is being procured through a compliant framework to develop fire strategies for the site, closing a key compliance gap. A fire infrastructure improvement programme continues alongside this, including a further phase of Central Block fire compartmentation and completed fire stopping to Sterile Services. Within the FY26/27 internal capital allocation, £743,000 has been prioritised to the fire programme as the Trust's highest risk, as set out in the E&F Capital Plan considered by NCGC on 17 June 2026.

Two Estate Strategy design workshops in July 2026 will shape deployment of the £140m Service Redesign capital programme over the next ten years, with Estates and Facilities ensuring critical infrastructure and fire safety compliance are embedded as design principles. Planned

developments, including the ward refurbishment programme and integrated front door, will address fire safety within their scope.

Ahead of the Fire Authority's inspection of Block 47, dependent inpatients were moved off ward C33. The Fire Authority noted that inpatients remaining in Block 47 would require evacuation across the roof in the event of fire and asked the Trust to resolve this within two years. The plan for C33 is to relocate the remaining mobile inpatients and convert the ward to fully independent outpatient use, enabled by the refurbishment of B12 into an inpatient ward area and the opening of the C16 Discharge Hub. In the interim, enhanced operational and evacuation procedures are in place to support roof evacuation should it be required.

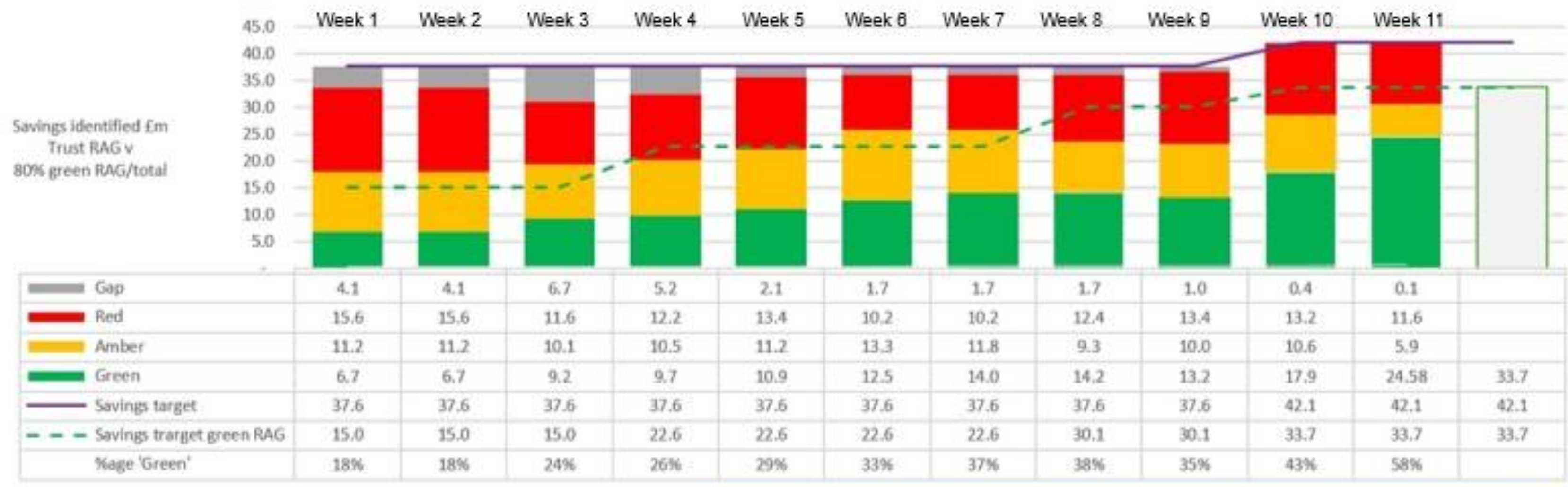
The Fire Authority will inspect Princess Anne Wing (Block 43) on 19 August 2026, with the area being assessed in advance to understand local risk and identify supportive works. Procedural improvements continue in the residential accommodation blocks, with further works progressed by Capital colleagues and a third party to achieve compliance within the Fire Authority's two-year window.

CIP update

Savings planning continues to deliver at pace. At week 11 (week ending 19 June) £24.58m (58%) of schemes were identified as Green (In delivery or Fully Developed), with £9.1m required to reach goal of 80% by end of June. Key priority areas identified by Financial Intervention Programme Board (FIPB) include Outpatients Productivity – and GIRFT and benchmarking best practice; Divisional transactional schemes stretch, and further maturity & stretch of Commercial Programme. 15% of schemes have been identified for Quarter 1

Programme Overview Week 11 – Savings Totaliser

The chart below provides a summary of the Trust's RAG-rated identified savings values against the total savings target. Separately, it shows the 80% of target value green RAG required by end of June 2026.



	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	
Gap	4.1	4.1	6.7	5.2	2.1	1.7	1.7	1.7	1.0	0.4	0.1	
Red	15.6	15.6	11.6	12.2	13.4	10.2	10.2	12.4	13.4	13.2	11.6	
Amber	11.2	11.2	10.1	10.5	11.2	13.3	11.8	9.3	10.0	10.6	5.9	
Green	6.7	6.7	9.2	9.7	10.9	12.5	14.0	14.2	13.2	17.9	24.58	33.7
Savings target	37.6	37.6	37.6	37.6	37.6	37.6	37.6	37.6	37.6	42.1	42.1	42.1
Savings trarget green RAG	15.0	15.0	15.0	22.6	22.6	22.6	22.6	30.1	30.1	33.7	33.7	33.7
%age 'Green'	18%	18%	24%	26%	29%	33%	37%	38%	35%	43%	58%	

Notes to the above

Require an additional £9.1m of green schemes to achieve 80%

- Overall RUHB CIP 26/27 savings target is increased to £42.1m.
- The savings totaliser has been updated with RAG shared at regional level, so we have a unified Trust and Hunter Healthcare CIP position for weeks 1 to 11
- NHSE has a requirement to progress the development of savings to 'Green' delivery RAG, which represents 80% of the total savings target by end of June 2026 (£33.7m)
- Total identified savings value of £42.0m currently falls short of 80% target, even if all converted to 'Green' / In delivery
- At Week 11, 'Green' RAG rated savings opportunities of £24.58m represent 58% of total savings target of £42.1m.

UEC – Care Quality Commission (CQC) Mitigation

The Emergency Department CQC report was published on the 13th May 2026, rated requires improvement. Actions have been taken to address immediate concerns, and the Medical Division are overseeing the implementation of the ED CQC improvement plan. We have received a letter of support from local MP Wera Hobhouse following the CQC publication, specifically regarding he Emergency Department environment and the current occupancy of patients who no longer meet criteria to reside. In addition, Gill Morgan the Regional Chair is also clear that capital investment is required to provide a purpose built integrated front door on the RUH site.

Work is progressing on the plans to provide a new modular UTC in Q3 this year; to improve pathways for patients and to create additional capacity in the main Emergency Department to support our goal to eliminate corridor care, improve the staff and patient experience through the department, and align to the NHS England Model Emergency Department high performing urgent and emergency care pathways. Stakeholder workshops commenced on the 10th June to kick off the development of the RUH Integrated Front Door which is the longer-term vision.

Building on the success and impact of the Elective 12-week challenge last year, the UEC 100-day challenge launched on the 2nd June. The Executive team meets twice a week with the Clinical Divisions, a forum for holding our teams to account for avoidable breaches, to identify themes and trends, and using the intelligence to support pathway or process change or individual staff development. Progress already made on the ENT pathway out of ED and plans to launch, by the end of June, a Gynaecology SDEC service outside of the ED.

Nationally the RUH continues to make progress on long length of stay, supported by the ongoing bi-weekly Multi-Disciplinary Team (MDT) long length of stay reviews which are now business as usual. Highlighting opportunities to improve clinical pathways with system partners, for example acute brain injury and patients with eating disorders and vulnerable adults requiring long term placements.

The RUH participated in a Getting it Right First Time (GIRFT) Mental Health review with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) colleagues on the 14th May, and the report is awaited. Early outcomes have supported publication of escalation processes to support reducing delays in the Emergency Department. AWP representatives are part of the 100-day challenge.

Nationally we are in the topmost improved 4-hour performance when comparing 24/25 and 25/26, receiving a £2m capital allocation that we can use to improve our UEC pathway / performance, linked to the improvement work in the Emergency Department when the UTC is relocated. In addition, capital funding has also been approved to redesign the Surgical Same Day Emergency Care (SDEC) Unit which will address capacity, as currently the environment does not meet the increased daily demand requirements.

People Programme / within the Group People Strategy

The Healthier Workforce Programme has been established to provide a coordinated and strategic approach to workforce improvement, bringing together initiatives focused on wellbeing, leadership and management capability, organisational culture, and system improvement. Progress is being made across a number of priority areas, including targeted support for workforce hotspots through the People Hub, strengthened oversight and management of long-term absence cases, enhanced wellbeing provision, and the development of digital case management solutions to improve consistency, insight, and operational effectiveness.

In parallel, work is underway to address the absence of a clearly defined People Programme for the Care Organisation. In June, the Strategic Executive Forum convened a senior leadership workshop to explore the workforce ambitions for 2030 and identify the critical priorities that will be required to deliver a sustainable, high-performing, and engaged workforce. The workshop generated strong consensus around a small number of strategic themes that should underpin future workforce planning and development.

The next phase of this work will involve engagement with the Group Chief People Officer to ensure alignment between the Care Organisation's workforce priorities and the emerging Group People Strategy. This will provide an opportunity to agree a coherent strategic direction, balancing local workforce needs with wider Group ambitions and ensuring that future people initiatives are both aligned and deliverable

EPR Organisational Readiness (drawn from June 2026 EPR committee papers)

The RUH EPR programme is making progress in establishing core governance structures, leadership frameworks, and enabling infrastructure. Training frameworks, device audits, and initial change and transformation arrangements are in place, with work underway to develop role-based training, define system profiles, and establish cross-organisational groups to support policies, procedures, and super user readiness.

However, overall organisational readiness remains at an early stage. While foundational elements are progressing, a significant proportion of readiness activity is either not yet started or remains at an early phase, with key dependencies still unresolved.

The programme continues to face a number of material risks:

- **Clinical workflow readiness** is currently off track, with validation, ownership and approval not yet in place. This is the most significant delivery gap and is critical to safe implementation.
- **Clinical and operational engagement** remains variable, with limited senior clinical attendance at readiness forums and unclear ownership across governance structures.
- **Programme coordination** is constrained by the absence of a fully aligned, shared programme plans to drive activity across sub-groups.
- **Technical dependencies** persist, including outstanding decisions on theatre equipment and integration risks (for example anaesthetic monitoring and pathology interfaces).

- **Workforce capacity and engagement pressures**, including vacancies and operational constraints, are impacting participation and pace of delivery

Readiness tracking across key domains indicates mixed progress. Some areas such as applications, workflows, and testing are progressing or planned, while others including ESR readiness, communications, and go-live preparation are at an early or not yet started stage.

Immediate priorities are focused on stabilising programme delivery and accelerating readiness. These include finalising and approving clinical workflows, confirming governance ownership and leadership accountability, publishing an integrated programme plan, progressing key technical and capital decisions, and strengthening engagement and communication across clinical and operational teams.

In summary, while there is a clear structure for delivery and early progress in key enablers, current readiness is not yet at the level required to support safe and timely implementation. Delivery over the coming weeks will be critical, with urgent, coordinated action required to address clinical workflow readiness, engagement, and technical dependencies to reduce risk to go-live.

Group assessment suggests a mixed picture of readiness; and our local interpretation of readiness attempts to make a detailed judgement of what needs to be activated to respond and numerate the level of work required to meet the challenge. We will be using this approach actively to trigger response from our teams over the next two months.

BSW HOSPITALS GROUP

Care Org Progress Tracker
ORA & Care Organisation Readiness View

Area	GWH	RUH	SFT
Training Rooms	In progress	In progress	In progress
Correspondence	In progress	In progress	In progress
Wasp	Discovery	Planned	Discovery
Referral Pools	Starting	Starting	Starting
Change Control	Planned	Planned	Planned
Reporting	Review	Review	Review
Testing SMEs	Ongoing	Ongoing	Ongoing
Devices	Starting	Starting	Starting
System Lists	Ongoing	Ongoing	Planned for sign off

Go-live is coming.
Over the coming months, we'll support you with training, testing and readiness activity—so you feel confident using the system from day one.

Led by our people.
Built for care.
Powered by digital.

RUH EPR ORGANISATIONAL READINESS

GROUP VIEW – JUNE 2026

Strong foundations are in place, but key enablers of adoption and integration remain off track, creating risk to a safe and successful go-live in October 2027.

SAFE EPR GO-LIVE
October 2027

DOMAIN		STATUS	KEY COMMENT	
ADOPTION READINESS People, workflows and change	Clinical Workflows	OFF TRACK	Validation, ownership and approval off track	CRITICAL ENABLERS OF ADOPTION
	Clinical Engagement	OFF TRACK	Limited engagement; medical staff off track across all organisations	
	Clinical Safety Case	NOT STARTED	Regulatory compliance risk if not resolved	
	Change & Communications	AT RISK	Inconsistent change processes and communications	
	Training Logistics & Readiness	AT RISK	Training delivery risks; super user coverage gaps	
DELIVERY BRIDGE Connecting foundations to go-live	Programme Planning & Governance	OFF TRACK	No fully aligned, shared programme plan	DELIVERY DISCIPLINE AND INTEGRATION
	Technical Integration & Data Readiness	OFF TRACK	Interfaces, data migration and integration off track	
	Operational Readiness	AT RISK	Processes and operational preparation immature	
	Reporting & Benefits Realisation	AT RISK	Reporting in review; benefits tracking maturing	
FOUNDATIONS IN PLACE Enablers established	Governance & Leadership	ON TRACK	Structures and escalation processes in place	STRONG FOUNDATION
	Executive Sponsorship	ON TRACK	Visible and active across the Group	
	Training Framework & Competency	ON TRACK	Standards, competency and role mapping defined	
	Infrastructure & Technical Foundations	IN PROGRESS	Device audit complete; network coverage maturing	
	Benefits Framework	ON TRACK	Benefits framework defined and progressing	

STATUS LEGEND
- ON TRACK – On plan and progressing
- AT RISK – Attention required
- OFF TRACK – Significant risk / delay
- NOT STARTED – Not yet commenced

OVERALL ORGANISATIONAL READINESS

32%
AMBER / RED
Early stage – foundations in place, adoption lagging

KEY RISKS TO GO-LIVE

- **Clinical workflow validation and approval** – Largest delivery gap; critical to safe implementation
- **Clinical and operational engagement** – Variable engagement and unclear ownership
- **Programme coordination** – No fully aligned, shared programme plan
- **Technical dependencies** – Theatre equipment decisions and integration risks (e.g. anaesthetic monitors, pathology interfaces)
- **Workforce capacity** – Vacancies and operational pressures impacting participation and pace

IMMEDIATE BOARD PRIORITIES (NEXT 90 DAYS)

1. Finalise and approve clinical workflows
2. Confirm governance ownership and leadership accountability
3. Publish integrated programme plan
4. Progress key technical and capital decisions
5. Strengthen engagement and communication across teams

Section 4: Risk Escalation

These risks are those that have moved most against baseline in the most recent governance cycles.

4.1 Escalation Gateway

Category	Risk ID & Title	5+5+5 Score	Reason for Escalation
☐ Strategic (G-Line)	None to escalate		
☐ Operational (T-Line)	3308 - There is a risk that current digital usability and interoperability issues within the obstetric ultrasound may lead to incomplete or inaccurate assessment of foetal wellbeing, delayed recognition of foetal compromise, and inappropriate care planning.	11	The risk has been re-evaluated following recent patient safety incidents (with no resulting harm) leading to an increased likelihood score.

Every escalated risk must be scored using the 5+5+5 methodology.

4.2 Risk Narrative

The operational risks outlined above were approved by the Management Executive Committee (MEC) at its meeting on 23 June 2026. At its most recent meeting, MEC reviewed the overall risk profile by domain. The risks scoring between 12 and 15 under the new 5+5+5 framework are as follows:

Domain	Risk Number and Description	Risk Score (5+5+5)
Patient Safety and Quality	2683: Emergency department unable to meet the NHS England target of four-hour waiting times	12
	3242: Delays in typing and sending clinical letters	12
	2973: Insufficient medical palliative care provision	12
	3230: Insufficient Patient Safety, Risk, Audit and Quality Improvement Resource	12
Finance	3288: Insufficient Capital Funding	12
	3289: Working Capital cash shortfall	13
Service Performance and Delivery	2110: Business interruption as a result of backlog maintenance, or critical infrastructure risks	12
	2988: Non-replacement of medical equipment	12
Workforce	2124: Oncology/Haematology Workforce and Service Delivery	12
	2075: ED Workforce Gaps Affecting Quality and Performance	12
Digital	3243 – IT equipment age replacement (laptops/desktops)	12
Statutory, Legal and Reputational	1882: Non-compliance with fire compartmentation	12
	3198: Inconsistent Consent Form 4 Documentation	12

Risk Management Improvement

Risk management improvement initiatives continue to advance focusing on the following key areas:

- Risk housekeeping in line with agreed KPIs
- Risk education for staff and senior leaders
- Governance reporting
- Risk register quality

A Risk Management Consultant has joined RUH on a fixed-term basis to support delivery across all workstreams with a particular emphasis on enhancing the quality of the risk register.

Engagement continues with all risk owners to review and strengthen controls, supporting the assessment of their control effectiveness in accordance with the new 5+5+5 methodology.

Section 5: Care Organisation Context

Care Organisation Governance Structure

The organisation is progressing the transition to the BSW Hospitals Group governance model, with revised Care Organisation governance arrangements approved at MEC for implementation from July 2026. Implementation of the revised governance model will commence from July 2026, with early focus on embedding the new committee structure, establishing consistent AAA reporting, and aligning divisional governance arrangements to the Group cycle. This will support clearer accountability and more structured assurance as the model becomes established.

National Outcome Framework (NOF) Scores - Year end 2025/26

The Care Organisation delivered the largest improvement in NOF score across the South West in Quarter 4, improving its national ranking by 20 places and moving from segment 4 to segment 3. This positions RUH as the 11th most improved trust nationally at year end, demonstrating a clear trajectory of sustained performance improvement.

Figure 4: RUH NOF Scores Q4 2025/26

RUH BATH: ONE OF THE FASTEST IMPROVING ACUTE TRUSTS IN ENGLAND

NHS Oversight Framework (NOF) – Q3 to Q4 2025/26

NHS
Royal United Hospitals Bath
NHS Foundation Trust

#1 IMPROVER IN THE SOUTH WEST | **#11** IMPROVER NATIONALLY | **+20** PLACES NATIONALLY | SEGMENT **4 → 3**

NATIONAL RANK	NOF SEGMENT	AVERAGE METRIC SCORE	SOUTH WEST IMPROVEMENT RANK	NATIONAL IMPROVEMENT RANK
102 → 82	4 → 3	2.73 → 2.40	#1	#11
+20 PLACES	↑ 1 SEGMENT	-0.33 IMPROVEMENT	LARGEST IMPROVEMENT	11TH MOST IMPROVED TRUST NATIONALLY

PERFORMANCE TRAJECTORY

- Q3 2025/26: Rank 102, Segment 4
- Q4 2025/26: Rank 82, Segment 3
- 2026/27+ AMBITION: Top 50 Nationally

RUH Bath has moved from a recovery organisation to a demonstrably **improving organisation**.

SOUTH WEST ACUTE TRUST POSITIONING (Q4 2025/26)

Tier	#	Trust	Rank
LEADING TIER	1.	University Hospitals Bristol & Weston	20
	2.	Gloucestershire Hospitals	22
	3.	Somerset NHS Foundation Trust	29
IMPROVING MIDDLE TIER	4.	University Hospitals Dorset	70
	5.	Salisbury NHS Foundation Trust	79
	6.	**RUH Bath**	**82**
LOWER RANKED TIER	7.	Royal Devon University Healthcare	86
	8.	Dorset County Hospital	86
	9.	Torbay and South Devon	102
	10.	University Hospitals Plymouth	105
	11.	Great Western Hospitals	113

CHANGE IN AVERAGE NOF METRIC SCORE (Q3 TO Q4)

Trust	Change
RUH Bath	-0.33
Avon & Wiltshire	-0.30
Plymouth	-0.29
Cornwall Partnership	-0.23
SWAST	-0.23
UHD	-0.17
Devon Partnership	-0.10
Dorset Healthcare	-0.06
Gloucestershire Hospitals	-0.03
Gloucestershire Health & Care	-0.03
UHBW	-0.01
North Bristol	-0.01

Axis: -0.40, -0.20, 0.00

More negative = greater improvement

WHAT IS DRIVING THE IMPROVEMENT?

- Managing increased ambulance demand
- Rising emergency demand
- RTT recovery & elimination of 65-week waits
- Significant cancer performance improvement
- Better operational grip & flow
- Productivity and efficiency gains

KEY MESSAGE

RUH Bath delivered the **largest improvement** in NOF score of any South West provider, improved its national ranking by **20 places**, moved from **Segment 4 to Segment 3**, and was the **11th most improved trust nationally** in Q4 2025/26.

→ RECOVERY → IMPROVEMENT → SUSTAINED PROGRESS → **TOP 50 AMBITION**

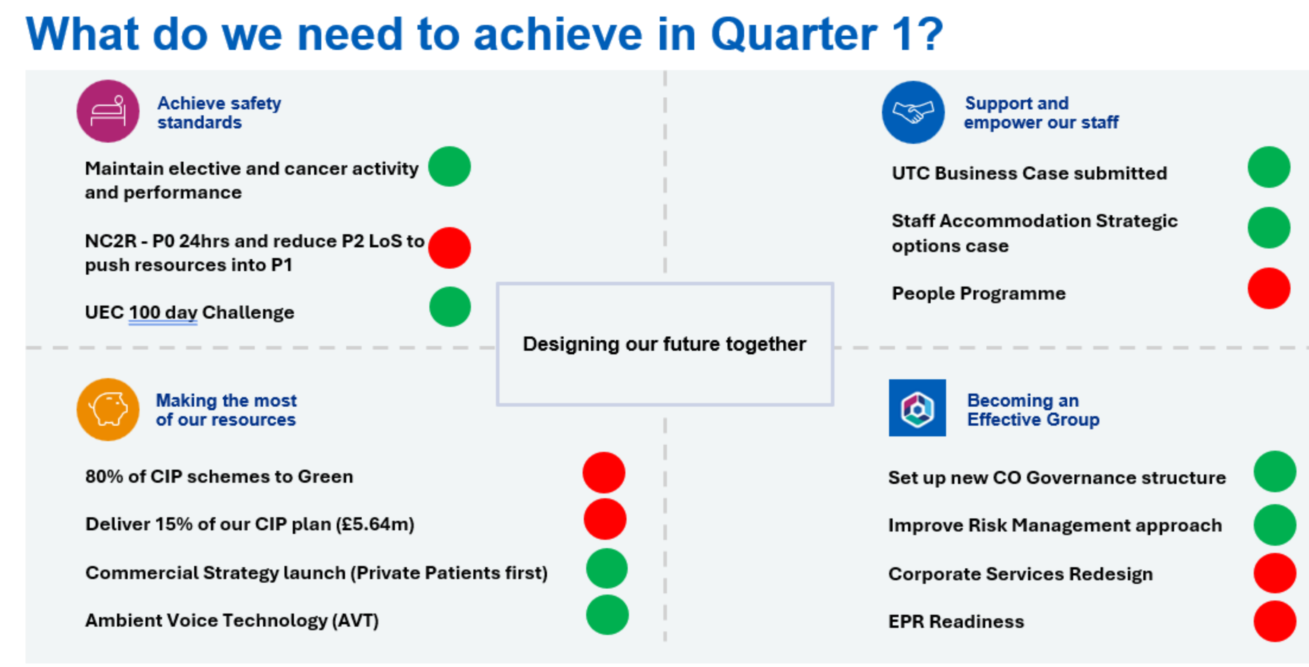
Headlines	Data period	Provider value	Peer average	National value	National value method	Chart
Adjusted segment	Q4 2025/26	3	NOF Score	Provider value		
Average metric score	Q4 2025/26	2.4	NOF Score	Provider value		
Unadjusted segment	Q4 2025/26	3	NOF Score	Provider value		
Financial override	Q4 2025/26	Yes	No	Yes	Provider median	

Domain Scores	Data period	Provider value	Chart
Access to services domain segment	Q4 2025/26	3	NOF Score
Effectiveness and experience of care domain segment	Q4 2025/26	2	NOF Score
Patient safety domain segment	Q4 2025/26	3	NOF Score
People and workforce domain segment	Q4 2025/26	3	NOF Score
Finance and productivity domain segment	Q4 2025/26	3	NOF Score

Financial and Operational Plan 2026-2029

Whilst the Organisation's plan is balanced, it remains extremely challenging with some very significant financial and operational risks. Key dependencies remain community demand management, a shift to larger scale transformational change supported by new capital investment, securing further elective and cancer funding, and benefits from new and innovative commercial opportunities.

The financial ask is heavily front-loaded to year-one and is in advance of critical enablers such as left shift of care, shared Electronic Patient Record (EPR), and capital investment. In particular, delivery of our CIP plan for 2026/27 will need a collective focus and the Organisation will also need to sustain activity levels achieved through the Q4 Elective Sprint to maximise income contribution whilst commercial and transformation schemes are matured.



Great Western NHS Foundation Trust

Managing Director's Report:

Report Title:	April 2026 GWH update – Item 5.3
Date of meeting:	July 2026
MD / Lead:	Lisa Thomas, Managing Director
Purpose:	☐ FOR ASSURANCE ☐ FOR DECISION ☐ FOR STRATEGIC STEER

Section 1: Executive Summary

1.1 Alert | Advise | Assure

ALERT:

RTT performance	Waiting lists have risen in the last 6 months which has led to a deterioration in RTT performance and a regulatory concern from NHSE. This has led to increased oversight from regional performance team. 80% of the waiting list growth is in the non-admitted pathway, significant validation issues have been identified. 4000 records are being validation through external company with a minimum of 25% expected to result in a clock stop. In addition, First outpatient appointment sprints underway in high volume specialities – ENT, Gynae and General surgery. There are additional ring-fenced procedures for day surgery – increasing capacity 40-50 per day. To support recovery there is a new recovery director in place from May and an improvement plan went to March PPC committee to support a deep dive, The waiting times for elective procedures are also one of the biggest drivers of complaints with 40% related to waiting times and access.
Corridor care & high bed occupancy	GWH was in critical incident from 23rd March to 2nd April related to poor flow and high levels of escalated patients. Trust occupancy levels peaked at 584 patients in the bed base at midnight which was one of the highest experienced during the winter period and 75 patients above core stock. This followed a surge in demand pre-Easter and a sustained period of lower discharges than planned Bed occupancy remains significantly high and the corridor care levels for March have been high. The hospital routinely has corridor care in - ED ambulatory chairs - ED temporary spaces

	- MAU temporary spaces - Additional patient in ward bays - Ward temporary spaces on corridor. - Bedding discharge lounge The Trust is taking part in the national collaborative for reducing corridor care, actions are in place for immediate safety of patients, the right care board to improve urgent and emergency care and working on longer term solutions for bed and assessment capacity.
Financial position	The financial plan for 2026/27 is incredibly challenging with currently no clear path to deliver the full £47m savings 9.6%. Turnaround support started 13th April which will help identify additional CIP opportunities and de-risk existing plans. More updated plans submitted in May to region – based on planning metrics show an increase in green rated schemes which is positive progress. The risk remains the delivery in the context of significant operational pressures and increased demand.
Stroke services	Stroke services are underperforming with a SNNAP score of E with 26.2 points, this service has also been part of a review from the stroke network and region. The Quality committee reviewed remedial actions related to improvements particularly in ED – access to CT 24/7 and stroke pre-alerts direct to the stroke team. The service is supported by locum consultants which is an unsustainable model. There is a requirement to improve the model of stroke care for patients recognising the national recruitment challenge for Stroke Consultants. The Group Transformation Officer is leading this work looking at different models of delivery.

ADVISE:

Demand	Patient demand remains sustained, as a proxy for UEC, October to March compared to the previous year shows a 12% increase in type 1 attendances and a 5 % increase in UTC attendances. This level of increase puts continued pressure on UEC pathways and capacity for planned care procedures.
Patient and carer concerns	There was an increase in concerns in March (544 concerns compared to 475 in February). The most common theme related to waiting times accounting for 43% of concerns, with a further 17% related to communication. There is a focus to improve our response to complaints

	and concerns which is targeting patient correspondence and telephone communication. This includes more information to the public on waiting times to help signpost for more information.

ASSURE:

Breakthrough objective – Reducing Falls	March closed down the breakthrough metric – reducing falls. This will be replaced by deconditioning for 2026/27. Overall, performance in 2025/26 demonstrates that the objectives for reducing inpatient falls has been met. Inpatient falls have reduced by 14.6% and the number of falls resulting in moderate harm or above reduced by 26.5%.
Sickness absence	Sickness absence continues to improve at 4.1%, long term absence is slightly below target, however short term absence is doing better than planned. Improvement work has been driven through an improving attendance working group, focusing on a burnout toolkit, support from Employee assistant programmes and QR reporting for medical staff absence reporting.
PFI update	Soft market engagement has taken place to test market for facilities management post PFI hand back in October 2029. There is a well established PFI expiring project board.
Modular ward	There is a slight delay to opening the modular ward to support PFI backfill ward refurbishment which is likely to be end of June due to remedial fire safety requirements. The decant plans have been through Trust management committee and approved.

1.2 Key Achievements and Good News

- Sustained improvement in falls performance in both numbers and a reduction in moderate/severe harm demonstrating impact of targeted improvement actions.
- MSSA reduction programme now implemented Trust wide including new cannula care policy education roll out and audit programme, providing strong foundations for infection reduction.
- Despite significant operational pressures comparing ambulance handovers the reduction since September is from 2.5 hours to 45 minutes.

Section 2: Performance Triangulation

2.1 SPC variation

All five breakthrough objectives are not showing significant changes. These are new objectives for 2026/27 so are in the early phases. Corridor care has reduced in May, and productivity due to being March data shows some year end anomalies.

- Reducing deconditioning in acute care
- Total Corridor Care (ED & Inpatient)
- RTT 18-week performance
- Staff Survey – Q25a Care of patients / service users is my organisation's top priority.
- Improving productivity

There are areas of underlying challenges which have trigged alerting watch metrics:

Metric	RTT performance – number of patients over 18 weeks
Data	The waiting list has grown since July 2025 which has meant the current 18-week performance is 58%.This performance overall is in the lower quartile nationally. Following investigation, the growth is partially explained by a process change leading to patients potentially incorrectly added to the waiting list, alongside growth in referrals from primary care and internal capacity challenges, in part linked to UEC demand pressures. The waiting list has reduced in the last few months following sustained work outlined below including validation and some areas of additional capacity ,

<table>
<tr><th>Metric</th><th>RTT performance – number of patients over 18 weeks</th></tr>
<tr><td></td><td>inevitably this means a lag in RTT performance as patients works their way through the system.</td></tr>
<tr><td>Actions</td><td>GWH has started a 12 week challenge programme with 5 workstreams to recover the position
Capacity/demand planning and bottom up trajectories per specialty.
Operational grip and planning
Admin process and outpatients improvement
Validation and accurate PTL management
Routines and strengthened governance.
A new RTT recovery Director started in May to support focus at divisional and specialty level to expedite recovery planning. There are six key internal metrics which are continually monitored, and these are discussed with regional colleagues on a fortnightly basis. These are: Over 18 Weeks

Over 52 weeks, OP 1st Booked >40 weeks, RTT Performance, Total Waiting List, Over 65 weeks

Along side this are a number of other metrics that remain a focus to support RTT performance improvement: -Wait to 1st Appt, Missing Outcomes, Duplicate Pathways

Since Mid April the position is as follows:
Steady reduction in over 18 weeks from a peak of 19,777 to 18,708
Over 52 week waits is static
RTT performance will fluctuate as the processes improvements to stop inappropriate referrals being added to the list will skew some performance in the interim period.
Over 65 weeks has fallen from 19 to 11 by end of May.</td></tr>
</table>

Metric	62-Day Cancer Standard

Data

62-day First definitive Treatment Performance (Combined Standard) by Month End Date

…lan Area	Measure Name	Target /SPC Target	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26
…ancer	% Cancer 62 day performance	85% (Nat)		61.6%	60.6%	72.0%	One mon… behind
	% Cancer 31 day performance	96% (Nat)		85.5%	85.3%	89.7%	One mon… behind
	% Cancer 2 week wait	93% (Nat)		62.3%	66.7%	67.4%	One mon… behind

62 day performance remains challenged, 28% of breaches were for Urology, with diagnostic reporting delays and 3 different pathways to onward care in other NHS Hospitals being key contributors.

31-day performance fell short in March 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 45% of all breaches, with Colorectal next with 31%. Capacity was the main reason for breaches, being responsible for 66% of breaches.

Actions

Further outsourcing of dermatology is being explored in anticipation of a rise in referrals during the summer months.

Support from the cancer network to review multi site pathways.

Metric	Emergency Department – 4-hour standard

Data

Plan Area	Measure Name	/SPC Target Icon	Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	66.5%	69.3%	68.6%	67.6%
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	10.7%	10.5%	8.5%	7.8%
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	44.0%	47.6%	47.9%	54.6%
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	19.6%	20.2%	16.1%	13.2%
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	93.6%	93.5%	90.8%	87.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC	H	6337	5608	6241	7093
	Emergency Care - AED - Median Stay	240 (Int)	F	326	290	296	238

4-hour performance (type 1 and 3) reported 67.6% in April. This is below the 25/26 national target. Performance has been more challenged in the last six months due to sustained demand increases.

Total % over 12 hours (Type 1) in April was an improvement to 7.8% from 8.5% in February.

The underlying issues remain flow from ED to assessment capacity and onward wards. This is reflected in bed occupancy at 98 % for April

Actions

- ED 4 hour performance remedial action plan across Type 1 admitted, Type 1 non-admitted and Type 3 UTC.
- Improvements are planned for a change in pathway for paediatrics ensuring all children are streamed through the separate area this will be in place from April.
- The Right care programme started in April which is the overall programme to ensuring patients are seen in the right place at the right time. The focus on improving flow across the hospital will help move patients more timely into admitted beds and SAU/SDEC assessment pathways improving ED metrics.
- A focus remains on working with community and primary care to reduce demand through preventative care in the community. Focus on relationships with primary and community care to look at alternatives to presenting at ED/UTC.

Metric	Concerns or complaints

Data

Plan Area	Measure Name	Target	SPC Improv. Icon	Dec-25	Jan-26	Feb-26	Mar-26
Concerns and Complaints	No. of concerns received	SPC		342	522	475	544

There was an decrease increase in complaints in April (544 in March compared to 495 in April). Waiting times remain the most common theme.

Actions

- Improvement actions are being taken through the outpatient working group, focusing on enhancing telephone communication and reviewing patient correspondence.
- Across 2 adult wards and the Children's Units, the National What Matters to you campaign is being piloted as an improvement action to strengthen personalised care by encouraging meaningful, person-centred conversations.

Metric	Finance

Data

For Period Ended - 30th April 2026						
	In Month			YTD		
Financial Position	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Operating Income from Patient Care Activities	41,349	40,641	(708)	41,349	40,641	(708)
Other Operating Income	2,971	3,284	314	2,971	3,284	314
Income	44,320	43,926	(394)	44,320	43,926	(394)
Pay - Substantive	(24,979)	(26,071)	(1,093)	(24,979)	(26,071)	(1,093)
Pay - Bank/Locum	(1,982)	(2,496)	(514)	(1,982)	(2,496)	(514)
Pay - Agency	(179)	(148)	31	(179)	(148)	31
Pay	(27,140)	(28,716)	(1,576)	(27,140)	(28,716)	(1,576)
Non Pay	(15,881)	(16,023)	(143)	(15,881)	(16,023)	(143)
Total Expenditure	**(43,021)**	**(44,740)**	**(1,719)**	**(43,021)**	**(44,740)**	**(1,719)**
EBITDA	**1,299**	**(814)**	**(2,113)**	**1,299**	**(814)**	**(2,113)**
Depreciation & Finance Charges	(2,999)	(2,649)	350	(2,999)	(2,649)	350
Surplus/(Deficit) incl deficit support	**(1,700)**	**(3,463)**	**(1,764)**	**(1,700)**	**(3,463)**	**(1,764)**
Less: Deficit Funding	**(564)**	**(564)**	**0**	**(564)**	**(564)**	**0**
Adjusted Surplus/(Deficit) excl Deficit Funding	**(2,263)**	**(4,027)**	**(1,764)**	**(2,263)**	**(4,027)**	**(1,764)**

Month 1 financial position was off plan by £1.8m, the most significant driver of the variance was unidentified CIP £0.8m, £0.4m associated with industrial action. There was also slippage against outpatient transformation £0.2m and ongoing costs related to demand increases across the urgent and emergency care pathway which in turn limit opportunities for cost reduction albeit will improve productivity metrics.

Actions

The financial plan remains a significant focus with the Trust with significant management time spent on financial grip and control with Hunter support.

	• Workforce control panels in place to limit recruitment to service necessity. • Turnaround support which started in April to help identify further savings for next year to reach £47m (9.6%). • Controls on discretionary spending. • Main areas of clinical transformation are Outpatients, theatres and Urgent and Emergency care. All are worked into programme approaches. • Looking to strengthen programme management resource to ensure delivery.

2.2 Cross-Domain Analysis

The high bed occupancy sustained in May has implied consequences (not always easy to explicitly triangulate across all quality and safety metrics).

The financial position is challenging going into 2025/26, with the help of Hunter Healthcare the Trust has been working on identifying more schemes to close the unidentified CIP gap, with the aim of achieving this by June 2026. The pressure on the organisation is significant with the need to see and treat more patients within 18 weeks, reduce the expenditure to achieve a significant and outlier level of CIP (9.6%) and cope with an increase in demand makes keeping a balance across key performance indicators very challenging for teams.

The continued hospital occupancy levels and use of outlier areas is impacting the ability to achieve planned care targets and productivity metrics, the sustained use of daisy (day surgery) as an escalation area limits the theatre productivity for day case throughput. The use of discharge lounges for bedded patients limits the ability to improve the number of patients discharged earlier in the day and Surgical Admissions (SAU) capacity is limiting length of stay improvements for patients awaiting onward beds in orthopaedics.

Capacity for change remains a significant challenge for the organisation as we are asking teams to apply more rigour and focus across a number of areas. The systems and processes at GWH remain a focus for improvement including needing a step change in capacity for business intelligence support to enable operational and clinical teams good robust information to support timely decision making. The changes to corporate functions as they work through the redesign process is having an impact on pace of change.

2.2 Assurance Committee Summary

Committee		Key Focus Areas	Unresolved / Escalated
Quality & Safety		• Procedural Safety Oversight Group • Maternity performance report • Risks including 15+ (old scoring) • Nursing & Midwifery Audit & Ward Accreditation • Clinical Audit & Effectiveness • Corridor Care • Integrated Front Door – Quality report	• Stroke service review – group led service review.
Finance & Performance		• Monthly position • Efficiencies update • Budget setting process • Overseas visitors • Health and safety • Staff accommodation • Pre- application for planning permission for additional wards/IFD2 • BAF	• Level of unidentified CIP in 2026/27 and risk to financial plan delivery.
People & Culture		No meeting	

Section 3: Deep Dive / Other Business

Maternity and Neonatal Services (Exception Update)

Patient Safety Events

One new severe patient safety event (57323) is reported this period, relating to a homebirth with a diagnosed breech baby with subsequent neonatal admission for therapeutic hypothermia. Antenatal care was provided by GWH with the family choosing independent midwifery care for the intrapartum period. An After Action Review has been completed with minimal initial Trust learning identified. The case has been referred to Maternity and Neonatal Safety Investigation

(MNSI) team, with Child Death Overview Panel processes underway. The Wiltshire Coroner has accepted the case and an inquest is anticipated.

There are no additional emerging trends or clusters of harm identified this month.

PMRT / MOSS Alerts

There are no new PMRT or MOSS alerts indicating systemic concerns or deterioration in outcomes during this reporting period. Routine PMRT processes remain in place, with continued monitoring of stillbirth data. Current reporting is noted to be limited by the inclusion of terminations within crude rate calculations which is impacting the SPC analysis of the local data.

Triage Performance

Performance against the triage standard shows that 81% of women were assessed within 15 minutes, with an average waiting time of 8 minutes.

Work is underway to improve flow and capacity within the triage environment through both short-term estate adjustments and development of a business case for reconfiguration.

Elective Caesarean Section Capacity

There remains a sustained mismatch between demand and capacity for elective caesarean sections. This continues to result in postponed procedures being undertaken outside planned theatre lists.

A cross-divisional programme of work is in progress to improve theatre utilisation, review workforce models and increase elective capacity. This includes consideration of recurrent investment and alternative commissioning approaches to better align funding with activity.

Neonatal Workforce – British Association of Perinatal Medicine (BAPM) Compliance

Neonatal staffing does not consistently meet BAPM standards in relation to staffing aligned to cot occupancy and QIS requirements. There is a 9.44WTE gap in funded establishment based on the BAPM nursing tool calculator which has been driven by increased cot occupancy and acuity over the last 2 to 3 years.

Daily safer staffing numbers are monitored via daily safety huddles and mitigations include escalation through bank and agency as required, ongoing recruitment, expansion of training programmes for QIS staff. A full review of the workforce model is underway to align with sustained increases in demand.

Regulatory and NHSE Requirements

Maternity Incentive Scheme (MIS) Year 8 is currently rated amber across all domains, reflecting a cautious baseline assessment in this transition year. A structured programme of work is in

place to progress compliance, with group peer review scheduled for September to support external assurance and trajectory planning.

Items for Escalation

· Ongoing gap between elective caesarean demand and capacity, with associated operational and financial implications.

· Neonatal workforce not meeting BAPM standards in line with demand, representing a sustained capacity risk.

· Limitations in data quality and completeness within the maternity dashboard, impacting benchmarking and performance oversight.

Overall, while no immediate patient safety incidents have arisen from current capacity and workforce pressures, these risks remain material and require continued executive oversight and system-level mitigation.

Deep Dive – ward accreditation framework

The quality committee received a report on the ward accreditation framework, The purpose of ward-based clinical audits is to ensure that patient care is safe, effective, and consistently delivered in line with the Trust's professional, regulatory, and organisational standards.

These audits provide a structured and systematic approach to reviewing current practice, measuring performance against agreed standards, and identifying opportunities for

improvement. This framework applies to all clinical areas across the Trust, including inpatient wards, Maternity, Outpatients, and Front Door services.

Current Position

• The ward audit programme is now well-established, with regular monthly and quarterly audits completed across all clinical areas.

• Clear governance and monitoring arrangements ensure that audit outcomes are reviewed, themes identified, and actions tracked through Divisional and organisational structures.

• Peer review processes are increasingly embedded, strengthening objectivity and promoting shared learning.

• Audit data is being actively reviewed for quality, realism, and value, ensuring it drives meaningful improvement rather than compliance for its own sake.

Key Themes

• Leadership visibility and consistency strongly correlate with higher audit performance; where leadership presence is variable, audit outcomes reflect this.

• IPC compliance is improving but remains inconsistent, particularly around hand hygiene and equipment cleaning.

• Peer review is strengthening objectivity and shared learning, though some wards are still developing confidence in giving and receiving feedback.

Improvement Actions

• Feedback is routinely given to the Ward Manager and Matron following each ward accreditation assessment irrespective of whether they are compliant or not.

• Complete the yearly audit reviews to ensure they are credible and appropriate

• Support Ward Managers with their improvement plans and identify blocks with the assessments

• Continue to provide education and support when completing the ward accreditation

Section 4: Risk Escalation

4.1 Escalation Gateway

Category	Risk ID & Title	5+5+5 Score	Reason for Escalation
☐ Operational (T-Line)	There is a risk that the high hospital occupancy leads to poor patient flow through the hospital affecting the delivery of safe care.	5+4+3 = 12	Consistent hospital occupancy is impacting quality of care. This requires longer term capital investment to ensure the number of beds matches expected demand c70+ below requirements.
☐ Operational (T-Line)	There is a risk that stroke patients will not receive quality care and timely interventions required to aid their recovery which can be evidenced SSNAP performance.	4+4+4= 12	To meet external review findings to improve stroke care will required additional investment and workforce both of which are significantly challenged therefore essential for wider group review of HASU status.
☐ Operational (T-Line)	There is a risk of potential harm to patients in need of review and/or treatment (including cancer) by the Plastics team.	4+5+3= 12	GWH does not provide plastics – this should be provided by ORH, who have not been able to fulfil their service. This is having significant impact on cancer and RTT waiting times. There is an opportunity to provide plastics service with SFT which is being progressed.
☐ Operational (T-Line)	There is a risk GWH does not have the capacity or capability to achieve the scale of the financial improvements to achieve the plan.	5+4+3=12	The level of change impacting the organisation is significant asking clinical teams to manage significant operational pressures/financial turnaround and clinical transformation over a short period of time. This is against the need for resource to be directed to strengthening and improving operational processes across the organisation e.g. RTT/Cancer/ complaints response.
☐ Operational (T-Line)	There is a risk to service provision & patient safety due to Interventional Radiologist shortage.	4+4+4= 12	No clear service for IR services (vascular is GHFT) leaves the Trust at significant risk out of hours for emergency patients.

Category	Risk ID & Title	5+5+5 Score	Reason for Escalation
☐ Operational (T-Line)	Estates – PFI Life cycle works and access	4+4+4=12	High hospital occupancy has led to a backlog of maintenance work due to the inability to decant clinical areas. Not completing this work before October 2029 which increase the financial liability to GWH in the context of very limited capital funding in the future.
☐ Operational (T-Line)	There is a risk to patient safety, privacy and dignity from the provision of Corridor care across the integrated front door in ED and MAU.	5+3+4=12	Corridor care is not designed or equipped for patient care, resulting in compromised privacy, dignity, as well as increased risk of harm. This can impact negatively on patient experience and breaches our regulatory obligations under (Regulation 10: Dignity and Respect & Regulation 12: Safe Care), which requires that to ensure care and treatment is delivered in a way which respects individuality and dignity.
☐ Operational (T-Line)	There is a significant risk to patients across the IFD in seated waiting rooms utilised by self presenting and ambulance 'fit to sit' patients within MAU, ED Ambulatory Majors and UTC due to increased demand and acuity within these departments at times.		Attendance surges and high occupancy can lead to delays in triage, time-critical and clinical interventions, medication administration, treatments, and delayed discharges or transfers to appropriate wards. Extended stays within these areas may also result in patients who are deemed 'Fit to Sit' experiencing clinical deterioration, thus rendering this classification no longer appropriate. Additionally, this increases the demand on both nursing and medical resource due to care interventions.
☐ Operational (T-Line)	There is a risk to service provision, reporting times and patient safety across the radiology department because of the vacancies	4+4+4=12	Significant gaps in radiology impacts on cancer pathway reporting times.

Category	Risk ID & Title	5+5+5 Score	Reason for Escalation
	within the radiologist team.		
☐ Operational (T-Line)	There is a risk of delayed diagnosis in Suspected Physical Abuse (SPA) cases due to lack of Paediatric Radiologists	4+4+4=12	There is a risk to service provision and patient safety at GWH due to the absence of paediatric radiologists and no formal SLA for reporting suspected physical abuse (SPA) cases. RCR guidelines require two specialist paediatric radiologists to provide a consensus report within 24 hours, but GWH currently has no internal or external reporting provision. Previously, SPA images were reviewed for quality by a GWH radiologist and then reported by two paediatric radiologists at Nottingham NHS Trust. However, Nottingham has withdrawn support, leaving GWH without a reporting pathway or contingency plan. We are currently not able to undertake gold standard investigations for non-mobile children at risk or who have experienced significant harm, and therefore GWH are not able to do any Child Protection Medicals for the under 1 age group with immediate effect.
☐ Operational (T-Line)	There is a risk that suboptimal clinical environment is impacting patient experience and effectiveness of clinical care.	4+4+4= 12	There are a number of areas like maternity triage, inefficient outpatient capacity, lack of theatre procedure rooms which are impacting the quality of patient experience, with both the PFI and limited capital funding there are limited short term solutions to resolve.
☐ Operational (T-Line)	Risk to Elective activity and RTT trajectory due to insufficient elective admissions resource	5+3+4= 12	There are gaps in admin resource associated with financial controls and limited recruitment. This impacts the

Category	Risk ID & Title	5+5+5 Score	Reason for Escalation
			effectiveness of booking and fulfilling both outpatient and theatre lists.
☐ Operational (T-Line)	Risk to patient experience and poor flow for Surgical Pathways	5+4+3= 12	Insufficient surgical admissions capacity leads to poor patient experience and risk to delay in treatment.

Every escalated risk must be scored using the 5+5+5 methodology.

4.2 Risk Narrative

The risks presented in the above table are a move towards the new scoring methodology. The process for the corporate risk register is immature at GWH currently and being further refined. As the new structure takes effective and adequate corporate governance support is put in place this will be further developed and put risk escalation at the centre of the corporate governance processes.

The Deputy Chief Nurse has developed an education programme to roll out the new scoring system across the organisation and identified a plan to ensure the scoring of controls can be incorporated into Datix recording. This will be rolled out in the next quarter.

Section 5: Care Organisation Context

GWH has been under sustained operational pressures in April with high demand through the Emergency Department (ED), and underlying capacity challenges with bed availability to sustain demand. This is explained in more detail in the information above.

Appendices

N/A

BSW Hospitals Group Board

Agenda item	6.1
Report title	Group Risk Register
Date of meeting	2nd July 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Simon Hackwell, Project Governance lead
Approval Process: (where has this paper been reviewed and approved)	No prior approval process for this cycle. Going forward the GRR will be reviewed by the Group Executive Committee and Risk and Assurance Committee prior to the Group Board.

☐ **FOR ASSURANCE**	☒ **FOR DECISION**	☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk R1	**Becoming an effective group**

KEY MESSAGES

The updated Group Risk Register identifies 42 risks scoring 12 or above across the three care organisations, compared with 35 in May.

The increase reflects a significant expansion of the active register this cycle, with 16 risks appearing at or above the threshold for the first time.

The single largest theme across the register is estate and infrastructure. Risks in this category span all three care organisations and represent a range of timescales, from immediate operational concerns to long-term capital planning.

Financial risks are present across all three care organisations and workforce risks represent a third recurring theme.

Two risks warrant particular attention as new additions. The discontinuation of the RUH Hospital at Home service (RUH-3314) has entered the register with no controls describing patient safety arrangements during the transition. The Building Safety Act compliance risk at GWH (GWH-1401) reflects an emerging regulatory obligation that has been actively managed, with named legal advisors and a defined engagement route with the Building Safety Regulator.

The Register continues to be developed and improved as the risk systems and approach are aligned across the Group.

For the Board meeting in September the Risk and Assurance Committee in August will have reviewed the register and any particular risks escalated by the Group Executive.

RECOMMENDATION

The Group Board is asked to:

1. Note the Group Risk Register.

APPENDICES

The Group Risk Register and detailed Controls Analysis are contained in the Reading Room for the Board's meeting.

BSW Hospitals Group Risk Register: June 2026

1. Introduction

This paper presents the risks in the BSW Hospitals Group Risk Register for June 2026 that score 12 or above under the 5+5+5 scoring model. The residual score for each risk is the sum of three components: Likelihood (L), Impact (I), and Control Score (C). Each component is rated on a scale of 1 to 5. The Control Score reflects the effectiveness of the controls in place, running from 1 (Fully Effective) to 5 (Absent): a higher Control Score indicates weaker controls and therefore a higher residual risk score. The active register threshold is 12.

The register covers 42 risks across the three care organisations: 15 from Great Western Hospitals NHS Foundation Trust (GWH), 17 from Royal United Hospitals Bath NHS Foundation Trust (RUH), and 10 from Salisbury NHS Foundation Trust (SFT). 17 risks are new to the active register this cycle, appearing at a score of 12 or above for the first time in June 2026. The remaining 25 are carried over from May 2026.

A Controls Quality Analysis accompanies this register and is available under separate cover alongside the full Excel Group Risk Register. The Controls Quality Analysis assesses the quality of the control descriptions for each risk against the three question test from the BSW Risk Management Strategy: is the control specific? Does it act directly on the risk? Could you audit it? **The Verdict column in this register reflects that assessment**. For any risk with a Partial or Fail verdict, the Control Position column provides a brief summary of the control position and key gap; the Controls Quality Analysis sets out the full evidenced assessment and should be read alongside this register.

Across all 42 risks, 14 receive a Pass verdict, 21 are Partial, and 7 are Fail. One SFT risk (SFT-5664) does not yet have a Control Score, although has been included the SFT return.

2. Executive Summary

The June 2026 Group Risk Register contains 42 risks scoring 12 or above across the three care organisations, compared with 35 in May. The increase reflects a significant expansion of the active register this cycle, with 16 risks appearing at or above the threshold for the first time. This does not necessarily indicate a deterioration in the overall risk position; it reflects care organisations bringing risks onto the register that were previously managed below the threshold or that have been newly identified as the 5+5+5 methodology embeds.

The single largest theme across the register is estate and infrastructure. Risks in this category span all three care organisations and represent a range of timescales, from immediate operational concerns to long-term capital planning. GWH has added two new risks relating to the expiry of its PFI contract in 2029, covering both the capital and funding position and the capacity and resourcing required to manage the transition. RUH carries a new risk around the absence of retrospective building fire strategies, alongside its existing fire compartmentation risk. SFT continues to carry risks relating to electrical power

infrastructure in theatres and the DSU estate, neither of which has seen substantive improvement in controls since May. The group-wide picture on estate risk is notable in its breadth and the extent to which capital solutions are described as planned rather than confirmed.

Financial risks are present across all three care organisations. GWH and SFT carry risks relating to the delivery of their annual financial plans. RUH carries two distinct financial risks this cycle: the delivery of the annual financial plan and a new working capital cash shortfall risk, which has entered the active register without operational controls in place. The two risks are related but distinct and both carry a residual score of 13.

Workforce risks represent a third recurring theme. GWH has added risks relating to clinical medical leadership capacity and legal services capacity, both new to the active register. RUH carries a risk around patient safety, risk, and quality improvement resourcing that has been partially addressed since May. SFT has added central booking workforce instability to the register. These risks share a common characteristic: they describe staffing gaps with limited structural mitigation, and the controls in place are largely interim rather than permanent.

Two risks warrant particular attention as new additions. The discontinuation of the RUH Hospital at Home service (RUH-3314) has entered the register with no controls describing patient safety arrangements during the transition. The Building Safety Act compliance risk at GWH (GWH-1401) reflects an emerging regulatory obligation that has been actively managed, with named legal advisors and a defined engagement route with the Building Safety Regulator.

Since May, a small number of risks have moved below the threshold. Three RUH risks: digital clinical safety, mental health provision in the emergency department, and respiratory lung cancer capacity, are no longer in the active register at 12 or above.

3. The Group Risk Register Summary June 2026

Risk Ref	Risk Title	L	I	C	Total	Direction of Travel	Verdict	Control Position
Great Western Hospital								
GWH-286	Utilities Site Infrastructure	5	3	4	12	New	**Partial**	Utilities Capacity Dashboard (kVA headroom, MW output, water metrics), capital gate sign-off, and Estates representation at Capital Group are in place. WFP funding avenues (item 6) is a planned action rather than a functioning control.
GWH-299	Life Cycle Works and Access	4	4	4	12	Unchanged	**Partial**	EFM Board oversight and named escalation ownership are present. The response protocol for when P2G flags delayed or cancelled works - who receives the alert, within what timeframe, and what the response authority is - remains undescribed.
GWH-1085	High Hospital Occupancy	5	4	3	12	Unchanged	**Pass**	Handover Improvement Group (weekly), nerve centre for live patient placement, Emergency Zone Operational Group, NCTR improvement plan, and UEC/Flow Programme are all in place and unchanged.
GWH-1230	Legal Services Capacity	4	4	4	12	New	**Partial**	Mutual aid from SFT or RUH and an approval gate for external legal advice are in place. The trigger for activating mutual aid and the structural response to the underlying staffing gap are not described.
GWH-1267	Stroke Care	4	4	4	12	Unchanged	**Partial**	SOP ringfencing two Falcon beds, Bournemouth predictor tool, bi-monthly SSNAP oversight, weekly ED improvement huddles, and a cross-divisional SSNAP recovery plan are in place. No contingency is described for when ringfenced beds cannot be maintained under pressure.
GWH-1314	Paediatric Radiology: Suspected Abuse Cases	4	4	4	12	Unchanged	**Partial**	RUH referral pathway for child protection medicals added in June. The primary tertiary centre reporting arrangement remains unspecified; TMC backup is noted as untested. Recruitment is listed without a timeline.
GWH-1382	Interventional Radiology Service	4	4	4	12	Unchanged	**Pass**	SLA with a third-party provider, agency staff cover, NHSE support for hub and spoke model, NBT agreement for emergency urology IR cases, and exec agreement at GRH for emergency IR cover are all in place. Improved from May.
GWH-1401	Building Safety Act	5	3	4	12	New	**Pass**	Named external legal advisor (Bevan Brittan), defined testing approach with the Building Safety Regulator, and co-ordinated BSR submissions via SERCO and THC covering named sites are specific and in place.

GWH-1493	Clinical Medical Leadership Capacity	4	4	4	12	New	**Fail**	New CMO appointment, AMD and Executive leadership support, and clinical leadership training (commenced May 2026) are noted. None of the three controls are described with sufficient specificity to address the divisional medical leadership gap.
GWH-1539	Elective Activity and RTT Trajectory	5	3	4	12	Unchanged	**Pass**	DD-led RTT recovery meeting with named attendees, Plans on a Page when gaps are identified, and Elective Delivery Group oversight are all in place. Improved from May.
GWH-1576	Capacity and Capability: Financial Plan	5	4	4	13	Unchanged	**Partial**	Monthly ERM reviews, external resourcing support (Hunter Healthcare), savings targets with named owners, financial reporting, and corporate project oversight are now described. Financial improvement programme specifics and savings delivery trajectory remain absent. Improved from May.
GWH-1577	Suboptimal Clinical Environment	4	4	4	12	Unchanged	**Partial**	IPC measures with audit, duty of candour mechanisms, health and safety monitoring, divisional governance review, and capital bids for named areas are in place. Improvement programme content and timeline are not described. Improved from May.
GWH-570	Surgical Assessment Unit: Patient Safety	5	4	3	12	New	**Partial**	Three daily divisional huddles, morning safety and quality meeting, and Matron of Day oversight are in place. No escalation pathway to senior leadership when safety thresholds are breached is described.
GWH-1608	PFI Expiry: Capital and Funding	4	4	4	12	New	**Partial**	Trust-approved PFI Expiry Capital and Betterment Plan, engagement with DHSC/IPA for central funding, and a resourced Programme Plan identifying critical activities are in place. The fundamental capital funding gap is not resolved by the controls described.
GWH-1613	PFI Expiry: Capacity and Resourcing	4	4	4	12	New	**Pass**	Named external support (legal, commercial, technical, IPA/NISTA), escalation routes (Programme Board to EFM Board to FIDC), and integration with capital and financial planning are specific and in place.

Risk Ref	Risk Title	L	I	C	Total	Direction of Travel	Verdict	Control Position
Royal United Hospitals Bath								
RUH-3165	Delivery of Annual Financial Plan	5	4	4	13	Unchanged	**Pass**	Savings programme 37% green (26 May 2026), enhanced pay controls (VCARP), non-pay controls (No PO No Pay, discretionary spend limits), System Triple Lock, and BSW Group collaboration are all in place.
RUH-3273	Future Site Development: Electrical Infrastructure	5	4	4	13	New	**Fail**	All new projects are screened through the Electrical Senior Estates Officer and electrical demand monitoring is in place. No capital programme for substation upgrade, no interim capacity management protocol, and no timeline for an infrastructure solution are described.
RUH-3289	Working Capital Cash Shortfall	4	5	4	13	New	**Fail**	No operational controls managing the cash shortfall are in place. One control is described as under development; one entry is a financial goal rather than a control. Revenue Support PDC application is a pending action.
RUH-3314	Discontinuation of RUH Hospital at Home Service	4	5	4	13	New	**Fail**	Both controls relate to the governance decision around service discontinuation. No patient safety controls, transition arrangements, or alternative pathway provision during the gap are described.
RUH-1977	Millennium Electronic Order Communications	4	4	4	12	Unchanged	**Partial**	Trust policy, induction training, and phlebotomist training are in place. No compliance audit and no systematic solution to the underlying Millennium workflow issue are described.
RUH-2973	Insufficient Medical Palliative Care	4	4	4	12	Unchanged	**Pass**	Dorothy House (4 sessions per week for 42 weeks), out of hours advice line, nurse-led 7-day service, and MD/CNO/CMO engagement with Dorothy House are all in place.
RUH-3198	Inconsistent Consent Form 4 Documentation	4	4	4	12	Unchanged	**Pass**	Named leads, full audit covering all elective surgeries for relevant patients, Datix reporting for non-compliance, MCA/DoLS in mandatory training, and interim documentation improvements submitted to Change Board are all in place.
RUH-3230	Patient Safety, Risk, Audit and QI Resource	4	4	4	12	Unchanged	**Partial**	Specific workforce gap data provided by band and stage. Business case partially approved; funding pending. Improved from May. Entry remains Partial as recruitment is not yet complete.
RUH-3235	Outdated Policies and Limited Governance Resource	5	3	4	12	Unchanged	**Fail**	A policy register maintained by Corporate Governance is in place. One of the two entries is a self-assessed gap rather than a control. No controls describe the update backlog, priority review schedule, or governance oversight of compliance.

RUH-3288	Insufficient Capital Funding	4	4	4	12	Unchanged	**Partial**	Group Strategic Capital Group oversight, Internal Audit assessment (Strong Assurance 2025/26), and four named sub-groups are in place. One generic phrase does not meet the specificity standard.
RUH-1882	Non-Compliance with Fire Compartmentation	4	5	3	12	Unchanged	**Pass**	Risk assessed remedial works, L1 fire detection, staff evacuation training, fire risk assessments incorporating known breaches, fire warden audits, and annual authorising engineer audit are all in place.
RUH-2110	Business Interruption: Backlog Maintenance	5	4	3	12	Unchanged	**Pass**	Prioritisation by Associate Directors of Estates and Capital Projects using condition reports, environmental reports, and risk assessments by technical leads. Improved from May; decision-making criteria and named roles now described.
RUH-2124	Oncology and Haematology Workforce and Service Delivery	5	4	3	12	Unchanged	**Pass**	Business case (MEC to F&P Committee), agency locum cover, waiting list and overbooking initiatives, cancer pharmacist utilisation, non-registered staff support, roster optimisation, and Bristol neuro cancer pathway are all in place.
RUH-2683	Emergency Department: 4-Hour Standard	5	4	3	12	Unchanged	**Pass**	GIRFT Tier 1, UEC Breakthrough Objective reporting (fortnightly to Engine Room), EEMAC (operational since February 2026), flow and capacity controls, ambulance handover SOP, 24/7 clinical oversight huddles, OPEL escalation, and workforce controls are all in place.
RUH-3242	Delays in Clinical Letters	5	4	3	12	Unchanged	**Partial**	Weekly Elective Delivery Group review, temporary staffing via MEC approval, and cancer navigator tracking are in place. Specialty triage against clinical risk and weekly trajectory monitoring remain absent.
RUH-3243	IT Equipment Age Replacement	5	4	3	12	New	**Partial**	Replacement prioritised to critical clinical areas; 750 devices replaced in 2025 with a noted reduction in IT support requests from those areas. Capital bid (5-year plan, not yet approved) is a planned action rather than a confirmed control.
RUH-3280	Absence of Retrospective Building Fire Strategies	4	5	3	12	New	**Partial**	Annual fire risk assessments, monthly authorising engineer audit reviews, compartmentation survey programme, and PPM for fire systems are in place. No action plan for producing the missing Retrospective Building Fire Strategy documentation is described.

Risk Ref	Risk Title	L	I	C	Total	Direction of Travel	Verdict	Control Position
Salisbury Hospital								
SFT-8102	Central Booking: Workforce and Process Instability	5	4	4	13	New	**Partial**	RPA for eRS tasks, booking working group, Datix and governance escalation, and DMT on-site intervention are in place. Transformation programme and recruitment are listed without milestones or outcomes.
SFT-6229	DSU Estate Infrastructure Failure	5	4	4	13	Unchanged	**Fail**	No systematic controls are in place. The ECC (Elective Care Centre) is a planned capital solution, not a current operational control. No preventative maintenance regime or service diversion protocol is described.
SFT-6412	Harm to Women and Babies: Lack of Second Obstetric Theatre	4	5	4	13	New	**Partial**	SOP with defined decision pathway, Datixing all instances of second theatre use, and MDT case review are in place. No arrangements are described for when both the main theatre and the anaesthetic room are simultaneously unavailable.
SFT-8791	Financial Position 2026/27	4	5	4	13	Unchanged	**Pass**	Cash flow forecasting, F&P monitoring, confirmed deficit support (£6.4m), ICB transitional funding, enhanced vacancy control, weekly agency monitoring, medical rate card adherence, NHSE enhanced oversight, and divisional escalation meetings are all in place.
SFT-7917	Fire Risk in Main Theatres Corridors	5	3	4	12	Unchanged	**Pass**	Weekly fire team walk-rounds, daily fire walk, weekly Theatre Fire Warden checklist, corridor clearance, fire door and extinguisher checks, increased Designated Fire Safety Officers, and daily housekeeping are all in place.
SFT-7931	Electrical Power Infrastructure in Theatres	4	4	4	12	Unchanged	**Partial**	Two-weekly PPM visual checks, daily walk-arounds, and work orders for remedial issues are in place. The capital programme for infrastructure upgrade is no longer referenced. Load management protocol remains undescribed.
SFT-7946	Transformation Programme Delivery	4	4	4	12	Unchanged	**Partial**	Corporate projects prioritisation group feeding into the Engine Room, resource scheduling bi-weekly meeting, UEC and Planned Care Boards, Small Projects Board, and an SFT turnaround team running bi-weekly CIP and transformation delivery meetings are all in place. Benefits tracking is defined and tracked per programme. Transformation programme delivery milestones are not described.
SFT-8068	Switchboard 2222: Lone Working Cover	4	4	4	12	New	**Fail**	A single shift rota adjustment (relief shift extended to 7pm) is the only control. No arrangements for 2222 call coverage overnight or at weekends under the lone working model are described. No backup system for the switchboard is in place.
SFT-7734	Capital Funding	5	4	3	12	New	**Partial**	Capital control group prioritisation, Datix monitoring, rolling 15-month cashflow forecast, risk assessed 5-year plan, and Estates Safety Fund are in place. Capital control group composition, decision criteria, and governance escalation are not described.

SFT-5664	Capital Required to Manage Backlog Maintenance	3	4	tbc	tbc	New	**Partial**	Trust capital bids and ERIC data tracking are in place. No controls describe the management of the backlog itself. Control score not yet assigned and must be confirmed before the July submission.

BSW Hospitals Group Board

Agenda item	7.1
Report title	Models of Care Transformation
Date of meeting	2 July 2026
Sponsor	Andrew Hollowood, Chief Clinical Transformation Officer
Prepared by	Fiona Bird, Deputy Director of Strategy, RUH Bath Simon Sethi, Elective Care Director, BSW Hospitals Group Emily Beardshall, Site Director – TIPS, GWH Rhiannon Hills, Group Director of Transformation, BSW Hospitals Group Heather Cooper, Director for Urgent and Emergency Care, BSW Hospitals Group Alicia Wyer, Programme Manager, BSW Hospitals Group
Approval Process:	None

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*	
☐ Developing an engaged workforce	☐ Making our teams diverse and inclusive
☒ Making our services safer	☒ Improving timely access to our services
☒ Improving the experience of those who use our services	☒ Improving our financial sustainability
☒ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	**Principal risk title**
R4	Transforming Models of Care

KEY MESSAGES

The Clinical Transformation Programme is a clinically led, group-wide initiative to redesign models of care across the BSW Hospitals Group in response to growing demand, workforce constraints and financial pressures, recognising that current service models are not sustainable.

In the last period, governance and delivery arrangements have strengthened, with an expanded Clinical Transformation Steering Group, appointment of a Group Director of Transformation, and mobilisation of Clinical Transformation Groups across priority specialties. Early engagement is underway with system partners and internal teams to support co-designed change.

Key delivery activity is progressing across three core areas: (1) a strategic elective care work plan to 2031 aimed at improving access and managing demand; (2) mobilisation of specialty transformation programmes and digital innovation (including ambient voice technology); and (3) system-wide work on urgent and emergency care and the Acute Services Review.

Risks relating to clinical engagement, capacity, and reliance on external resources are being actively managed. Continued pace will depend on securing leadership capacity and developing strong engagement across clinical and operational teams.

RECOMMENDATION

The Group Board is asked to:

- receive and note this update and provide assurance on progress and direction of the programme.

Board is not alerted to any urgent areas of concern.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
None	

Models of Care Transformation

1. Executive Summary

The Clinical Transformation Programme is a clinically led, group-wide initiative to redesign models of care across the BSW Hospitals Group in response to growing demand, workforce constraints and financial pressures, recognising that current service models are not sustainable.

Alert:

No matters are raised to Board for immediate escalation

Assure:

Key delivery activity is progressing across three core areas:

- a strategic elective care work plan to 2031 aimed at improving access and managing demand;
- mobilisation of specialty transformation programmes and digital innovation (including ambient voice technology); and
- system-wide work on urgent and emergency care and the Acute Services Review. A UEC deep dive is in progress and will be presented to a future Board.

Advise:

In the last period, governance and delivery arrangements have strengthened, with an expanded Clinical Transformation Programme Board, appointment of a Group Director of Transformation, and mobilisation of Clinical Transformation Groups across priority specialties. Executive Sponsors and project resourcing have been agreed for the majority of the six first wave Clinical Transformation Groups. Early engagement is underway with system partners and internal teams to support co-designed change.

Risks relating to clinical engagement, capacity (clinical leadership and transformation support), and reliance on external resources remain and are being actively managed. Continued pace will depend on rapid progression of the Corporate Services Review within the transformation team in particular, along with securing clinical leadership capacity and developing strong engagement across wider clinical and operational teams.

2. Context

Demand, workforce and financial pressures mean our current service models are not sustainable. Unwarranted variation in access and outcomes persists across our communities, alongside growing inequality and risk. At the same time, our population is changing — with more people living longer and with multiple long-term conditions.

Doing nothing is not an option. We must fundamentally redesign how care is delivered, rather than continuing to do more of the same.

The *Models of Care Transformation Programme* is a clinically led, group-wide initiative to design future models of care that are sustainable, equitable and high quality.

It is focused on the NHS 10-Year Plan shifts: hospital → community, analogue → digital, sickness → prevention, and built around co-design with clinicians, patients and partners, using evidence, data and best practice.

Delivering meaningful change for our communities will require transformation at multiple levels across our hospital group:

- **Specialty level** — through Clinical Transformation Groups
- **Modality level** — focusing on how care is delivered, including urgent and emergency care, elective, diagnostics, and outpatients care
- **System level** — through the Acute Services Review

The Clinical Transformation Programme is underpinned by complementary investment in our clinical infrastructure, particularly digital and estates.

At a time of significant change across the BSW health and care system, we are working closely with partners in commissioning and service delivery to ensure a coherent, consistent and effective approach to transforming care and improving outcomes together.

3. Programme update

3.1 Programme

- Clinical Transformation Programme Board and Working Group in place. Working Group membership has expanded to allow further knowledge sharing between workstreams, and to reflect emerging corporate structures as the Group Corporate Service Redesign programme matures.
- Group Director of Transformation appointed through the Corporate Service Redesign programme, Rhiannon Hills, currently Director of Transformation at RUH Bath. This post will lead the transformation teams which will support clinical leaders to design and deliver change. Interim transformation project management resource has also been agreed in the last month and is outlined in section 3.3.
- The Clinical Transformation Steering Group has agreed the expansion of the Clinical Transformation Groups (CTGs), adding Stroke and Robotics to the specialties/pathways agreed following the 2025 clinical stocktake.
- External partner briefings are underway, with the ICB, primary care leads, HCRG, Universities and Health and Wellbeing Boards being engaged, and approaches to other key partners (VCSE, other health partners) to follow. Internal comms have begun on the overall programme; first wave specialties will be shared widely once the clinical teams and Divisions are briefed and engaged.

3.2 Workstream 1: Productivity

Elective Care

Strategic Work Plan

Work has now been completed to develop a Strategic Work Plan for Elective Care 2026 – 2031. The formation of the BSW Hospitals Group is a once-in-a-generation opportunity to scale the impact of elective service improvement and design services that draw on the collective strength of the three Trusts as well as enable more equable access for the population that the group now services.

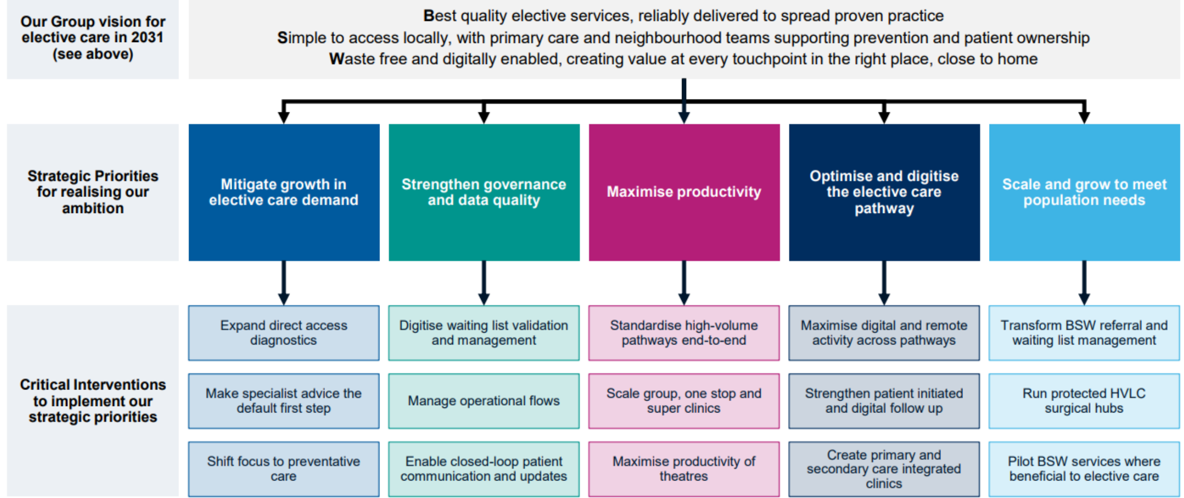
The scope of this strategic work plan is all elective services provided across the group. It has been developed from a 'whole group' perspective, rather than built up from each site individually, and so is intended to support increasingly close joint working at Group level. Engagement undertaken to develop the plan included:

- A steering group of BSW Hospitals Group representatives meeting weekly throughout the project, guiding developments and shaping the outputs of the review.
- Meetings with Leadership Teams from all Care Organisations
- Discussions with stakeholders (including the ICB, HCRG, Sulis and other partners), which provided valuable insights on current services as a whole and opportunities for change; and
- Service level discussions with clinical and operational staff to provide specific insights on both current clinical services and associated opportunities for change. This was supplemented by a session which brought together the Chief Medical Officers from each Trust.

The resulting plan sets out our vision for how elective services will be optimised over the next 5 years, and how we will work together to deliver it. It is structured around three key questions :

- Where we are now? (the current position and case for change)
- Where do we want to be? ('BSW 2031' – our vision and strategic priorities)
- How will we get there? (implementation planning)

Figure 1. Elective Strategic Work Plan



The plan is underpinned by demand and capacity modelling, which suggests that delivery of the interventions in the plan has the potential to mitigate waiting list growth through to 2031, despite expected continued growth in demand, if the proposed interventions are successfully implemented and resourced.

Next steps:

- BSW Elective Delivery Group workshop being arranged to identify gaps between current implementation and the work plan, with an annual delivery plan for Elective Care for BSW Hospitals Group to be developed using the output
- Further demand and capacity analysis to understand the implications and quantify the benefits of the plan in detail

Delivery in 26/27

Eight priorities have been set for the Elective Delivery Programme for 26/27 - these will then be refreshed for 27/28 based on year 1 of delivery of the Strategic Work Plan. The priorities are illustrated in the table below, and some highlights of current delivery included below.

Figure 2. Eight elective priorities for BSW HG in 26/27

Priority	Objective
1. Elective Strategic Workplan	Write an elective strategy for BSW and deliver year 1
2. RTT support and shared tools	Deploy shared approach and tools to deliver RTT. Create tools for capacity/demand planning, performance improvement, A+R
3. RSS + Advice and Refer	Pilot group RSS/SPOA and deploy A+R in 10 specialties
4. Dermatology	Transformed model of care and left-shift
5. FDP	Expand FDP – Single Waiting List, Patient-led Validation, further tool roll out as becomes available.
6. Sulis	Sulis Orthopaedic Centre fully utilised for BSW
7. Diagnostic Delivery	Progress three major CDC builds across BSW. Transform pathways in gastro, ENT, cardiology.
8. Elective High Cost Spend	Review areas of high cost spend such as locums or in-sourcing across BSW. Review if group solutions exist in these areas to improve sustainability.

Some of the key progress in Q1 includes:

- **Strategic Work Plan** – as outlined above, the work plan is now completed and work is now progressing into the implementation phase.
- **Dermatology** – the Hospital Group aims to significantly redesign dermatology pathways across BSW in the face of high demand, insufficient workforce, high spend on outsourcing and locums, and performance challenges. A project team has now been established led by the Director of Elective Care with a clinical and primary care lead. This group aims to deliver a revised specification and business case by October 2026 for roll out from April 2027.
- **Advice and Refer –** the roll out of A+R across the group in 10 specialties is a requirement of NHSE by October 2026. This is a key transformation as it could improve patients experience and reduce patients unnecessarily being brought in for outpatient appointments thereby improving system productivity and reducing waiting lists . Project leads are in place in the 3 COs with strong COO leadership. A BSW HG A+R Group oversees and supports roll out ensuring aligned approaches are adopted and that the hospitals are working closely with primary care and the ICB on the required digital enablers from ERS/Cinapsis.
- **Performance Recovery** – a set of tools have been developed to support performance improvement particularly in RTT across Group – these have been initially developed via

the RUH RTT recovery process and are now being implemented at GWH. These aim to create: standardised diagnostic tool to inform recovery plans; capacity/demand tools to inform capacity requirements to meet RTT standards, standardised reporting packs to track delivery. The toolkit is summarised in the graphic below- the aim is this approach and the tools it includes are iteratively developed as hospitals implement improvements.

Figure 3: BSW RTT recovery toolkit

Urgent and Emergency Care

- The system-wide UEC Reset Programme across all partners has launched with clear priority system actions, target outcomes and priority acute actions identified to support the key system challenges. The target outcomes are:
    - Eliminate corridor care
    - Improve ED performance (4-hour & 12-hour waits)
    - Reduce mental health delays
    - Reduce acute attendances
    - Improve discharge timelines (NCTR delays)

- The delivery groups are being established this month with the first UEC Executive Pathways meeting to be held on 8th July.

- UEC metrics have been agreed and are being shared across the system through the UEC weekly update call.

- UEC Summit being planned for 15th July with system leaders attending chaired by the group CEO.

- UEC system deep dive underway to develop understanding as to demand at the front doors of acutes, to be shared at the UEC Summit and subsequently with Group Board.
- BSW Group Corridor Care Action Plan in place alongside each acute's own UEC improvement plan.

- Each Care Organisation has refreshed its improvement plan to align with internal actions needed to improve internal flow.

3.3. Workstream 2: Clinical Transformation Groups

- The first wave of specialties agreed following the December 2025 stocktake are Dermatology, Diabetes and Paediatric Orthopaedics. Stroke has since been added as part of this work as it has emerged as a material issue. Robotics and Microsoft Dragon will also be included alongside the first wave of specialties.
- Executive Sponsors and Senior Responsible Officers have now been agreed for each specialty/pathway, and Transformation Lead and Project Management support for majority of the wave 1 specialties have been assigned.
- Each specialty is now entering the Discovery Phase and identifying stakeholders and preparing project outline documents. Of note:
  - **Paediatric Orthopaedics –** clinical engagement underway with a view to beginning the 90 day sprint approach in July 2026
  - **Stroke –** At GWH, work is ongoing with Dr Louise Shaw (RUH clinical lead and GIRFT stroke clinical lead) around short-term actions to increase sustainability of the service focusing on improving the SSNAP indicators. Across the Group stakeholder mapping has started to support bringing teams together. A conversation around geospatial demand mapping is in place with the South West CSU.
  - **Microsoft Dragon –** RUH locality proof of concept of ambient voice technology (AVT) is currently running from October 2025 to September 2026. Within Rheumatology, the letter typing backlog has reduced from >1,300 letters to <150, with further productivity benefits for clinicians and administrators. AVT will expand in 2026 with launch of the Microsoft Dragon pilot across the three Care Organisations, using the product offering that sits within the Group's existing IT software. Phase 1 will roll out 450 licenses across the Group, with support from Microsoft for training and floor walker adoption to support adoption. Phase 2 will provide a proof of concept of an integrated option utilising Accenture to support integration with Oracle Millennium at the RUH. Work is expected to start in January 2027 following the upgrade of the current Millennium version at the RUH. A full benefits case and future funding arrangements will be developed as part of the pilot.
  - **Robotics –** This project will develop the next phase of the Robotics Strategy for the BSW Group. The first workshop is scheduled for 26 June 2026

Diabetes has moved to a new SRO who is now scoping the work programme.

Pharmacy has been identified as an area for potential in year cash releasing savings; work is ongoing to scope the opportunity and allocate resource, potentially through pausing work currently in train.

Pillar	Corporate Project	Exec Sponsor	SRO	Clinical Leads	Due date	On / off track	Transformation Lead	Project Support	Governance - Delivery
Clinical transformation	**Paediatric Orthopaedic Surgery – CTG**	Andrew Hollowood	Rhiannon Hills	Nicole Corin / James Fagg, RUH Clinical lead, GWH	Mar-27	Scoping	Alicia Wyer	Ilaria Idini, RUH	Clinical Transformation Steering Group
	Dermatology	Andrew Hollowood	Simon Sethi	Beth Wright, RUH Ruth Alexander, BEMS	Mar-27	On track	n/a	Peter O'Connor, RUH	Clinical Transformation Steering Group
	Diabetes	Andrew Hollowood	Tony Mears	Marc Atkin, RUH James Lawrence, SFT	Mar-27	Scoping	tbc	SFT	Clinical Transformation Steering Group
	Stroke	Andrew Hollowood	Emily Beardshall	Louise Shaw, RUH Stephan Hinze, GWH	Mar-27	Scoping	Alicia Wyer	GWH	Clinical Transformation Steering Group
	Robotic Strategy	Andrew Hollowood	Rhiannon Hills	Melissa Davies / Rob Ritchie, SFT Sarah Richards / Marc Bullock, RUH	Mar-27	Scoping	Alicia Wyer	n/a	Clinical Transformation Steering Group
	Microsoft Dragon Pilot	Jonathan Hinchcliffe	Rhiannon Hills	Roger Steadman / Paul Devenish, GWH Ian Kerslake, RUH Tbc, SFT	Mar-27	On track	Alex Bushell / Pete Justin (RUH) Tbc (GWH) Ardeshir Nasarwanji (SFT)	Nicola Ford, SFT Catherine Ball, RUH (admin support)	Clinical Transformation Steering Group
	Acute Services Review – first phase	Bernie Marden Andrew Hollowood	Jane Rowland Fiona Bird	tbc	Mar-27	On track	Alicia Wyer	Toma Kwakpovwe, RUH	Clinical Transformation Steering Group
	Pharmacy (*New*)	Andrew Hollowood	Chief Pharmacists (tbc)	Chief Pharmacists	Nov-26	Scoping	tbc	Mercy Ogunbawo, RUH	Clinical Transformation Steering Group
Commercial	**Commercial Strategy**	John Palmer	Fiona Bird	Various	Mar-27	On track	tbc	Zainab Owoyomi, RUH	Commercial Board

Figure 4: Group Clinical Transformation Programme: Resourcing matrix

3.4 Workstream 3: Acute Services Review

BSW ICB are leading on the procurement of a consultancy partner to deliver an Acute Services Review that will begin to take a long term view of acute services provision across BSW, to match future populations needs and deliver a sustainable health system for our population. The Hospitals Group is working closely with the ICB to design the clinical engagement that will support this first phase of work.

4. Risks

Theme	Risk	5+5+5 score	Mitgations	Escalation to Board
Leadership and clinical engagement	Risk that Clinical Lead roles are not secured quickly, delaying mobilisation and reducing momentum.	(C+L+CE) 4+3+4=**11**	Engagement plan in development; CMOs supporting warm up conversations	None
	Without sufficient engagement the pace and sustainability of change could be limited	4+4+4=**12**	Development of engagement plan to maximize involvement and support delivery.	None

			stocktake, sharing the evidence base for the work	
Capacity and change overload	Risk of clinical capacity constraints limiting meaningful engagement, particularly given operational pressures and concurrent programmes of work e.g. EPR.	4+3+4=**11**	Engagement of divisional teams Support from GEC.	None
Resource dependency	Programme delivery was partly dependent on external support (Teneo) pending internal resource coming fully into place via Corporate Service Redesign	3+4+3=**10**	Teneo resource currently paused. Resourcing being allocated from within existing teams where possible, though vacancies and uncertainty means the teams are under significant pressure.	None
	Finance, Digital, People, E&F, BI, clinical, transformation and project support capacity will need to be actively protected to maintain pace.	3+4+4=**11**	Progress CSR at pace to move to new structure designed to support programme Workshop to review opportunities for interim arrangements and focus on in year opportunities to be held in July	To note
Programme delivery	SFT and GWH have cash releasing savings on their programmes associated with this work for 2026/26 – pace, scale and capacity risk delivery	4+4+4=**12**	In addition to mitigations outlined above; comparison of Care Org CIP plans to identify further opportunities.	To note

BSW Hospitals Group Board

Agenda item	7.2 Corporate Services Transformation Programme
Report title	Corporate Services Transformation update
Date of meeting	July 2026
Sponsor	Jude Gray, Group Chief People Officer
Prepared by	Eugenie Mellon, Associate Director for HR Operations Claire Warner, Site HR Director
Approval Process: (where has this paper been reviewed and approved)	

☐ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

All eight functions in scope of the CST programme have established their future-state designs and are now moving into the delivery phase of change. As functions are progressing at different rates and across different organisational levels, implementation of activity varies. The enclosed report provides a summary of the current position across all functions.

Financial Position and Savings Delivery

Early Month 1 financial performance for 2026/27 indicates a broadly stable position, although Q1 results will provide a more reliable assessment of the underlying expenditure run rate. Budget-setting activity is also progressing to ensure financial allocations appropriately reflect emerging service redesigns and operating models.

At the end of 2025/26, early indications suggested that approximately £6m (4%) of the Group's £15m savings requirement had been identified, largely through vacancy management. Within this, £1.4m of recurrent vacancy savings are assumed to contribute towards the £8m year one savings target; however, further assurance is required to confirm these savings are sustainable and not subsequently reinvested through service redesign activity.

The full £15m CST savings requirement has been incorporated within CIP plans across all three Care Organisations, ensuring alignment between system financial objectives and organisational delivery plans. Ongoing engagement with functions continues to ensure appropriate finance support is in place to deliver efficiencies and maintain robust financial control.

Communications

Communications plan in place and being delivered with the emphasis on SROs and Design Leads engaging regularly with their teams and providing opportunity to ask questions, supported by Group and Care Org-wide updates on the progress of the programme.

Digital Transformation opportunity

Opportunities for Digital Transformation within the Corporate Services Transformation Programme are progressing in the Finance and Workforce workstreams. However, competing priorities are limiting capacity and pace to deliver.

Host Employer Model

A multi-disciplinary Task & Finish Group established to undertake a business case for workforce arrangements for Shared Corporate Services across the BSW Hospitals Group. The first meeting scheduled for 26 June.

Design Authority Workshop

An in-person workshop was held on 16 June, where all eight functions presented progress updates on emerging Service Level Agreements (SLAs) and governance arrangements.

The SLAs going forward to Steering Group for approval are Procurement and Digital.

The Governance structures recommended by Design Authority to move forwards to Steering Group for information are People, Finance, Communications, Procurement and Digital.

RECOMMENDATION

The Group Board is asked to:

[State clearly what is being asked, using Receive / Note / Approve / Endorse.]

1. The Group Board is being asked to note the update

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix A	Corporate Service Transformation June 2026 update (slide deck)

BSW Corporate Services:

One Group, One Team, One Service on behalf of many.

Joint Committee

July 2026

Key Updates

Since last Steering Group 13/04/2026

Host Employer Model

- Task & Finish Group set up, first meeting to be held on the 26/06 (Nick Johnson, SRO)

Design Authority

In person workshop held 16/06;

- Digital presented Co-pilot premium to raise awareness of functionality and how it can support future designs.
- Functions provided updates on SLAs, Governance structures, and Communications (what they have done to date, and planned for next 6 months)
- Agreed Procurement and Digital SLAs to go forward to Steering Group
- Governance structures for People, Finance, Communications, Procurement and Digital to go forward to Steering Group

Upcoming

Steering Group (1st July)

Summarises the SLAS and Governance Structures going forward to CST Steering Group

	Governance Structure	SLAs
People	Y	TBC
Finance	Y	N
Corporate Governance	TBC	TBC
Estates & Facilities	N	N
TIPS	N	N
Communications	Y	N
Procurement	Y	Y
Digital	Y	Y

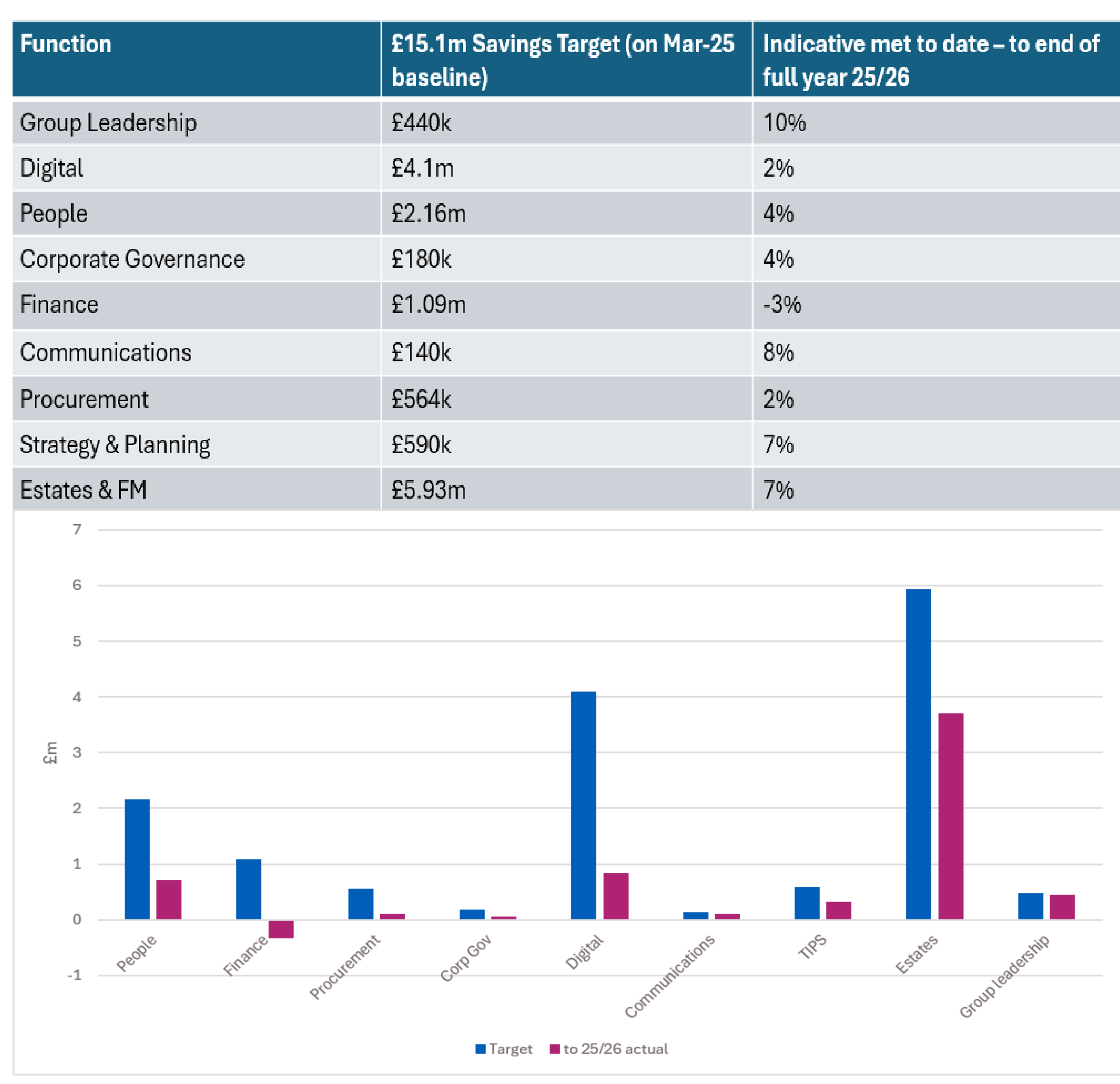
Function Status

Role/Function	Senior Responsible Officer	Design Leads	Current Scope	Design Stage: Design Authority Status	Design Stage: Steering Group status	Pre-Consultation Stage: Draft consultation paper	Draft Equality Impact Assessment (EQIA)	Draft Implementation & Impact Assessment (IIA)	Draft Job Descriptions (JDs) and Person Specifications (PS)	Job evaluation panel (external)	Confirm final JDs/PS after banding outcome	Initial Trade Union / Staff-side discussions (GWH / RUH / SFT)	Incorporate Trade Union feedback and update consultation paper	Consultation Launched	Consultation Closed & Implementation in Progress
Communications	Jude Gray	Emma Mooney	All *TBC	Supported	Complete	In progress	In progress	In progress	In progress	Planned	Planned	Planned	Planned	Planned	Planned
Corporate Governance	Mark Ellis	Caroline Coles	All	Supported	Supported	Complete	Complete	Complete	In progress	In progress	In progress	Complete	Complete	In progress	Planned
Digital	Jonathan Hinchliffe	Jonathan Luff, Tracy Farrow, Spencer Thorn and Cheryl Scott	Level 1 (8c's and above)	Supported	Supported	Complete	Complete	Complete	Complete	Complete	In progress	Complete	Complete	In progress	Planned
Estates & Facilities	Martin Duggan (shared)	Ian Robinson, Rupert Turk, Jamie Caulfield, Jaz Claxton, John O'Keefe, Paul Jenkins (shared)	Level 1-3	Supported	Supported	Complete	Complete	Complete	In progress	In progress	In progress	Complete	Complete	Complete	Complete
Capital	Martin Duggan (shared)	Ian Robinson, Rupert Turk, Jamie Caulfield, Jaz Claxton, John O'Keefe, Paul Jenkins (shared)	All	Supported	Supported	Complete	Complete	Complete	Complete	In progress	In progress	Complete	Complete	Complete	Planned
Finance	Simon Wade	Johanna Bogle, Jon Lund	Level 1 (8c's and above)	Supported	Supported	Supported	Complete	Complete	In progress	In progress	In progress	Complete	Complete	Complete	Complete
People	Jude Gray	Claire Warner, Matt Foxon, Ian Crowley	Level 1-3	Supported	Supported	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Procurement	Rob Webb	Kelly Willoughby	All	Supported	Supported	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Strategy, Planning, Transformation and Improvement	Andy Hollowood	Chris Trow (Strategy), Alex Talbott (Improvement)	Level 1 - 3	Supported	Supported	Complete	Complete	Complete	In progress	In progress	In progress	Complete	Complete	Planned	Planned

Financial position

John Ridler, Finance Lead

- As at the end of 2025/26 outturn there is indication that savings have already been made – largely through vacancies being held – 4% of the 11% group requirement is indicated (c.£6m of the £15m required).
- £1.4m of recurrent vacancies are already assumed to be contributing to this 4% achievement to date – this is part of a £8m target to be achieved in year 1 (2026/27).
- The key is that these remain recurrent savings into the future and not reinvested in new designs – this will be confirmed once all functions have been through the change processes – so still work to do.
- Month 1 actuals for 2026/27 indicates a stable position but Q1 will give a more reliable view of run rate spend.
- Budgets for 2026/27 are being reviewed to ensure envelopes for new designs are acceptable.
- CST £15m savings target are already part of CIP plans for all three care organisations.
- Engagement continues to ensure all functions have the necessary finance support.



Function	£15.1m Savings Target (on Mar-25 baseline)	Indicative met to date – to end of full year 25/26
Group Leadership	£440k	10%
Digital	£4.1m	2%
People	£2.16m	4%
Corporate Governance	£180k	4%
Finance	£1.09m	-3%
Communications	£140k	8%
Procurement	£564k	2%
Strategy & Planning	£590k	7%
Estates & FM	£5.93m	7%

Functions plan for savings

Digital

£0.6m pay vacancies held
£1m non-pay
£1.6m-£2.4m contract consolidation from genie

Corp Gov

All in year 1 through team consultation changes

Communications

£120k to come from workplace system – an internal comms channel that has stopped

Strategy & Planning

All in year 1 through consultation changes.(Excludes 2 posts due to ICB changes)

People

Years 1 and 2 through consultation layers

Finance

£0.3m vacancies
£0.2m in yr 3 for ledger system enablement

Procurement

Years 1 and 2 phasing and later savings dependent on ledger changes

Estates & FM

Years 1 and 2 phasing

Communications

Tim Edmonds, Comms Lead

- Communications plan in place and being delivered – emphasis is on SROs and Design Leads engaging regularly with their teams and providing opportunity to ask questions, supported by Group and Care Org-wide updates on the progress of the programme.
- Each service area has provided assurance of how they are updating and engaging with their teams at the Design Authority workshop (16 June).
- A new set of answers to frequently asked questions has been produced and added to Care Org intranets.
- These will continue to be updated as the programme progresses, with updates date-stamped to enable staff to easily see what's new.
- The FAQs were promoted in a message to all staff across the Group from the Group CPO in May.
- Updates on progress of the CST programme have featured in each of the Group Q&As.
- An all-staff message from the CEO in May provided an update on progress.
- A further all-staff message in June will update on progress on designs along with SLAs and governance.

Digital Transformation Opportunity

Finance, Jonathan Luff, Lead

- Stakeholders from BSW Hospitals Group met with NHS England and FDP colleagues to explore how the FDP “Grip and Control” capability could support BSW acute hospitals in consolidating finance data across three Care Organisations.
- The tool enables integration of multiple data sources into a single near real-time view, improving visibility of cost drivers, financial performance, controls, and decision-making.
- Early incubator results suggest potential for significant benefits, including automated detection of control breaches and cost-saving opportunities, though based on limited scope.
- Next steps include sharing further product detail, defining a potential pilot, and estimating timelines, resources, and costs to integrate general ledger and wider finance data into a unified reporting view.
- NHS England will use this information to assess pilot site suitability and ensure alignment with local priorities.
- Alternative options involving Oracle and Microsoft are under consideration but are less advanced than the FDP approach.

Digital Transformation Opportunity

Workforce Systems, Howard Chitty

- A Workforce Systems Group established to identify and reduce operational friction experienced by managers and staff relating to people management. An initial discovery phase is underway to map current workforce systems, processes, and dependencies including ESR, payroll, recruitment, workforce management, and digital barriers. A prioritised 'friction register' is being developed to identify the most significant barriers to overcome to support Group working.
- Early engagement has taken place with the electronic rostering supplier to understand the feasibility and implications of moving Corporate rostering to a single database for the Group.
- Outputs from this early phase will be used to distinguish operational management issues which can be resolved through process and system changes from those that may require future changes to employment architecture.

Host Employer Model

Nick Johnson, SRO

- A multi-disciplinary Task & Finish Group has been established to undertake an options appraisal of workforce hosting arrangements for Shared Corporate Services across the BSW Hospitals Group.
- The first meeting is scheduled and will focus on the problem statement.
- A structured business case will be developed, supported by engagement with key stakeholders including Trade Unions and system partners, to set out the strategic direction in addressing the problem statement.

Programme Risks - Escalate

Risk ID	Risk Title	Care Org	Risk Description	Risk Owner	Current Score (5x5)	Likelihood (L)	Impact (I)	Inherent Score (L+I) This represents the risk level WITHOUT any controls in place.	Description of Controls in Place	Updates/Comments	Control Score (C) This represents how well your controls are actually working.	Residual Score (L+I+C) This represents the risk level WITH current controls in place.	Date Risk Added	Review Date	Current Status >8 escalates to Care Org >10 escalates to Group
R019	Finance Tracker	Group	Financial baseline and forecasting continue to be in development	John Ridler	25	5	5	10	Forecasting tracker needs to be built to enable finances to be tracked and when savings will be released to be able to track benefits realisation	**June 2026:** Monthly reporting to track 11% remain a challenge. Services who have not met the target include Estates, Finance. Additional headcount and cost in Strategy/planning due to the ICB work transfer.	5	**15**	Dec-25	Jul-26	Escalate
R021	Digital Enablement	Group	Recognition that new models for the corporate services require investment for digital enablers to be able to achieve future service states. However investment is not currently affordable	SROs	25	5	5	10	Digital enabler task and finish group set up. Request at DA 17/12/2025 to capture baseline of the digital ask for services.	**April 2026:** Ongoing discussions at Design Authority Nov 25 and Apr 26 about need for one corporate front door - multifaceted with own dependencies as well as resource implications. Needs to be scoped **June 2026:** Competing priorities is limiting capacity and pace to deliver	5	**15**	Dec-25	May-26	Escalate
R024	Outsourcing of temporary staffing provision (Also a risk on the HR risk register)	Group	Outsourcing the temporary staffing model could affect staffing levels across the AFC staff group, potentially reducing fill rates and creating gaps within the service. This may increase workload for permanent staff and, ultimately, impact patient care quality and safety. Also on the Corporate Services Risk Register. Increased public concerns have been raised via MP, Governors, Council	Jude Gray	New	5	4	9	1. Stakeholder Communication Plan - Led by Director of Comms 2. Implementation Plan with senior nursing leadership attendance 3. Goverance structure, project management 4. Contract management and SLA 5. Paper for EPF on TUPE (June) 6. Review how many workers have joined bank partners 7. Action plan for any concerns/hot spot departments	May 2026: Communication plan in place, twice weekly meeting to ensure responses on time. June 2026: Whilst responses have been made to all external concerns. It remains a risk that implementation may be impacted. (Board report going to Group Board for July)	5	**14**	Apr-26	Aug-26	Escalate

BSW Hospitals Group Board

Agenda item	7.3
Report title	EPR Update
Date of meeting	2nd July 2026
Sponsor	Jonathan Hinchliffe, Group Chief Digital & Information Officer, SRO EPR
Prepared by	Claire Strathern, EPR Programme Director
Approval Process: (where has this paper been reviewed and approved)	• EPR Programme Board (18th June 2026) • EPR Joint Committee (26th June 2026)

☐ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*	
☒ Developing an engaged workforce	☒ Making our teams diverse and inclusive
☒ Making our services safer	☒ Improving timely access to our services
☒ Improving the experience of those who use our services	☒ Improving our financial sustainability
☒ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	**Principal risk title**
BAF R1	Becoming an effective Group
BAF R3	Delivering Digital Maturity
BAF R4	Transforming models of Care
BAF R7	Improving Value and Productivity
BAF R10	Cyber Security

KEY MESSAGES

The EPR Programme status remains AMBER for the June 2026 reporting month, reflecting active management of key risks to maintain delivery momentum (please see Appendix A – EPR Programme Update). Resourcing and capacity constraint remains the most significant delivery challenge in this period.

The key messages are:

1. **Organisational Readiness and release of workforce**– groups are now well established however several critical incidents across the care organisations have impacted attendance to readiness meetings. This has been escalated through programme governance for support to ensure that EPR remains a priority through the coming months. Now the programme plan has been baselined, key dates for critical activities requiring organisational assistance are being socialised to retain delivery momentum.
2. **Workforce & capacity issues** – whilst programme resourcing is sufficient for next phase of delivery there is an identified challenge in the PAS Inpatients workstream. This has been compounded by national demand for EPR experience. The programme is considering alternate approaches to mitigate this issue. Following active comms and engagement, there has been a positive response to critical SME roles across the three care organisations which should help reduce critical SME gaps. However, it is noted that clinical engagement is increasingly constrained by capacity and availability due to competing priorities.
3. **System Testing** – is on track and as at week ending 19th June 2026, reported a completion rate of 57% (circa 13k test scripts) with a 77% success rate. No critical defects are currently open. This is a high success rate for the first test cycle and shows the excellent workflow development conducted during the programme reset.
4. **Trial Load 1 Testing** – checkpoint passed and technical work completed, with data loads commenced to plan week commencing 22nd June 2026. This is progressing despite the known subset of KPI shortfalls for GWH, which are being managed through mitigation actions, but as previously acknowledged, will not meet the exit criteria.
5. **New baselined plan** – approved and operational with governance and maintenance processes agreed. Following the agreement of dates, a 'Road to EPR' roadmap has been generated to support broader comms and engagement (please see Appendix B).
6. **Training** – Lead Trainers now onboard ready to commence detailed lesson planning. The Learning Management System (LMS) procurement is progressing with some delays but anticipated to be completed by the end of June 2026. Early engagement with the three care organisations has commenced to support the identification of appropriate onsite training facilities.
7. **External dependencies and concurrent programmes** – the programme is entering a significant delivery phase with critical activities across testing, training, and organisational readiness over the next few months. It is acknowledged that the misalignment of timelines and competing demand for resources (both workforce and infrastructure) needs to be closely monitored to mitigate risk to delivery.

RECOMMENDATION

The Group Board is asked to:

1. To note the BSW EPR Programme update and continue to support continued prioritisation of this programme across the BSW Hospitals Group.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
A – EPR Programme Update	The formal summary report submitted to EPR Programme Board and EPR Joint Committee
B- The Road to EPR	A one-page visual to support broader socialization of the EPR timeline and activities

EPR Programme Update

Claire Strathern, EPR Programme Director
June 2026

Executive Summary | EPR Programme Board

EPR Programme | Summary Progress June Report

Headlines & Progress

Risk & Issues

Headlines

Testing– System testing commenced and on track; data migration Trial load 1 checkpoint complete and technical work on track to commence data loads 22nd June 2026

New baseline plan approved – baseline plan now operational with governance and maintenance processes agreed

BSW Resources
Programme team reset now stable for next phase. Key vacancies in SME roles remain priority to fill.

Change Requests – Configuration Change Requests (CCR's) critical to go live are being actively monitored and strict criteria for acceptance has seen a significant drop in the number being raised pre-Go Live.

Rationale / Next Steps

- System testing commenced on 25th June 2026 and we are currently in week 3 or 7. Test execution is tracking to plan and the current pass rate is 73%. Test issue resolution is being actively managed day to day. Data Migration Trial Load 1 technical activities are on track to commence loading data on the 22nd June 2026. There is one known issue for GWH data that will impact their exit criteria but it is being actively addressed to resolve ahead of Trial Load 2.
- **Next steps:** Commence data loading for Trial Load 1.

- Programme team resourcing now sufficient for next phase of programme however key gaps in SME resourcing (12WTE) and GWH and RUH programme managers have interim cover but require local resource in post to drive organisational readiness. In addition the PAS IP workstream has lost it's resourcing and mitigations are being sourced to ensure continuity.
- **Next steps:** Key SME vacancies actively being recruited currently but require Care Org leadership support to ensure staff can be released

- Organisational readiness groups now well established however a number of critical incidents across the Care Organisations this month have impacted readiness meetings. This has been escalated to ensure that EPR remains a priority programme throughout the coming months.
- **Next steps –** With the programme plan and key dates now socialised across the organisations, critical activities requiring organisational assistance are being planned and actioned.

- Training workstream will gain momentum with Lead Trainers due to commence from the 15th June 2026. The Learning Management System (LMS) procurement is still in flight with some delays but aiming to now finalise by end of June 26.
- **Next steps –** Finalise LMS procurement and commence detailed lesson planning with lead trainers.

Risks

The programme has 115 open risks; a reduction of 7 compared to last month
There are 2 black risks and 24 red risks - using the 5+5+5 scoring system.

- Risk 170 - PACS / RIS Project - GWH
- Risk 360 - OCS SFT Pathology unable to support EPR delivery from July 2026

Issues

The programme has 35 open issues; this is a decrease of 5 since last month.
There are 2 black issues and 21 red issues.

- Issue 114 - POA CR sign off, workflows and test scripts
- Issue 115 - OH Resource Challenges

Executive Summary | EPR Programme Board

First in Type Tri-Trust EPR Programme | Assurance Next Steps

Programme Fundamentals and governance

Programme Milestones and gateways)

Risk and Issues

Our people - Communication & Engagement

Description & Activities

In June 2026 the overall programme status remains AMBER. The programme has passed the re-entry gateway and testing checkpoints and is on track with current System testing and data migration activities. Key risks being closely monitored across integration, pathology and key PAS and Data migration requirements for the next cycle of testing.

By June 2026

- Data Migration Trial Load 1 commenced
- System testing in progress
- Next phase resourcing complete
- Support for data migration screen validation confirmed with orgs
- LMS installation and e-learning development commenced
- Integration mitigations progressed
- Finance Admin Design Authority commenced

By July 2026

- LMS installed and eLearning development commenced
- Immunology work off plan on track
- Cutover managers procurement commenced
- System testing and TL1 on track
- Start Stop Continue in flight and organisational readiness activities on track

By August 2026

- System testing successfully exited
- Configuration changes required for Integration Testing 1 complete
- Cutover managers procurement complete
- Trial Load 1 on track for exit
- Organisational readiness activities on track with critical activity planning and validation resources secured
- Training activites on track for eLearning development and schedule validated ready for release

Strategic Risk Mitigated

Singular EPR Plan	Plan in place to have critical path & plan including Berkley assurance activities
Gateway activity delays	Plan track enable and improve approach in situ with task forces to optimise DCWs, Workflows and CCRs
Our people	Drive resource plan, Approach designed for greater engagement

Workstream RAG Breakdown

#	Status
6	Red
19	Amber
7	Green

Implementation Resource Required

#	Role
37	Key vacancies in SMEs, Technical roles and Clinical Informatics roles

Our People (Change & Engagement)

#	Digital Champions
RUH	180*
SFT	177*
GWH	303*

*Signed up but not yet confirmed

The Road to EPR

1 PREPARATION
March – May 2026

RESHAPING THE PROGRAMME

START

Mar 2026

Programme Restart

2 TESTING & VALIDATION
May 2026 – Apr 2027

- System Testing
- User Validation
- Testing Gateway

User Validation
Mid Mar - Mid Apr

Testing Gateway
Mid May

May 2026 - Apr 2027

Testing, validation & risk reduction

3 TRAINING & READINESS
July 2026 – October 2027

FDR 1
May end - Mid Jun

- eLearning (4 weeks pre go live)
- Super User Training (10 weeks pre go live)
- Classroom Training (8 weeks pre go live)
- Practice Labs & Demonstrations (8 weeks pre go live)

- Organisational Readiness
- Standard Operating Procedures
- Workflow validations
- Sustainment Planning

July 2026 - Oct 2027

Building confidence & capability

4 GO-LIVE ACTIVATION
July / October 2027

GWH GO-LIVE
Jul'27

FDR 2
Sept - Early Oct

RUH + SFT GO-LIVE
Oct'27

- Go-live + Early Live Support
- Floorwalking
- Rapid issue resolution
- Just-in-time learning
- Safe & effective system use

July/October 2027

Go-Live at GWH, SFT & RUH

5 STABILISATION
July 2027 onwards

ONE SINGLE EPR

Safer, connected care for all

- Stabilisation support
- Future training
- Optimisation
- System improvements

July 2027 onwards

Deliver lasting benefits

Agenda item	7.4
Report title	Group Strategy Officer Report
Date of meeting	2 July 2026
Sponsor	Judy Dyos – Chief Strategy Officer
Prepared by	Chris Trow – Associate Director of Strategy (GWH) Fiona Bird – Dep Director of Strategy (RUH)
Approval Process: (where has this paper been reviewed and approved)	N/A

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*	
☒ Developing an engaged workforce	☒ Making our teams diverse and inclusive
☒ Making our services safer	☒ Improving timely access to our services
☒ Improving the experience of those who use our services	☒ Improving our financial sustainability
☒ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R1	Becoming an effective Group

KEY MESSAGES

Strategy development is on track for September sign-off, with engagement under way and clear delivery priorities emerging. A summary of themes from staff engagement will be presented to Board, and a Board development session focussed on strategy development is planned for August.

No immediate escalation risks identified, with progress across strategy development and planning capability.

Board decision required to approve delegated authority for the Swindon Sexual Health procurement and the RUH PET-CT procurement

RECOMMENDATION

The Group Board is asked to:

1. Receive an update on the development of the Group Strategy, including ongoing engagement activity supporting this work.
2. Approve the delegation of authority to GWH Managing Director and Group Chief Financial Officer to approve the final submission in response to the procurement for the Swindon Integrated Sexual Health Service.
3. Approve the delegation of authority to RUH Managing Director and Group Chief Financial Officer to approve the final submissions in response to the procurement for the PET-CT service.

APPENDICES

None	

Group Strategy

1. Executive Summary

This paper provides Board of Directors with an update on the development of the Group Strategy and will be followed by a paper summarising key themes from the ongoing staff engagement. Short updates on planning at Group level and on two current business development opportunities are also included.

Alert

- Delegation request: Board is asked to approve delegation of authority to GWH Managing Director and Group Chief Financial Officer to approve the bid for the Swindon Integrated Sexual Health Service procurement, given the compressed procurement timeline.

- Delegation request: Board is asked to approve delegation of authority to RUH Managing Director and Group Chief Financial Officer to approve the bids for the PET-CT procurement, given the compressed procurement timeline.

- Commercial risk exposure: Ongoing competitive procurements (Sexual Health and PET-CT) present potential income and service continuity risks if contracts are not secured or subcontracting arrangements change.

Assure

- Strategy development on track: work underway with planned Board sign-off in September 2026, supported by current engagement activity with staff and partners

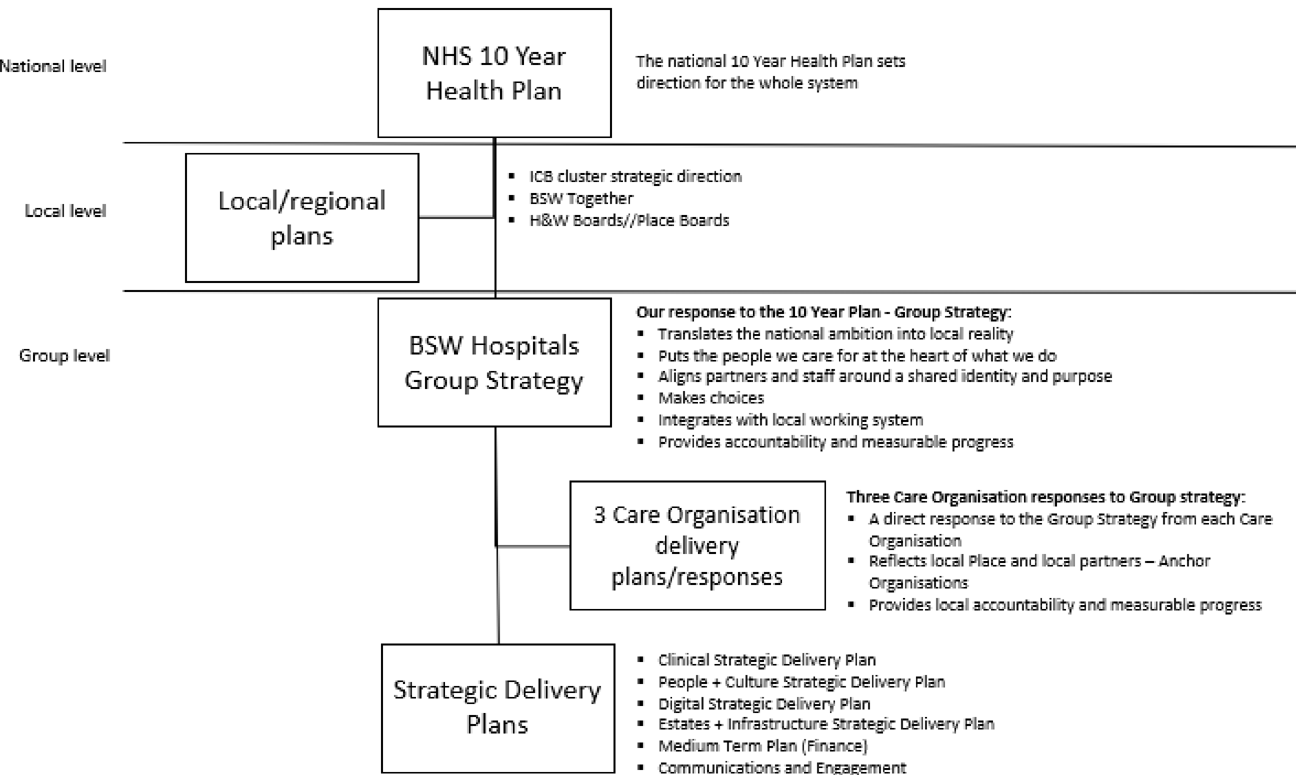
- Establishment of a single Group planning function as part of the Corporate Services Redesign programme will better position the Group for a more consistent future planning cycle

Advise

- Strategy delivery: While development is progressing well, successful delivery will depend on maintaining engagement momentum and translating priorities into executable plans. A Board Development session is planned for August 2026 to support this work. Group Engine Room standard work will need to be in place to cascade Group strategy, including scorecard agreements with Care Organisations and process standard work for Care Organisation Engine Rooms.

2. Group Strategy development

Work to develop our Group Strategy has been underway since September 2025. Over this period, we have engaged extensively on our vision and, more recently, on a set of four draft strategic pillars/priorities. These build on the insight we already hold from previous engagement, our data and performance intelligence, national policy direction, and discussions with senior leaders, non-executive directors and Governors. Collectively, these help us shape our Strategy as a response to both national direction and local need.



2.1 Engagement

In recent weeks, we have expanded this work by engaging with our staff and volunteers, the people who make our services real every day. Their experience and judgement are helping us strengthen and finalise the elements of the strategy that will guide how we focus our effort and make choices in the years ahead.

Clever Together have been engaged to support this work, bringing both their expertise in engagement of large groups, and access to their online portal, which allows staff to anonymously post ideas and respond to ideas shared by others. As of 22 June 2026, there have been over 2,000 interactions (ideas shared, comments and votes) on the portal.

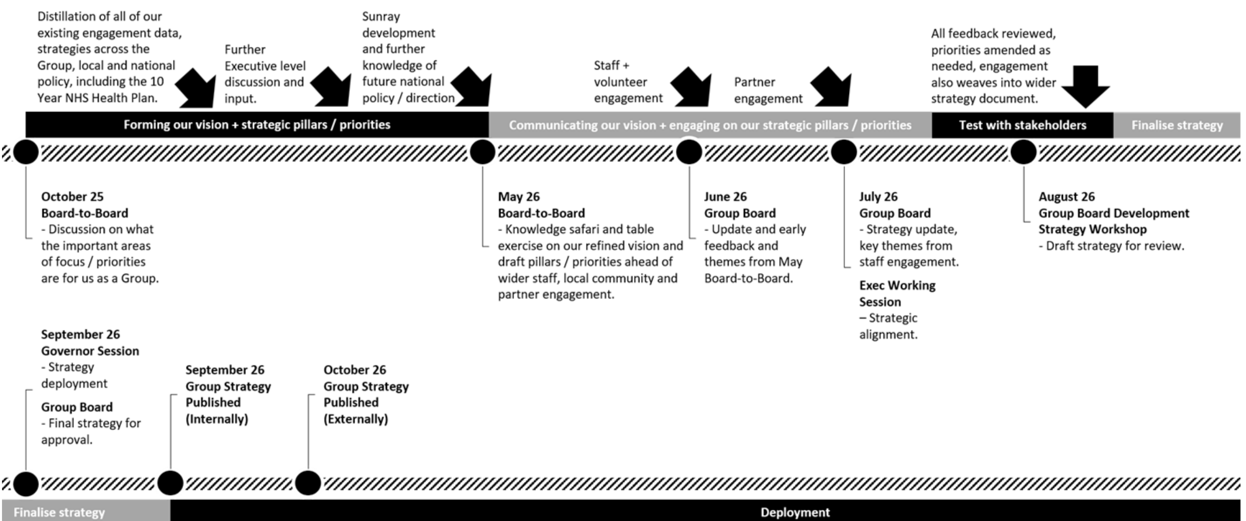
Alongside this, we have sought the views of our system partners to ensure the strategy reflects the priorities of our places and supports the wider ambitions we share, particularly around prevention, reducing inequalities, supporting vulnerable communities and strengthening integrated working.

A summary of learning from the staff and partner engagement, along with the insights from discussions with public and staff Governors in autumn 2025, will be presented to a Group Board Development Strategy Workshop in August.

2.2 Timeline

Over the coming weeks, we will be finalising the draft Group Strategy, with the intention to launch it internally in September and publish it externally in October. This will mark an important milestone in setting a clear, shared direction for the BSW Hospitals Group, one that builds on our decade of collaboration and positions us to meet the challenges and opportunities ahead with confidence and collective purpose.

High-level timeline: BSW Hospitals Group Strategy



The content and approach to this paper will be reviewed to ensure alignment with the Strategy, including delivery progress of strategic initiatives and ongoing horizon scanning to support the Board's overview and assurance of the strategy.

3. Group Approach to Planning

Planning aligns our long-term aspirations, outlined in the Strategy, with our in year operational, financial, workforce and quality goals.

In recent years we have moved progressively closer to developing a single integrated business plan across our three Care Organisations. While this has resulted in greater alignment and the use of planning assumptions, our submissions have ultimately remained three separate plans brought together at the end of the planning round, or indeed this year submitted as three individual providers (as directed by NHSE).

As part of the Corporate Services Redesign (CSR), we have now reshaped the planning function to establish a single, coherent planning team for the Group. This includes clear ownership of planning

methodologies, assumptions, governance, and the needed to closely collaborate and integrate finance, workforce, activity, performance and quality. Moving forward, dedicated planning support will be provided within each Care Organisation, with an equitable level of resource maintained locally.

To ensure we are well prepared for the next formal NHSE/DHSC planning round, we will convene a Group-wide planning workshop over the summer. This will allow us to reflect on the most recent round, identify good practice and lessons learned, and begin early preparation for the forthcoming cycle. This proactive approach will support the development of a more streamlined, consistent and deliverable single Group plan and an approach that we can maintain year-round.

4. Business Development:

There are two active procurement opportunities that the Group is pursuing:

4.1 Integrated Sexual Health, Swindon

Swindon Borough Council (SBC) has begun Pre-Market Engagement ahead of re-commissioning the Integrated Sexual Health Service (ISHS). Great Western Hospitals NHS FT (GWH) is the long-standing incumbent provider, delivering a stable, high-quality service under a Section 75 agreement since 2015. SBC is exploring a system-lead provider model, which aligns strongly with the Trust's existing role, established partnerships and integrated clinical pathways.

The opportunity is valued at £2.62m per year with a proposed 5-year contract and two optional 2-year extensions (up to 9 years).

GWH submitted a detailed Pre-Market Engagement response in May 2026 and intends to participate in the next formal stage of the procurement process which is expected to start in July and conclude in August 2026

Given the short procurement timeline, Board is asked to delegate authority to the Group Chief Financial Officer and GWH Managing Director to approve the final submission, with a full briefing given to GWH COLT.

4.2 National tender for provision of Positron Emission Tomography – Computed Tomography (PET-CT) Services

The South West regional contract for PET-CT services between NHS England and Alliance Medical Limited (AML) runs until 31st March 2027. The NHSE tender for PET-CT provision over the following 10 years is now live and due to complete in July 2026.

The RUH is currently a sub-contractor to Alliance for this contract, and, uniquely in the South West, owns both the PET-CT and provides the staff who undertake the service. Ownership of the service offers supports the RUH to offer both a private patient PET-CT service and include it within the RUH research portfolio. The service currently generates income of under £1m annually.

The RUH will not be bidding as lead provider and is instead working with two potential bidders on their separate bids as lead provider, with a view to maintaining our current subcontract arrangement. Governance arrangements are in place to mitigate any potential conflict of interest for the teams involved.

Given the short procurement timeline, Board is asked to delegate authority to the Group Chief Financial Officer and RUH Managing Director to approve the final submissions, with a full briefing given to RUH COLT.

BSW Hospitals Group Board

Agenda item	8.0
Report title	Group Governance
Date of meeting	2nd July 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Simon Hackwell, Project Governance lead
Approval Process: (where has this paper been reviewed and approved)	Most of the items have been reviewed by either the Joint Committee, Risk and Assurance Committee or Group Executive.

☐ FOR ASSURANCE	☒ FOR DECISION	☐ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk R1	**Becoming an effective group**
BAF R3	**Delivering Digital Maturity**

KEY MESSAGES

This report contains several items for the Board to either approve or note as part of the new governance arrangements. Each item has a report and in some cases the supporting information is held in the Board meeting depository.

The **Risk Management Policy** was previously been approved by the Joint Committee in March and the underlying principles have been in use since then. However, it **requires formal adoption** by the Board to replace existing risk management policies.

The **Performance Management Policy** has been reviewed by the pilot Risk and Assurance Committee and requires approval.

The **Group BAF** is still in development and will remain as ‘initial’ in status until the Group has completed its work on the strategy and risk appetite. However, the Board is **asked to approve** the current version, noting that the Risk and Assurance Committee will be leading the work on building the substantive version.

The report on **maternity oversight** sets out how the Group will discharge its Board-level responsibilities for the oversight of maternity and neonatal services. This is obviously a high-profile area and it is important that the Group is able to translate the national framework for Board accountability into the Group's governance architecture.

A paper presents the BSW Group **Data Sharing Agreement** (Joint Controller Agreement) **for approval**, establishing the formal data protection governance arrangements between Royal United Hospitals Bath NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust as constituent organisations of the BSW Hospitals Group.

The Agreement is required as part of the Group operating model, the Trusts jointly determine the purposes and essential means of processing personal and special category data for defined Group-level functions.

The **Board cycle of business** is also contained in this report to provide an overview of the forthcoming months. This is being disseminated through the Care Organisations and corporate service functions to inform individual committee workplans. While complete alignment across the Care Organisations – in terms of reporting to the Group Board – may not achievable within 26/27, the expectation is that this will become the norm from 27/28 so that the Group Board receives assurance and reports (e.g. Annual Infection Prevention and Control) from the three Care organisations at the same time.

The **Register of Declared Interests** for the Group Board is being compiled, using the three Care Organisation Registers. The Group Board Register will be held by the Chief Risk Officer / Company Secretary and any amendments should sent to them. This is a public document.

Finally, there is a list of the current **Board Statutory obligations / duties** and where responsibility for these sits at Board level.

RECOMMENDATION

The Group Board is asked to:

1. Adopt the Group Risk Management Policy.
2. Approve the Group Performance Management Policy.
3. Approve the Initial Group BAF.
4. Note the Maternity Oversight Framework.
5. Approve the Group Data Sharing Agreement.
6. Note the Group Board Cycle of Business.
7. Note the Register of Interests for the Group Board is in development
8. Note the allocation of Statutory responsibilities at Board level.

APPENDICES

To help manage the volume of information the following items have been placed in the reading room for this Board meeting:

- Risk Management Policy
- Data Sharing Agreement
- Cycle of Business
- Statutory Responsibilities.

BSW Hospitals Group Board

Agenda item	8.1.1
Report title	Risk Management Policy
Date of meeting	2nd July 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Simon Hackwell, Project Governance lead
Approval Process: (where has this paper been reviewed and approved)	Previously approved by the Joint Committee on 20th March 2026.

☐ FOR ASSURANCE	☒ FOR DECISION	☐ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk R1	**Becoming an effective group**

KEY MESSAGES

The Board is asked to formally adopt this policy so that it replaces the Care Organisation's current risk management policies.

The Joint Committee has spent considerable time developing enhanced arrangements for risk management across the Group. This has led to the development of a Group Risk Register and implementation of the new risk scoring approach across the Group. As a result, the Group is developing a much stronger focus around risk controls and formal escalation processes.
The Risk Management Policy has been updated from the one approved by the Joint Committee in March to reflect changes in nomenclature and confirm the mandatory risk escalation threshold of 12 and above. It is presented here for the Group to formally adopt under its delegated powers.

RECOMMENDATION

The Group Board is asked to:

1. Adopt the previously approved Group Risk Management Policy.

APPENDICES

The Risk Management Policy is contained in the Reading Room for the Board's meeting.

BSW Hospitals Group Board

Agenda item	8.1.2(b)
Report title	Performance Management Policy
Date of meeting	2 July 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Mark Ellis, Chief Risk Officer
Approval Process: (where has this paper been reviewed and approved)	Pilot RAC May 2026

☐ **FOR ASSURANCE**	☒ **FOR DECISION**	☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title

KEY MESSAGES

The Performance Management Policy supports the Performance Management framework (an element of the Operating Blueprint) previously approved by the Group Joint Committee. The policy was presented to the Pilot Risk and Assurance Committee on 18 May 2026, the document was supported and requires final approval by the Group Board.

RECOMMENDATION

The Group Board is asked to:

1. Approve the policy for implementation as part of the wider Operating Blueprint.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

Performance Management Policy

Version:	[DRAFT v0.2]
Date:	09/03/2026
Approved by:	
Review date:	[Date]

Contents

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Document Information

Document Title	Performance Management Policy
Document Reference	BSW-GRP-GOV-PMP-001
Version	1.0 (Draft)
Status	Draft for Consultation
Date	February 2026
Author	Group Chief Risk Officer
Owner	Group Chief Executive
Approved by	Group Board (pending)
Review Date	February 2027
Replaces	Care Organisation-level performance policies (RUH, GWH, SFT)

Version Control

Version	Date	Author	Description of Change
0.1	February 2026	Group Chief Risk Officer	Initial draft for stakeholder consultation
1.0	May 2026	Group Chief Risk Officer	Draft version presented to Group Board for approval

1. Introduction and Context

The BSW Hospitals Group (the Group) comprises Royal United Hospitals Bath NHS Foundation Trust (RUH), Great Western Hospitals NHS Foundation Trust (GWH), and Salisbury NHS Foundation Trust (SFT). The Group was formally established to enable the three NHS trusts to work together systematically, reducing unwarranted variation, sharing resources, and improving outcomes for patients and communities across Bath, Swindon and Wiltshire.

The Group Operating Blueprint establishes the architecture within which the Group operates, including the Accountability Framework, Governance Framework, and Performance Management Framework. This Policy translates those principles into specific, operational requirements for all staff, leaders and committees across the Group.

The Framework sits alongside the Group's Risk Management Framework and Board Assurance Framework as a core component of Group-wide governance. Together they provide the Group Board with the assurance it requires to meet its obligations to NHS England and its patients.

Effective performance management is a statutory and regulatory requirement. The Group Board is accountable to NHS England for meeting the NHS Constitution standards and all other performance obligations placed upon the constituent trusts. This Policy gives effect to that accountability.

2. Purpose and Scope

2.1 Purpose

This Policy:

- defines a standardised, systematic approach to performance management applicable across all three Care Organisations and Corporate Services;
- establishes clear accountability and ownership for performance at every level of the Group;
- specifies the core Key Performance Indicators (KPIs) and metrics to be monitored, aligned with NHS England requirements;
- sets out the reporting and review cadence to be followed at Group, Care Organisation and divisional level;
- defines the thresholds and protocols for escalation and de-escalation;
- establishes the process for mobilising support when performance deteriorates; and
- fosters a culture of continuous improvement, transparency and collective responsibility.

2.2 Scope

This Policy applies to:

- all three Care Organisations: RUH, GWH and SFT;

- all Corporate Services operating at Group level;
- all clinical and operational divisions within each Care Organisation;
- all leaders, managers and staff who hold performance accountability within the Group.

This Policy does not apply to individual staff performance management (which is governed by the Group's People policies), nor to the management of individual patient complaints (which is governed by the Patient Experience and Complaints Policy).

3. Principles

The Group's approach to performance management is built upon five core principles, aligned with NHS England's national performance management approach:

1. Alignment: All performance objectives and metrics, from Group level to individual department, must align with the Group's overarching strategic goals and the NHS Constitution.
2. Transparency: Performance data and review findings will be shared openly and consistently across all relevant levels. There should be no surprises — issues should be surfaced promptly through appropriate channels.
3. Ownership: All leaders and staff own responsibility for their contribution to achieving performance targets. Performance management is a shared obligation, not a function of a central team.
4. Continuous Improvement: This Policy and the supporting Framework are tools for ongoing learning and improvement. Escalation is a professional mechanism to secure the right resources and expertise — it is not punitive.
5. Data-Driven Decisions: Performance will be measured using objective, verified data, using Statistical Process Control (SPC) time series methodology to distinguish common cause variation from special cause signals requiring intervention.

In addition, the following operational principles govern how decisions are made:

- Subsidiarity: issues are resolved at the lowest appropriate level. Escalation occurs when local resolution is not possible or not appropriate given the severity or duration of underperformance.
- Proportionality: the Group's response to underperformance is scaled to severity and duration, avoiding over-intervention for transient issues.
- Collective Responsibility: the Group's reputation and regulatory standing depends on collective performance. All Care Organisations have a shared interest in supporting each other to succeed.

4. Governance and Accountability

4.1 Accountability Hierarchy

Performance accountability flows through a clear, four-level hierarchy within the Group:

- Group Board: Accountable to NHS England for meeting statutory obligations and performance targets across the Group. The Group Chief Executive, as Accounting Officer, is personally accountable for stewardship of public funds and the overall performance of the Group.
- Risk and Assurance Committee (RAC): Receives escalated risks and performance metrics from Care Organisations. Tests whether controls are effective, if investigations and robust, and if themes are being appropriately identified. Provides Group Board with and operationally independent view.
- Group Executive Committee: Provides monthly oversight of integrated performance across all Care Organisations and Corporate Services. Makes executive decisions on issues escalated from Care Organisations. Determines what requires escalation to the Board Risk and Assurance Committee and Group Board.
- Care Organisation Management Committees: Responsible for delivery of clinical, operational, workforce and financial objectives within delegated authority. Conduct monthly performance reviews of divisions and departments. Care Organisation Managing Directors are responsible to the Group Chief Executive for performance within their hospital.
- Divisions and Departments: Responsible for frontline delivery. Hold weekly or fortnightly performance meetings. First point of identification, escalation and response for operational performance issues.

4.2 Delegated Authority

Performance management operates within the Group's Scheme of Delegation and Standing Financial Instructions. These set the specific financial and operational thresholds that determine when decisions must be escalated from Care Organisation to Group level. Where this Policy references escalation, it is read alongside the current Scheme of Delegation.

Care Organisation Management Boards have delegated authority to make decisions affecting performance within their sites. Certain areas require Group-wide consultation and agreement as specified in the Scheme of Delegation.

4.3 Accountability vs Responsibility vs Ownership

The Group distinguishes between three related but distinct concepts:

- Accountability — the Group Board is accountable to NHS England for performance across all three organisations. This accountability is singular and cannot be delegated.
- Responsibility — Care Organisation Managing Directors and their leadership teams are responsible for delivery within their hospitals. This responsibility is delegated and requires clear parameters for decision-making.

- Ownership — leaders at all levels must demonstrate ownership by being proactive, escalating appropriately and committing to collective Group success.

5. Performance Domains and Metrics

5.1 Performance Domains

Performance is monitored and reported across four domains, aligned with the NHS England Performance Assessment Framework. These are applied consistently across all three Care Organisations to enable meaningful comparison and to identify unwarranted variation.

Domain	Core KPIs and Metrics	Breakthrough / Priority Metrics
Quality and Safety	Patient safety incidents (PSIRF), clinical effectiveness, patient experience (FFT), CQC compliance, mortality (SHMI/Crude), infection control (HCAI), pressure injuries, falls with harm, mixed sex accommodation breaches	Reducing Pressure Injury (breakthrough); Mortality surveillance; Infection Control thresholds
Operational Performance (Access and Flow)	A&E 4-hour standard, RTT 18-week performance %, Cancer 62-day standard, Cancer 28-day FDS, Diagnostics DM01 (6-week standard), ambulance handover times, elective waiting list size	Reducing time to first outpatient appointment (breakthrough); ED 12-hour breaches; RTT performance %; 52-week waiters
People and Workforce	Staff vacancy rate, sickness absence %, turnover, mandatory training compliance, appraisal rates, staff survey results, safe staffing levels, bank/agency spend, WTE vs funded establishment	Reducing staff unavailability (breakthrough); vacancy rate trajectory; sickness absence
Finance and Use of Resources	In-month and year-to-date I&E position, efficiency programme delivery, capital expenditure, cash position, income and activity, productivity index vs 2019/20 baseline	Productivity (breakthrough); efficiency programme delivery; I&E variance vs plan

5.2 Metric Classification

Within each domain, metrics are classified as follows:

- Strategic Initiatives: Trust-wide areas of strategic focus for a 36-60 month period. The Group is striving for improvements of more than 30% in the relevant metric over the period.

Breakthrough objectives are reviewed and may be refreshed when sustained common cause variation near target is observed, redirecting focus to other key improvement areas.

- Key Performance Indicators (KPIs): Core metrics monitored as part of the NHS National Operating Framework. These are mandatory measures relating to improving patient care and delivering constitutional standards.
- Alerting Watch Metrics: Metrics that have triggered one or more business rules and should be monitored more closely to address worsening performance.
- Non-Alerting Watch Metrics: Metrics being monitored but not currently a cause for concern as they are within the expected range.
- Statutory and Mandatory Metrics: Metrics with additional business rules that are statutory or mandatory at Trust level. For these metrics, whether or not the target has been met each month is explicitly recorded, along with the number of consecutive months the target has not been achieved.

5.3 SPC Methodology and Standardisation

All metrics are assessed using Statistical Process Control (SPC) time series methodology. SPC provides a robust, evidence-based basis for distinguishing between:

- Common cause variation: normal variation within the system that does not require intervention, but informs longer-term improvement work;
- Special cause variation (improvement): a statistically significant positive signal requiring recognition and learning; and
- Special cause variation (deterioration): a statistically significant negative signal requiring investigation and intervention.

SPC charts are re-based when sustained special cause improvement is observed in order to establish a new, higher baseline from which to measure further improvement. SPC charts are standardised in methodology and presentation across all three Care Organisations to ensure that the Group's Integrated Performance Report enables valid comparison.

5.4 Change Control

Amendments to the metric set — including additions, removals, definition changes, and target revisions — are subject to formal change control. All changes are documented in the Performance Report Change Control Log, recording the date of change, the metric affected, and the description of the change. Changes to the core Group metric set require approval from the Group Executive RAC.

6. Performance Classification

The Group Executive RAC will assign each Care Organisation a performance level that indicates its overall level of delivery, calibrated across the four performance domains. This classification drives the intensity of oversight and support applied.

Level	Definition	Escalation	Trigger	Expected Actions
1	High performing: consistently delivering against plans; risks understood and well controlled	Maintain oversight	All KPIs on track; no sustained red flags	Monthly performance review; update on previous actions; review risk scores
2	Good performance with specific issues; plans in place	Track delivery of plans	One or more KPI in escalated business rules with recovery plan	Deep dives on specific issues; present delivery against agreed trajectories; CO MD attendance at Group Executive RAC
3	Off track in multiple areas; gaps in risk control evident; support required to deliver recovery plans	Allocate resources	Persistent underperformance (escalated business rules); SPC special cause deterioration	Comprehensive improvement plans with agreed milestones; subject-specific improvement meetings; automatic risk register entry
4	Significantly off track; risk control not evident; bespoke Group Executive support required	Group Executive support	Statutory duty/licence risk; sustained failure to meet constitutional standards; Board to NHS England escalation	Enhanced monthly performance meetings; bespoke support package agreed by Group Leadership Team; NHSE engagement as required

Performance level assignments are reviewed monthly at the Group Executive RAC. Assignment is based on the holistic picture across all four domains, taking account of SPC signals, duration

of underperformance, quality of recovery planning, and the effectiveness of existing controls. A Care Organisation's performance level will not be set on the basis of a single metric in isolation.

7. Performance Review Meetings

7.1 Standard Meeting Format

All performance review meetings at every level of the Group shall follow a consistent format:

1. Data review: examination of current performance against KPIs and SPC signals.
2. Strategic Initiative and Breakthrough objective updates: progress against the Group's strategic focus areas.
3. Exception reporting: structured discussion of underperforming areas, including root cause analysis.
4. Risk review: review of significant relevant risks, agreement of control scores, and identification of further mitigating actions.
5. Action tracking: review of progress against previously agreed actions, with clear owners and due dates.
6. New actions: agreement of any new actions required, with named owners and timescales.
7. Escalation decisions: agreement on whether any issues require escalation to the next level.

7.2 Meeting Cadence

The following meeting cadence is mandatory across the Group:

- Group Level: Monthly Group Executive RAC reviews integrated performance across all Care Organisations and Corporate Services, using the three-lens approach of data, risks and narrative.
- Care Organisation Level: Monthly Management Committee reviews Care Organisation performance against all four domains. Monthly divisional performance meetings. Weekly operational huddles for urgent patient safety and operational issues.
- Division Level: Weekly or fortnightly divisional performance meetings using standardised templates and metrics.

Meeting frequency may be increased in response to performance concerns. Care Organisation Managing Directors in performance Level 3 or Level 4 will be required to attend subject-specific improvement meetings in addition to the standard cadence.

8. Escalation and De-escalation

8.1 Escalation Triggers

Escalation is required when performance issues cross defined thresholds or when local resolution is not achievable within reasonable timescales. Specific triggers for escalation include:

- Any KPI showing special cause deterioration on the SPC chart;
- Any KPI in sustained underperformance when measured against a local or national target (alerting status for three or more consecutive months);
- Any risk associated with performance reaching a residual score of 12 or above (post-controls) under the Group's 5+5+5 risk scoring methodology;
- Any actual or anticipated breach of a statutory duty or NHS licence condition;
- Any actual or anticipated failure to meet a constitutional standard for a sustained period; and
- Any performance issue that carries significant reputational, financial or patient safety risk that the Care Organisation cannot resolve within its delegated authority.

8.2 Escalation Protocol

Escalation shall follow the four levels defined in Section 6. The Care Organisation Managing Director is responsible for notifying the Group Chief Executive and relevant Group Executive of an escalation.

The Group Executive RAC reviews all active escalations monthly. Escalations to Level 4 are reported to the Group Board at its next scheduled meeting, and to NHS England as appropriate in accordance with the Group's regulatory obligations.

8.3 De-escalation

De-escalation is an equally important part of this Policy. A Care Organisation may be de-escalated when:

- sustained improvement has been demonstrated for typically three consecutive months;
- the sustainability of improvements is evidenced and not solely attributable to temporary resource increases;
- effective local controls are in place and risk scores have reduced accordingly; and
- the Group Executive RAC is satisfied that the Care Organisation can maintain performance independently.

De-escalation decisions are made by the Group Executive RAC and reported to the Board Risk and Assurance Committee.

9. Support and Improvement

The Group's philosophy is that escalation is a mechanism for ensuring the right expertise and resources are applied to performance challenges, not a punitive intervention. When performance is escalated, appropriate support is mobilised proportionately to the level of concern.

9.1 Group Executive Support

Group Executive support includes deep-dive reviews in which Group and Care Organisation leadership work together to identify solutions. These forums provide space for detailed assurance discussions, escalation of key issues and shared problem solving. Deep dives are time-limited and linked to improved performance and confidence in sustainability. Where appropriate, peer support from other Care Organisations may be arranged, alongside temporary additional resources.

9.2 External Support

Where the scale or nature of the performance challenge warrants external support, the Group will access:

- NHS England support packages;
- Getting It Right First Time (GIRFT) reviews;
- Model Hospital benchmarking;
- External advisory support as agreed by the Group Executive RAC.

9.3 Protected Capacity

Where a Care Organisation requires dedicated improvement capacity, the Group will consider arrangements including backfill to enable improvement work, project management support, and data analytics capability. Such arrangements are agreed by the Group Executive RAC and funded appropriately.

9.4 Recovery Planning

Any Care Organisation at Level 3 or Level 4 is required to develop a comprehensive Improvement Plan with agreed trajectories and milestones. Improvement Plans must be approved by the Group Executive RAC, and progress reviewed monthly. Improvement Plans must include named leads for each workstream, clear timelines, identified risks and mitigations, and defined criteria for de-escalation.

10. Reporting and Information Flows

10.1 Reporting Structure

Standardised performance reports operate at each level of the Group. All reports use consistent metrics, definitions and presentation formats to ensure a single source of truth and to enable meaningful comparison across Care Organisations. Narrative accompanies data to explain performance context, root causes and recovery actions.

Report	Audience	Frequency / Timing	Content
Group Integrated Performance Report	Group Board; Board Risk and Assurance Committee	Monthly (via Managing Directors' report)	All four domains across all three Care Organisations; exception reporting; key risks; recovery actions
Group Executive RAC Performance Pack	Group Executive Committee	Monthly	Integrated performance across COs; three-lens approach (data, risk, narrative); escalation decisions
Care Organisation Integrated Performance Report	CO Management Committee; Finance & Performance Committee	Monthly	Divisional breakdowns across all four domains; SPC time series; breakthrough objectives; KPI trends
Divisional Performance Dashboard	Divisional leadership; departmental managers	Weekly / Monthly	Operational delivery metrics; exception items; countermeasure actions; staffing and finance
Operational Huddle Summary	CO operational teams	Daily / Weekly	Urgent operational issues; patient safety; bed state; escalation items

10.2 Integrated Performance Report Standards

The Group Integrated Performance Report (Group IPR) and each Care Organisation's Integrated Performance Report (CO IPR) must meet the following standards:

- Present SPC time series charts for all Breakthrough Objectives and KPIs.
- Clearly identify Alerting Watch Metrics and the business rules triggered.
- Include a Change Control Log recording any metric, target or definition changes in year.

- Provide a narrative for all metrics in special cause deterioration or sustained underperformance, setting out root cause analysis, countermeasure actions, owners and due dates.
- Include a risks and mitigations section for areas of concern.
- For Statutory and Mandatory Metrics, indicate whether the target was met each month and how many consecutive months the target has not been achieved.

10.3 Single Source of Truth

The Group is committed to maintaining a single source of truth for performance data. Care Organisations must use the agreed Group data infrastructure and definitions. Locally-produced shadow reporting must not be used to create alternative narratives at governance meetings. Where data quality issues are identified, these must be notified to the Group Chief Information Officer and corrected through the agreed data quality process.

11. Integration with Risk Management

Performance management and risk management are closely integrated within the Group's governance architecture. This Policy operates alongside the Group Risk Management Framework and the Board Assurance Framework.

11.1 Performance Issues to Risk Register

Persistent performance underperformance automatically generates a risk register entry at the appropriate level. Specifically:

- Any KPI in sustained underperformance (red for three or more consecutive months) requires a risk register entry at divisional level as a minimum.
- Performance issues that meet principal risk criteria — a residual risk score of 12 or above under the Group's enhanced 5+5+5 risk scoring methodology, and a threat to one or more strategic objectives — are escalated to the Group Risk Register.

11.2 Board Assurance Framework

The Group's Board Assurance Framework maps strategic objectives to principal risks and sources of assurance. Performance data from the Group IPR constitutes a primary source of assurance evidence. Where performance data indicates that the Group is at risk of failing to achieve a strategic objective, this is reflected in the BAF and reported to the Board Risk and Assurance Committee.

11.3 Bifurcated Assurance Model

The Group operates a bifurcated assurance model in which the executive provides performance evidence and operates controls, whilst the Risk and Assurance Committee provides

independent scrutiny of that evidence. This separation is fundamental to the integrity of the Group's governance. It is the responsibility of the Group Executive RAC to ensure that performance evidence presented to the Board is accurate, complete and presented without material omission.

11.4 Risk Scoring Alignment

The Group's enhanced 5+5+5 risk scoring methodology — assessing impact, likelihood and control effectiveness — applies to both risk management and performance escalation decisions. The control score in particular reflects the extent to which performance management controls are operative: a control score of 3 (controls in progress) or above indicates that performance management interventions are not yet fully effective and should prompt a review of the support package in place.

12. Roles and Responsibilities

The following RACI matrix summarises key responsibilities under this Policy (A = Accountable; R = Responsible):

Responsibility	Group Board / RAC	Group Executive RAC	CO Management Committee	Division
Approval of this Policy	**A**			
Annual review of Performance Management Framework	**A**	**R**		
Accountability to NHS England for statutory performance	**A**			
Monthly oversight of integrated performance across all COs		**R/A**		
Determination of escalation to Group Board		**R**		
Delivery of clinical, operational, workforce and financial objectives			**R/A**	
Monthly Care Organisation performance review			**R**	
Production of Care Organisation Integrated Performance Reports			**R**	

Frontline delivery against divisional KPIs				**R/A**
Weekly/fortnightly divisional performance meetings				**R**
Escalation of issues to CO Management Board				**R**

Detailed role descriptions are set out in the Group Operating Blueprint Accountability Framework and the individual job descriptions of post-holders. This Policy does not alter the underlying employment or statutory responsibilities of any post-holder.

13. Training and Communication

The Group Chief Risk Officer is responsible for ensuring that this Policy is communicated effectively to all leaders with performance accountability.

The following training and communication obligations apply:

- All newly appointed divisional managers, Care Organisation executive directors and Group executive directors must receive induction training on the Group Performance Management Framework and this Policy within three months of appointment.
- The Group's standard SPC methodology and IPR presentation standards are included in the Group's data and analytics training programme, available to all relevant staff.
- This Policy will be published on the Group policy library and accessible via each Care Organisation's intranet.
- Any material change to this Policy will be communicated to Care Organisation Medical Directors, Finance Directors, Nursing Directors, Operations Directors and Managing Directors via the Group Chief Risk Officer.

14. Policy Review and Compliance

14.1 Review

This Policy will be reviewed annually by the Group Executive RAC and approved by the Group Board. The initial review will take place no later than six months after implementation to assess effectiveness and make necessary adjustments as the Group matures. More frequent review may be triggered by:

- material changes to NHS England's Performance Assessment Framework or national guidance;

- significant structural changes to the Group; or
- evidence that the Policy is not operating effectively.

14.2 Compliance Monitoring

The Group Chief Risk Officer is responsible for monitoring compliance with this Policy. Compliance monitoring includes:

- quarterly review of whether all required performance review meetings are being held to the required cadence;
- annual audit of whether Escalation Notification Templates are being completed as required;
- annual review of whether risk register entries are being created in accordance with Section 11.1; and
- six-monthly review of the Group IPR and CO IPRs to ensure they meet the standards set out in Section 10.2.

Compliance reports are provided to the Group Executive RAC. Significant non-compliance is reported to the Board Risk and Assurance Committee.

14.3 Superseded Documents

Upon approval of this Policy, it supersedes any performance management policies previously in place at RUH, GWH and SFT that address the same subject matter at Group level. Care Organisation-specific policies addressing local operational performance processes may be retained provided they are consistent with this Policy. Any conflict between a Care Organisation-specific policy and this Policy is resolved in favour of this Policy.

Appendix A: DRAFT Performance Metric Definitions (contingent on NOF changes)

The following table provides the standard definitions for core metrics included in the Group and Care Organisation Integrated Performance Reports. These definitions are mandatory across all three Care Organisations to ensure consistency in the single source of truth.

Metric	Domain	Definition / Numerator / Denominator	National Standard / Target
A&E 4-Hour Standard	Operational	% of A&E attendances seen and discharged, admitted or transferred within 4 hours	
RTT Performance %	Operational	% of patients on incomplete referral-to-treatment pathways waiting 18 weeks or fewer from RTT clock start	
Cancer 62-Day Standard	Operational	% of patients receiving first definitive cancer treatment within 62 days of urgent GP referral	
Cancer 28-Day FDS	Operational	% of patients receiving a cancer diagnosis or ruling-out within 28 days of urgent referral	
Diagnostics DM01	Operational	% of diagnostic tests completed within 6 weeks of referral	
SHMI	Quality	Summary Hospital-level Mortality Indicator: ratio of observed to expected deaths within 30 days of admission	
Crude Mortality Rate	Quality	Number of deaths per 1,000 finished consultant episodes	

Hospital-Acquired Pressure Ulcers	Quality	Number of hospital-acquired pressure ulcers (categories 1–4) per 1,000 occupied bed days (excluding specialist areas)	
Staff Sickness Absence	People	% of available working days lost to sickness absence (including all leave categories for unavailability metric)	
Staff Vacancy Rate	People	% of funded posts that are vacant at month end	
YTD Variance to Plan	Finance	% reported variance to financial plan	
CIP YTD Variance to Plan	Finance	% variance from planned CIP delivery	
Productivity Index	Finance	Implied productivity % calculated by adjusting pay and non-pay costs for cumulative inflation since 2019/20 and valuing activity at a standard rate	

This table is reviewed and updated as part of the annual Change Control process. The definitive current metric definitions are maintained in the Group Performance Report Business Rules document held by the Group Director of Information Services.

BSW Hospitals Group Board

Agenda item	8.1.3(c)
Report title	Group Board Assurance Framework
Date of meeting	2 July 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Mark Ellis, Chief Risk Officer
Approval Process: (where has this paper been reviewed and approved)	Shadow RAC (June'26) Group Joint Committee (June'26)

☒ **FOR ASSURANCE**	☒ **FOR DECISION**	☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*	
☒ Developing an engaged workforce	☒ Making our teams diverse and inclusive
☒ Making our services safer	☒ Improving timely access to our services
☒ Improving the experience of those who use our services	☒ Improving our financial sustainability
☒ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK	
BAF risk ID	**Principal risk title**

KEY MESSAGES

This paper presents the Initial Group Board Assurance Framework and seeks Board approval to adopt it as the Group's strategic risk management and assurance framework.

The framework establishes a baseline strategic risk position for the newly formed Group, consolidating risks from the three Care Organisations into ten Group principal risks and providing a single view of strategic exposure.

The review identifies several strategic risk themes not yet represented within the Group BAF (estates and fire safety, partnerships, health inequalities and net zero) and highlights variation in inherited risk appetite and tolerance positions across organisations.

A full refresh of the BAF will be undertaken alongside development of the Group Strategy and Risk Appetite Statement to ensure the framework reflects agreed Group objectives, appetite and governance arrangements.

RECOMMENDATION

The Group Board is asked to:

1. Approve and adopt the Group Board Assurance Framework

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

Purpose

The Board Assurance Framework (BAF) is a strategic tool used by Boards to identify, assess and monitor the key (Principal) risks to achieving an organisation's strategic objectives.

Status of the Initial Group BAF and planned refresh

The Board Assurance Framework presented in this report is, by design, an Initial BAF. It has been produced to give the Group Board and its committees a documented strategic-risk position at the point of Group formation, by drawing the ten emerging Group strategic risks together from the strategic risks already held by the three Care Organisations. It is explicitly a baseline and a transitional artefact — the starting point of an iterative process, not a settled or final framework.

The Initial BAF will be refreshed in parallel with the development and publication of the Group strategy, which is expected in September 2026. As the Group's strategic objectives are articulated and agreed, the principal risks to their achievement will be (re)defined against them; risk appetite will be set through the Group risk appetite development session held alongside the strategy; and the residual scoring of each principal risk will be completed and calibrated on the additive 5+5+5 model. This strategy-aligned refresh is the mechanism by which the framework matures from a consolidation of Care Organisation views toward a set of independently articulated Group principal risks, and is the route to "Established" reporting maturity.

It is therefore anticipated that the coverage gaps identified in tis report will be closed through this process rather than addressed in isolation. In particular, the absence of a Group-level principal risk for collaborative partnerships and system working — an exposure currently carried at Care Organisation level (for example SFT's partnership, ICS and Place risk, and GWH's partnership and inequalities risk) but with no equivalent in the Initial BAF — is expected to be resolved as the Group's strategic objectives for place-based and system working are defined, since a principal risk can only be articulated once the objective it threatens has been agreed. The same applies to the other identified gaps: estate and fire safety, environmental sustainability and net zero, and health inequalities.

Where the refresh concludes that an exposure is more properly held at Care Organisation level than as a Group principal risk, that determination will itself be recorded, so that the eventual coverage of the Group BAF is the result of a deliberate act of articulation and not of omission.

Method

This report establishes a documented baseline for the Group's strategic risk position at the point of formation. It does three things: First, it maps the strategic (Board Assurance Framework) risks held by each of the three Care Organisations into the ten strategic risks of the Initial Group BAF, and makes explicit where a Care Organisation risk has no equivalent at Group level. Second, it sets out, for each existing strategic risk, where the Care Organisation's risk appetite currently sits, expressed as an appetite category rather than a score so that the inherited position can later be compared against the Group appetite once agreed. Third, it assesses the actual (residual) risk scores now carried, against

existing appetites, to show what level of risk the Group is in practice tolerating, where risks sit inside or outside tolerance, and which areas are furthest from previously stated appetite.

The report is deliberately a baseline. The Group has not yet agreed a risk appetite this is scheduled for a Group risk appetite session which will be informed by the Group strategy. Until that statement is agreed, the Group operates on the interim principle set out in the Risk Management Strategy: any risk scoring 12 or above on the 15-point residual scale requires active Board-level oversight, and no risk is tolerated without explicit acknowledgement at the appropriate level.

Each Care Organisation currently maintains its own Board Assurance Framework, scored on the traditional 5×5 (likelihood × consequence) matrix. The Group adopts a different methodology — the additive 5+5+5 model, in which likelihood, consequence and control effectiveness are each scored 1–5 and summed to a residual score in the range 3–15. The two scales are therefore not directly comparable, and this report does not treat them as such; Care Organisation scores and Group scores are reported separately and on their own terms throughout.

Mapping of Care Organisation strategic risks into the Initial Group BAF

CO	Ref	Care Organisation strategic risk	Maps to	Note
RUH	1.1	Quality & safety – risk of harm to patients / poor experience	R8	Patient-safety risk;
RUH	1.2	UEC demand exceeding capacity / ED overcrowding & corridor care	R6	Urgent & emergency side of access
RUH	1.3	Planned-care demand exceeding capacity / RTT breaches	R6	Elective side of access
RUH	2.1	Culture of inclusion / discrimination; recruitment & retention	R2	Primary R2 (culture); secondary R9 (retention)
RUH	2.2	Management & leadership development / succession planning	R2	Workforce capability for transformation
RUH	3.1	Delivery of financial plan / financial recovery & sustainability	R5	Core financial sustainability risk
RUH	3.2	Sulis Hospital subsidiary not delivering financial target	R5	Subsidiary-specific; no Group commercial/subsidiary risk – partial fit only
RUH	3.3	Unwarranted variation / inequity of care / health inequalities	R4	Partial – health-inequalities element is largely a Group gap
RUH	3.4	Ageing estate / backlog maintenance / fire & infrastructure	— NO GROUP EQUIVALENT	Estate & fire safety not a Group BAF risk (current score 20), but present on GRR
RUH	3.5	Climate change / failure to achieve net zero	— NO GROUP EQUIVALENT	Environmental sustainability not a Group BAF risk (R5 is financial)
RUH	3.6	Insufficient digital capabilities	R3	Digital maturity
RUH	3.7	Cyber-security breaches	R10	Direct fit
RUH	3.8	Delayed / suboptimal EPR deployment	R3	EPR within digital maturity
SFT	1	Delayed / suboptimal EPR deployment	R3	EPR within digital maturity
SFT	2	Some services are not sustainable (fragile services)	R4	Service sustainability / transformation
SFT	3	Non-delivery of Digital Plan programmes	R3	Digital maturity
SFT	4	Critical plant & building infrastructure failure	— NO GROUP EQUIVALENT	Estate not a Group BAF risk (current score 16), but present on GRR
SFT	5	Cyber attack / IT network shutdown	R10	Direct fit; source states risk “always out of tolerance”

CO	Ref	Care Organisation strategic risk	Maps to	Note
SFT	6	Board limited capacity to oversee organisation in transition	R1	Governance / leadership capacity at formation
SFT	7	Inability to plan for, recruit and retain staff; morale & wellbeing	R9	Primary R9; secondary R2
SFT	8	Demand outweighs capacity – risk to patient safety & quality	R6	Primary R6 (access); secondary R8 (safety)
SFT	9	Unable to reduce expenditure to deliver financial sustainability	R5	Core financial sustainability
SFT	10	Failure to establish effective partnerships / ICS / Place	— NO GROUP EQUIVALENT	No dedicated Group partnership/system risk – partial R1/R4 only
SFT	11	Not achieving transformation at the pace required	R4	Primary R4; secondary R7 (productivity)
SFT	12	Sustained deterioration across elective performance metrics	R6	Elective access
GWH	SR1	Quality of care – failure to meet quality & safety standards	R8	Patient-safety risk;
GWH	SR2	Inclusive, diverse, accountable culture / engagement / turnover	R2	Primary R2 (culture); secondary R9
GWH	SR3	Ineffective workforce planning / recruitment / retention / agency	R9	Primary R9; secondary R2
GWH	SR4	Performance – failure to recover services (UEC, RTT, cancer)	R6	Access & performance recovery
GWH	SR5	Failure to maintain collaborative partnerships / inequalities	— NO GROUP EQUIVALENT	Partial R4; partnership & inequalities largely a Group gap
GWH	SR6	Finance – failure to control / manage the financial position	R5	Core financial sustainability
GWH	SR7	Estate not fit / resilient for the future	— NO GROUP EQUIVALENT	Estate not a Group BAF risk but present on GRR
GWH	SR8	Digital environment not stable / resilient / responsive	R3	Digital maturity
GWH	SR9	Cyber-attack or data breach	R10	Direct fit
GWH	SR10	Delayed / suboptimal EPR deployment (new risk)	R3	EPR within digital maturity

Coverage analysis

Care Organisation risks with no Group equivalent (gaps). Four themes carried as strategic risks by one or more Care Organisations have no home in the Initial Group BAF:

- Estate, infrastructure and fire safety — RUH 3.4 (current score 20, including multiple fire-management risks), SFT 4 (16) and GWH SR7 (12). A high-scoring, capital-constrained exposure across all three sites with no Group articulation.
- Environmental sustainability / net zero — RUH 3.5 (15). Note the name clash: the Group's R5 "Increasing Sustainability" is financial, not environmental.
- Partnership / system / Place working — SFT 10 and GWH SR5. Only partially reflected within R4.
- Health inequalities — RUH 3.3 and GWH SR5. Partially within R4 but not separately articulated.

Inherited risk appetite by Group BAF risk

The table below shows where each contributing Care Organisation risk's appetite currently sits, grouped under the Group BAF risk it maps to. Appetite is shown as a category, not a score, so that the inherited position can be compared with the Group appetite once agreed. Where more than one appetite level feeds a single Group risk, the Group-risk cell is split across the contributing rows.

Two appetite terms used by RUH — "Balanced" (RUH 3.1) and "Varied" (RUH 3.6) — fall outside the Group's five-band scale (Averse, Minimal, Cautious, Open, Eager) and will need to be normalised during appetite-setting.

Group BAF risk	CO source	Care Organisation appetite (category)	Inherited appetite range
R1 · Effective Group	SFT 6	Cautious	Cautious
R2 · Taking Our People With Us	RUH 2.1	Cautious	Cautious (consistent)
	RUH 2.2	Cautious	
	GWH SR2	Cautious	
R3 · Delivering Digital Maturity	RUH 3.6	Varied (Cautious storage / Open use)	Cautious, with one Varied/Open element
	RUH 3.8	Cautious	
	SFT 1	Cautious	
	SFT 3	Cautious	
	GWH SR8	Cautious	
	GWH SR10	Cautious	
R4 · Transforming Models of Care	RUH 3.3	Open	Spans Minimal – Open
	SFT 2	Minimal	
	SFT 11	Minimal	
	GWH SR5	Open	
R5 · Increasing Sustainability	RUH 3.1	Cautious (financial) / Balanced (spend to improve patient safety)	Cautious, with Balanced & Open elements
	RUH 3.2	Cautious & Open (assets/estates)	
	SFT 9	Cautious	
	GWH SR6	Cautious	
R6 · Reducing Waits	RUH 1.2	Open	Spans Minimal – Cautious – Open (three levels)
	RUH 1.3	Open	
	SFT 8	Minimal	
	SFT 12	Minimal	
	GWH SR4	Cautious	
R7 · Improving Value & Productivity	—	No equivalent CO strategic risk – appetite to be established	To be established at Group level
R8 · Reducing Avoidable Harm	RUH 1.1	Open	Spans Minimal – Open
	GWH SR1	Minimal	
R9 · Improving Staff Satisfaction	RUH 2.1	Cautious	Cautious (consistent)
	SFT 7	Cautious	
	GWH SR3	Cautious	
R10 · Cyber Security	RUH 3.7	Cautious	Spans Minimal – Cautious
	SFT 5	Cautious	

Group BAF risk	CO source	Care Organisation appetite (category)	Inherited appetite range
	GWH SR9	Minimal	

Averse	Minimal	Cautious	Open	Eager

Observation

Appetite is already broadly consistent for some Group risks (R2, R9 – Cautious; R5 and R10 predominantly Cautious) but materially divergent for others. R6 (Reducing Waits) is the clearest divergence: RUH treats access risk as Open, SFT as Minimal and GWH as Cautious for essentially the same exposure. R8 (Avoidable Harm) splits Open (RUH) against Minimal (GWH). These divergences are the substantive content for the appetite session: the Group cannot hold a single residual score for a risk on which its constituent organisations disagree about how much risk is acceptable.

Actual risk scores and tolerance position

Care Org	Strategic risks	Out of tolerance / above target	Summary
GWH	10	**7 of 10**	Outside tolerance: SR1 Quality (20 vs Minimal 6–10), SR3 Workforce (16), SR4 Performance (16), SR6 Finance (20), SR8 Digital (16), SR9 Cyber (20 vs Minimal 6–10), SR10 EPR (16). Within tolerance: SR2 Culture (9), SR5 Partnership (16, Open 12–20), SR7 Estate (12).
SFT	12	**11 of 12**	All outside of tolerance other than (BAF12) Performance
RUH	14	**9 of 13 (inferred)**	No numeric tolerance bands published, based on target scores. Highest current scores (20): Quality/harm (1.1), Financial plan (3.1), Estate/backlog (3.4). Several others at 16 against targets of 12 (e.g. UEC 1.2, RTT 1.3, Digital 3.6).

Areas furthest from previous appetite

Ranked by how far the inherited Care Organisation position sits beyond stated appetite/tolerance. Distances are on the 5×5 scale.

#	Area (Group risk)	Inherited position vs appetite	Why this matters
1	**Cyber security (R10)**	GWH SR9 = 20 vs Minimal (6–10); SFT 5 = 20, "always out of tolerance"; RUH 3.7 = 16 vs Cautious	Furthest from appetite across all three COs; Group additive score (13) understates the inherited position (two COs at 20).
2	**Quality / Avoidable Harm (R8)**	GWH SR1 = 20 vs Minimal (6–10); RUH 1.1 = 20	Among the furthest from appetite
3	**Finance / Sustainability (R5)**	GWH SR6 = 20 vs Cautious (9–15); SFT 9 = 20; RUH 3.1 = 20	Out of tolerance at every CO; the most consistently breached appetite. Group score (14) reflects this.
4	**Estate & fire safety (GRR)**	RUH 3.4 = 20; SFT 4 = 16; GWH SR7 = 12	High and capital-constrained, carried by Group Risk Register rather than BAF at present
5	**Waits / transformation (R6, R4)**	SFT 11 = 20 vs Minimal; SFT 8 = 16 vs Minimal; GWH SR4 = 16 vs Cautious; RUH 1.2/1.3 = 16 vs Open	Access and transformation risk is out of tolerance at CO level.

Conclusion

The Initial Group Board Assurance Framework achieves its intended purpose. It provides the Group Board with a single, documented view of the principal strategic risks facing the newly formed Group, establishes a clear baseline against which future development can be measured, and makes explicit both the areas of alignment and the areas requiring further articulation as the Group matures. It also provides transparency over inherited risk appetite positions and highlights those strategic risk areas where current exposures exceed established tolerances.

The analysis demonstrates that the ten principal risks within the Initial BAF provide a coherent framework through which the majority of strategic risks currently held by the three Care Organisations can be understood and overseen at Group level. Where gaps in coverage exist, these have been explicitly identified and will be addressed through the planned refresh aligned to the development of the Group Strategy and Group Risk Appetite Statement.

As such, the Initial BAF represents a proportionate and effective assurance tool for the Group at this stage of its development. It establishes the foundations for consistent strategic risk oversight while providing a clear route to further maturity as the Group's objectives, appetite and governance arrangements become established.

The Board is therefore invited to approve the Initial Group Board Assurance Framework and adopt it as the Group's strategic risk management and assurance framework, pending its planned refresh following agreement of the Group Strategy and Risk Appetite Statement.

BSW Hospitals Group

Initial Board Assurance Framework

Draft v0.2 July 2026

Note on this draft: *This populated draft has been developed to give the Group Chief Risk Officer and SROs a working starting point. Scores and assurance levels have been left blank. Risk descriptions are taken from the agreed risk statements in the GEC paper of 14 April 2026.* ***Three lines of defence content and SMART action examples are illustrative and intended for SRO refinement.*** *SROs are recorded as roles pending confirmation of named individuals on appointment.*

Summary: All Risks at a Glance

Assurance level: Substantial | Reasonable | Limited | Minimal. Scores, appetite, assurance levels and GRR references to be completed once Initial BAF is populated.

Ref	Strategic Priority	SRO(s)	Inherent	Residual	Target	Assurance Level	Trend	GRR Ref	Key gap / status
R1	Becoming an Effective Group	CSO	[8]	**[10]**	[8]	*[TBC]*	→	*Pending*	*CO BAFs are scheduled to retire at go-live and an Initial Group BAF will be used ahead of agreement of the Group Strategy and Risk Appetite.*
R2	Taking Our People With Us	CPO	[8]	**[11]**	[7]	*[TBC]*	→	*Pending*	
R3	Delivering Digital Maturity	CDIO	[8]	**[12]**	[9]	*[TBC]*	→	*Pending*	
R4	Transforming Models of Care	CCTIO	[8]	**[12]**	[8]	*[TBC]*	→	*Pending*	
R5	Increasing Sustainability	CFO	[10]	**[14]**	[9]	*[TBC]*	→	*Pending*	
R6	Reducing Waits	TBC	[ ]	**[ ]**	[ ]	*[TBC]*	→	*Pending*	
R7	Improving Value and Productivity	CFO	[10]	**[14]**	[9]	*[TBC]*	→	*Pending*	
R8	Reducing Avoidable Harm	TBC	[ ]	**[ ]**	[ ]	*[TBC]*	→	*Pending*	
R9	Improving Staff Satisfaction	CPO	[7]	**[10]**	[6]	*[TBC]*	→	*Pending*	
R10	Cyber security	CDIO	[9]	**[13]**	[11]	*[TBC]*	→	*Pending*	

Summary: Risk Position by Level (illustrative tbc)

Risks grouped by residual score. High = 12–15 | Significant = 9–11 | Moderate = 8 or below. Scores to be populated.

Level	Risks
HIGH Residual 12–15	**R3** -Delivering Digital Maturity *Score: [12] → CDIO* **R4** -Transforming Models of Care *Score: [12] → CCTIO* **R5** -Increasing Sustainability *Score: [14] → CFO* **R6** -Reducing Waits *Score: [ ] → TBC* **R7** -Improving Value and Productivity *Score: [14] → CFO* **R10** -Cyber Security *Score: [13] → TBC*
SIGNIFICANT Residual 9–11	**R1** -Becoming an Effective Group *Score: [10] → CSO* **R2** -Taking Our People With Us *Score: [11] → CPO* **R8** -Reducing Avoidable Harm *Score: [ ] → TBC* **R9** -Improving Staff Satisfaction *Score: [10] → CPO*
MODERATE Residual 8 or below	

R1	Becoming an Effective Group	**SRO** CSO	**Strategic Objective** Becoming an Effective Group	**GRR Reference** *[Pending]*	**Last Reviewed** *[Date]* *Next Review: [Date]*

Risk Description There is a risk that the Group fails to establish effective governance, leadership and operating arrangements following formation, caused by the complexity of integrating three established organisations with different cultures, systems and accountability structures, resulting in unclear accountability, governance failure and an inability to realise the intended benefits of group formation.

GRR cross-reference:
Pending -covered in part by candidate GR-05 (Group governance maturity, to be confirmed)

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[8]	**[10]**	**[8]**
Max 10 (Likelihood + Consequence)	*Max 15 (L + C + Control Effectiveness)*	*Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional]	***[TBC]***	➔
To be agreed at Group risk appetite workshop	*Substantial / Reasonable / Limited / Minimal*	*Stable (initial position)*

R1 Becoming an Effective Group - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Operating Blueprint and Assurance Manual agreed ● Group Partnership Agreement, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation in place from go-live (July 2026) ● Group Board, Joint Committees and Group Executive Committee operating to agreed terms of reference, meeting cycle and forward plan ● Functions and Decision Map maintained by the Group Company Secretary, setting out decision authority across Group and CO levels ● CO Boards continuing to operate with their own assurance committees during the transition period ● Managing Director reports to each Board meeting include summary from each Assurance Committee ● Safe to start ongoing assessment – beyond first Group Board meeting.	*Oversight, monitoring and challenge functions* ● Pilot Risk and Assurance Committee oversight of governance development through to go-live ● Group Audit Committee review of internal control arrangements once formed ● Company Secretary monitoring of compliance with Standing Orders and SoRD across the three COs ● External governance review (planned, post go-live) to confirm arrangements are operating as intended	*Independent assurance: audit, regulator, peer review* ● Internal Audit review of governance framework (planned, autumn 2026) ● External Well-Led review (planned Q4 26/27) ● NHS England oversight via the System Oversight Framework ● External Auditor Annual Report on governance and value for money

Gaps in Controls and Assurance

Group Board not yet formed, Group Strategy and risk appetite not yet agreed at Group level. CO BAFs are scheduled to retire at go-live and the Group BAF will be in its initial form. Functions and Decision Map remains in development and will require iteration once the Group Executive is in place. No Group-level Internal Audit plan in place yet.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group Board inaugural meeting and adoption of Group governance framework, including updated Operating Blueprint and Assurance Manual	Group Chair / GCEO	July 2026	*Complete*
Group Strategy agreed	CSO	September 2026	*Under development*
Group risk appetite statement developed and agreed by the Group Board	Group CRO	September / October 2026	*Under development*

First Group Internal Audit plan agreed	Group Audit Committee Chair	October 2026	*Not started*
Functions and Decision Map reviewed against operating experience and updated	Group Company Secretary	December 2026	*Not started*

R2	Taking Our People With Us	**SRO** CPO	**Strategic Objective** Taking Our People With Us	**GRR Reference** *[Pending]*	**Last Reviewed** *[Date]* *Next Review: [Date]*

Risk Description There is a risk that the Group fails to carry its workforce through the changes required to deliver the Group Strategy, caused by insufficient engagement, communication and change management capability, resulting in staff disengagement, cultural fragmentation, deteriorating morale and an inability to deliver the Group's objectives.

GRR cross-reference:
Pending -overlaps with candidate GR-04 (Workforce Sustainability and Pipeline)

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[8] *Max 10 (Likelihood + Consequence)*	**[11]** *Max 15 (L + C + Control Effectiveness)*	**[7]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	➔ *Stable (initial position)*

R2 Taking Our People With Us - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Development and implementation of Group people delivery plan ● Development and implementation of a Group communications and engagement plan Director of Comms ● Joint staff-side and Trust partnership arrangements in operation across the three Cos ● Change management capability and capacity across the Group ● Care Organisation POD and Group POD ● Executive leadership	*Oversight, monitoring and challenge functions* ● People and Culture Committee oversight of staff engagement and culture indicators ● Pulse survey and NHS Staff Survey results monitored at Group and CO level ● Group CSR Design Authority oversight of consequential workforce changes ● EPR Programme Bpard ● Clinical Transformation Programme Board oversight of consequential changes ● Care Organisation governance arrangements ● UEC Board ● Elective Recovery Board	*Independent assurance: audit, regulator, peer review* ● NHS Staff Survey national benchmarking ● Internal Audit review of change management arrangements ● External cultural review or 360-degree assessment (option for the Board to consider)

Gaps in Controls and Assurance

No agreed Group-level set of culture and engagement indicators yet in place. HR change management capacity has been flagged at SFT (SFT-8780) and may apply across the Group.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group staff engagement plan agreed and published	Group CPO	August 2026	*Not started*
Set of Group culture and engagement indicators agreed for People and Culture Committee	Group CPO	September 2026	*Not started*
First Group-wide pulse survey completed and reported	Group CPO	November 2026	*Not started*

R3	Delivering Digital Maturity	SRO CDIO	Strategic Objective Delivering Digital Maturity	GRR Reference *[Pending]*	Last Reviewed *[Date]* *Next Review: [Date]*

There is a risk that the Group fails to deliver the digital maturity required to enable safe, efficient and transformed care, caused by fragmented legacy systems, material technical debt, unsupported infrastructure, inconsistent cyber and digital controls across the three Care Organisations, constrained capital investment, Digital services capacity and the complexity of delivering major programmes such as EPR, resulting in operational inefficiency, avoidable clinical risk, reduced resilience, inability to standardise pathways and failure to realise the clinical, productivity and financial benefits of group working.

GRR cross-reference:
Aligns with candidate R10 Cyber Security and Digital Infrastructure Resilience and should cross-reference Group Digital Service risk register covering technical debt, unsupported systems, EPR delivery, infrastructure resilience, clinical system continuity, data quality, interoperability and capital affordability.

R4 Transforming Models of Care – digital capability enables pathway transformation.
R5 Increasing Sustainability – capital constraints limit digital remediation.
R7 Improving Value and Productivity – productivity benefits depend on digital standardisation.
R10 Cyber Security – technical debt increases cyber exposure.
R6 Reducing Waits – operational performance depends on reliable digital systems and data.

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[8] *Max 10 (Likelihood + Consequence)*	**[12]** *Max 15 (L + C + Control Effectiveness)*	**[9]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	➔ *Stable (initial position)*

R3 Delivering Digital Maturity *- Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Group-wide technical debt register, consolidated from RUH, GWH and SFT digital risk registers ● Prioritised remediation plan for unsupported servers, operating systems, network infrastructure, end-user devices and high-risk clinical systems. ● Architecture review board and Digital Design Authority to prevent further divergence and manage exceptions. ● Capital prioritisation process linked to digital risk scoring, clinical impact and cyber exposure. ● Lifecycle management standards for infrastructure, applications and medical/IoT devices. ● Cyber security single operational team in place with updated tools and standardised operational risk management.	*Oversight, monitoring and challenge functions* ● Group Digital Oversight Committee review of technical debt, infrastructure resilience and programme delivery risk. ● Group Risk and Assurance Committee oversight of aggregated digital risk profile ● Finance and capital governance review of unfunded digital risk and deferred remediation. ● Clinical safety review of digital risks affecting patient pathways, diagnostics, prescribing, imaging, pathology and EPR dependencies. ● Digital risk heatmap at Group/CO, showing common risks, outliers and escalation requirements prior to standardisation of service deliver, tools and teams.	*Independent assurance: audit, regulator, peer review* ● Independent review of digital maturity and technical debt baseline across the Group. ● Internal Audit review of digital governance, digital programme controls and benefits realisation. ● External assurance of EPR readiness, interoperability and clinical safety case. ● DSPT, penetration testing and cyber assurance only where they evidence maturity dependencies. ● Benchmarking against NHS digital maturity assessment, WGLL DMA and peer acute provider groups. ●

Gaps in Controls and Assurance

Group Digital Strategic plan is to be initiated, with a single consolidated view of digital maturity, technical debt, infrastructure resilience and digital investment across RUH, GWH and SFT work in progress. Group Digital and CO risk registers identify common exposure around ageing infrastructure, unsupported systems, inconsistent tooling, system resilience, constrained capital, EPR delivery dependency and capacity to deliver remediation alongside business-as-usual operational demand. Work is in progress to score Digital risks consistently, prioritised and reported through a single Group digital risk framework. There is also limited independent assurance over the totality of technical debt and the affordability of the remediation plan. A project has been initiated and is awaiting reporting of findings.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Consolidate RUH, GWH and SFT digital risk registers into a single Group digital risk and technical debt heatmap, identifying common risks, outliers and highest clinical/service impact exposures.	Group CDIO	August 2026	In progress
Establish a Group technical debt register covering infrastructure, clinical systems, end-user devices, networks, integration, data platforms and unsupported software.	Group CDIO	September 2026	In progress
Agree a risk-based digital investment and remediation plan, prioritised by patient safety, operational resilience, cyber exposure, EPR dependency and regulatory compliance.	Group CDIO/Group CFO	November 2026	Planned
Approve the Group Digital Strategic plan and digital maturity roadmap, including target maturity level standards.	Group CDIO	December 2026	In progress
Establish a Group Digital Design Authority to manage architecture standards, technical debt exceptions and convergence decisions.	Group CDIO	September 2026	In progress
Present quarterly digital maturity and technical debt assurance report to Group Digital Oversight Committee, including risk movement, funding gaps and delivery confidence.	Group CDIO	October 2026	In Progress
Commission independent assurance review of technical debt, digital governance and maturity roadmap delivery.	Group CDIO	July 2026	In progress

R4	Transforming Models of Care	**SRO** CCTIO	**Strategic Objective** Transforming Models of Care	**GRR Reference** *[Pending]*	**Last Reviewed** *[Date]* *Next Review: [Date]*

Risk Description There is a risk that the Group fails to transform its models of care at the pace and scale required, caused by lack of dedicated clinical and project resource, insufficient clinical engagement, competing operational pressures and system complexity during transition, resulting in failure to improve patient outcomes, reduce variation, ability to provide a sustainable service, and deliver population health impact.

GRR cross-reference:
Pending -overlaps with candidate GR-05 (UEC Demand and Patient Flow) for flow-related elements

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[8] *Max 10 (Likelihood + Consequence)*	**[12]** *Max 15 (L + C + Control Effectiveness)*	**[ ]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	➔ *Stable (initial position)*

R4 Transforming Models of Care - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team • Clinical Transformation programme structure under the Group CCTIO including the Clinical Transformation Steering Group • Weekly working group which provides a forum for cross transformation workstream sharing (UEC and Elective) • CO-level clinical leadership engaged through Group clinical fora • Specific transformation workstreams (e.g. UEC, elective recovery, community pathways) operating with named leads • Patient and public involvement arrangements across the three COs	*Oversight, monitoring and challenge functions* • Clinical Senate or equivalent Group-wide clinical advisory function • Quality and Safety oversight of transformation impacts on outcomes • Outcomes and variation reporting to the Group Quality Committee • Engagement with the BSW ICB and population health intelligence functions	*Independent assurance: audit, regulator, peer review* • External clinical peer review of transformation programmes (where commissioned) • GIRFT and other national programme benchmarking • Internal Audit review of programme management arrangements • Royal College and specialty body assurance visits

Gaps in Controls and Assurance

Clinical Transformation programme architecture is still being established. Outcomes baseline at Group level is not yet defined. Pace of transformation will be constrained by operational pressures, particularly UEC. Patient engagement arrangements vary across the three COs.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group Clinical Transformation programme plan agreed by the Group Board	Group CCTIO	September 2026	*Not started*
Outcomes and variation baseline agreed for Quality Committee reporting	Group CCTIO / Group Quality Director	November 2026	*Not started*
Patient and public involvement framework harmonised across the three COs	Group CCTIO	December 2026	*Not started*
Resource requirements scoped, identified, and confirmed	Group CCTIO	May 2026	*Overdue*

R5	Increasing Sustainability	**SRO** CFO	**Strategic Objective** Increasing Sustainability	**GRR Reference** *[Pending]*	**Last Reviewed** *[Date]* *Next Review: [Date]*

Risk Description There is a risk that the Group fails to achieve and maintain financial sustainability, caused by structural deficits across member organisations, rising demand, inflationary pressures and the complexity of managing finances across three sites during integration, resulting in an inability to invest in transformation and compromised service delivery.

GRR cross-reference:
Pending -directly aligns with candidate GR-02 (Financial Sustainability)

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[10] *Max 10 (Likelihood + Consequence)*	**[14]** *Max 15 (L + C + Control Effectiveness)*	**[9]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	➔ *Stable (initial position)*

R5 Increasing Sustainability *- Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Group financial plan for 2026/27 in place, with CO-level budgets and delivery responsibility ● Monthly reporting cycle ● Group efficiency programme ● Cash flow forecasting and treasury management at Group level ● Deficit support funding and ICB transitional funding arrangements confirmed??	*Oversight, monitoring and challenge functions* ● Four tier reporting and scrutiny structured introduced with monthly financial reporting to Group Executive Committee and Group Board ● External turnaround team? ● Group CFO review of CO-level forecasts and risk-adjusted positions ● Internal Audit financial controls reviews ● Group SFIs providing the financial governance framework	*Independent assurance: audit, regulator, peer review* ● External Auditor opinion on financial statements and value for money ● NHS England financial regime oversight and reporting ● Internal Audit head of audit opinion on financial controls

Gaps in Controls and Assurance

Aggregate Group financial position not yet reported as a single risk (flagged as candidate GR-02). CIP delivery confidence varies across the COs. Recurrent versus non-recurrent split in the plan needs to be made transparent to the Board. Capital affordability constrains backlog and digital investment (links to R3 and to candidate GR-01).

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
First Group financial position report to Group Board including aggregate risk-adjusted forecast	Group CFO	September 2026	
CIP delivery confidence assessment by workstream presented to Joint Finance and Performance Committee	Group CFO	Monthly from August 2026	
Medium-term financial plan (3-year) presented for Group Board agreement	Group CFO	March 2027	

R6	Reducing Waits	SRO CO COOs (x3)	Strategic Objective Reducing Waits	GRR Reference *[Pending]*	Last Reviewed *[Date]* *Next Review: [Date]*

Risk Description There is a risk that the Group fails to reduce patient waiting times to meet constitutional and national operational standards, caused by demand exceeding capacity, workforce constraints and pathway inefficiency, resulting in harm to patients, regulatory intervention and reputational damage.

GRR cross-reference:
Pending -overlaps with candidate GR-05 (UEC Demand and Patient Flow) on the urgent and emergency side

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[ ] *Max 10 (Likelihood + Consequence)*	**[ ]** *Max 15 (L + C + Control Effectiveness)*	**[ ]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	➔ *Stable (initial position)*

R6 Reducing Waits - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● CO-level operational delivery against RTT, cancer, diagnostic and ED standards ● Elective recovery plans in operation at each CO with named SROs ● Tier 1 / GIRFT support arrangements where in place (e.g. RUH ED) ● Patient Tracking List management and validation processes at CO level ● Cancer pathway navigators and tracking arrangements	*Oversight, monitoring and challenge functions* ● Joint Finance and Performance Committee oversight of access standards ● BSW system-level UEC and elective coordination through ICB arrangements ● Group operational performance reporting to GEC ● Harm review processes for patients waiting beyond agreed thresholds	*Independent assurance: audit, regulator, peer review* ● GIRFT national benchmarking ● NHS England operational oversight and tier rating ● CQC inspection outcomes ● Internal Audit review of waiting list management (planned, on a rolling basis)

Gaps in Controls and Assurance

Aggregate Group performance against access standards not yet reported as a single position. UEC and elective demand and capacity assumptions are not yet harmonised across the three COs. Validation methodology variation across the three sites has not been tested.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group performance scorecard for access standards agreed	Group COO function / CO COOs	August 2026	*First iteration complete*
Harmonised approach to long waiter harm review agreed across the three COs	CO CMOs / Group Quality Director	October 2026	*Not started*
Demand and capacity assumptions reviewed at Group level for 2027/28 planning	Group COO function	January 2027	*Not started*

<table>
<tr><td>R7</td><td>Improving Value and Productivity</td><td>SRO
Op DoFs (x3)</td><td>Strategic Objective
Improving Value and Productivity</td><td>GRR Reference
[Pending]</td><td>Last Reviewed
[Date]
Next Review: [Date]</td></tr>
<tr><td colspan="6">Risk Description There is a risk that the Group fails to improve its productivity and deliver value for money, caused by inefficient use of resources, unwarranted variation in practice across sites and failure to realise group-level efficiencies, resulting in ongoing financial deficit and an inability to reinvest in service improvement.
GRR cross-reference:
Pending -links to candidate GR-02 (Financial Sustainability)</td></tr>
<tr><td colspan="2">INHERENT SCORE
[10]
Max 10 (Likelihood + Consequence)</td><td colspan="2">RESIDUAL SCORE
[14]
Max 15 (L + C + Control Effectiveness)</td><td colspan="2">TARGET SCORE
[9]
Planned destination</td></tr>
<tr><td colspan="2">RISK APPETITE
[Provisional]
To be agreed at Group risk appetite workshop</td><td colspan="2">ASSURANCE LEVEL
[TBC]
Substantial / Reasonable / Limited / Minimal</td><td colspan="2">DIRECTION OF TRAVEL
➔
Stable (initial position)</td></tr>
</table>

R7 Improving Value and Productivity *- Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● CO-level CIP plans with named workstream leads and delivery trajectories ● Group efficiency programme covering corporate services and clinical productivity ● Theatre, outpatient and bed productivity metrics tracked at CO level ● Procurement collaboration where established ● Agency and bank usage controls	*Oversight, monitoring and challenge functions* ● Joint Finance and Performance Committee scrutiny of productivity and CIP delivery ● Group CFO and CO Operational Directors of Finance review of productivity reporting ● Model Hospital and GIRFT data benchmarking ● Internal Audit reviews of specific productivity workstreams	*Independent assurance: audit, regulator, peer review* ● GIRFT national benchmarking and peer comparison ● Model Hospital benchmarking ● NHS England productivity programme oversight ● Internal Audit head of audit opinion

Gaps in Controls and Assurance

Group-level productivity baseline and definitions not yet harmonised across the three COs. CIP risk-adjusted forecasting confidence varies. Corporate services rationalisation programme is in early stages. Recurrent CIP delivery (versus non-recurrent) needs sharper visibility.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group productivity dashboard agreed for Joint Finance and Performance Committee	Op DoFs (x3)	September 2026	*Not started*
Corporate services rationalisation plan presented to GEC	Group CFO / Group CPO	December 2026	*Not started*
First annual benchmarking review across the three COs presented to the Board	Group CFO	March 2027	*Not started*

<table>
<tr><td>R8</td><td>Reducing Avoidable Harm</td><td>SRO
CNOs (x3)</td><td>Strategic Objective
Reducing Avoidable Harm</td><td>GRR Reference
[Pending]</td><td>Last Reviewed
[Date]
Next Review: [Date]</td></tr>
<tr><td colspan="6">Risk Description There is a risk that the Group fails to maintain and improve patient safety standards, caused by workforce pressures, governance immaturity during the transition period and the challenges of integrating safety systems across three sites, resulting in avoidable harm to patients and potential regulatory intervention.
GRR cross-reference:
Pending -operational harm risks remain primarily on CO registers; Group-wide aggregation under development</td></tr>
<tr><td colspan="2">INHERENT SCORE
[ ]
Max 10 (Likelihood + Consequence)</td><td colspan="2">RESIDUAL SCORE
[ ]
Max 15 (L + C + Control Effectiveness)</td><td colspan="2">TARGET SCORE
[ ]
Planned destination</td></tr>
<tr><td colspan="2">RISK APPETITE
[Provisional]
To be agreed at Group risk appetite workshop</td><td colspan="2">ASSURANCE LEVEL
[TBC]
Substantial / Reasonable / Limited / Minimal</td><td colspan="2">DIRECTION OF TRAVEL
➔
Stable (initial position)</td></tr>
</table>

R8 Reducing Avoidable Harm - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Patient Safety Incident Response Framework (PSIRF) implementation across the three COs ● Datix or equivalent incident reporting in operation at each site ● Mortality review processes and learning from deaths reporting ● Infection prevention and control teams and surveillance ● Safe staffing reviews and acuity tools at ward level	*Oversight, monitoring and challenge functions* ● Quality and Safety Committee oversight at Group level ● Patient Safety Specialists and Group-level patient safety leadership ● Group Quality Director coordination of safety reporting and themes ● Safeguarding Committee oversight	*Independent assurance: audit, regulator, peer review* ● CQC inspection outcomes and ratings ● Healthcare Safety Investigation Branch (HSIB) reviews where applicable ● Internal Audit reviews of patient safety arrangements ● External clinical audits (NCEPOD, Royal College reviews) ● NHS Resolution claims data and learning

Gaps in Controls and Assurance

Aggregate Group-level safety position and themes not yet reported as a single picture. Variation in PSIRF implementation maturity across the three COs. Workforce pressure on safety (links to R2 and R9) is a persistent driver. Safety Improvement Plan harmonisation is not yet in place.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group safety scorecard agreed for Quality Committee reporting	Group Quality Director / CNOs	September 2026	*Under development*

R9	Improving Staff Satisfaction	SRO Op DoPs (x3)	Strategic Objective Improving Staff Satisfaction	GRR Reference *[Pending]*	Last Reviewed *[Date]* *Next Review: [Date]*

Risk Description There is a risk that the Group fails to improve staff experience and retain a productive workforce, caused by the uncertainty of changes needed to deliver Group strategy, cultural differences across organisations and ongoing workforce pressures, resulting in high turnover in hard to recruit areas, stagnation and recruitment difficulties and a deterioration in the quality of care delivered.

GRR cross-reference:
Pending -overlaps with R2 and candidate GR-04 (Workforce Sustainability and Pipeline)

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[7] *Max 10 (Likelihood + Consequence)*	**[10]** *Max 15 (L + C + Control Effectiveness)*	**[6]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	➔ *Stable (initial position)*

R9 Improving Staff Satisfaction - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Development and implementation of Group People Delivery Plan ● NHS Staff Survey administration and action planning at CO level and Group level ● Pulse survey arrangements where in place ● Health and wellbeing offer for staff at each CO ● Recognition schemes and long service arrangements ● Freedom to Speak Up Guardian arrangements at each CO	*Oversight, monitoring and challenge functions* ● People and Culture Committee oversight of engagement indicators ● Group CPO and Site HRDs review of turnover, vacancy and sickness data through Care Org POD and Group POD ● Speak Up Guardian reporting to the Board	*Independent assurance: audit, regulator, peer review* ● NHS Staff Survey national benchmarking ● Workforce Race Equality Standard and Workforce Disability Equality Standard returns ● Gender Pay Gap reporting ● NETS Survey ● MEQR annual review ● External cultural reviews (where commissioned)

Gaps in Controls and Assurance

Group-level staff experience indicators not yet agreed. Health and wellbeing offer varies across the three COs. Turnover hotspots (e.g. nursing, specific specialties) are known but mitigation impact is not yet assessed at Group level.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group staff experience indicator set agreed for People and Culture Committee	Group CPO / Site HRDs	September 2026	*Not started*
Health and wellbeing offer reviewed for harmonisation opportunities	Site HRD for Culture & OD	November 2026	*Not started*

R10	Cyber Security	SRO CDIO	Strategic Objective Delivering Digital Maturity	GRR Reference *[Pending]*	Last Reviewed *[Date]* *Next Review: [Date]*

Risk Description:

There is a risk that the Group experiences a significant cyber security incident, ransomware attack or data breach, caused by the evolving threat landscape, fragmented legacy infrastructure across the three Care Organisations, material technical debt, unsupported systems, inconsistent cyber controls, medical and IoT device exposure, third-party and supply chain vulnerabilities, and constrained capacity to remediate known digital risks, resulting in disruption to clinical services, compromise or loss of patient and corporate data, financial loss, regulatory action, loss of public confidence and reputational damage.

GRR cross-reference:
Linked BAF dependencies: R10 is a cross-cutting enabling risk. It has a direct dependency relationship with R3 Delivering Digital Maturity, R6 Reducing Waits and R8 Reducing Avoidable Harm, and a significant enabling relationship with R4 Transforming Models of Care and R7 Improving Value and Productivity. It also has consequential links to R5 Financial Sustainability, R1 Group Effectiveness, R2 Taking Our People With Us and R9 Staff Satisfaction through service disruption,

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[9] *Max 10 (Likelihood + Consequence)*	**[12]** *Max 15 (L + C + Control Effectiveness)*	**[11]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	➔ *Stable (initial position)*

R10 Cyber security *- Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team • Group-aligned cyber security framework and operating model developed, with clear accountabilities across Group Digital services. • Group-wide technical debt and cyber exposure heatmap, drawing from CO digital risk registers. • Prioritised remediation plan for unsupported operating systems, servers, applications and high-risk clinical systems. • Identity and access management improvement plan, including MFA expansion, privileged access management and joiner/mover/leaver controls. • Medical and IoT device cyber monitoring and risk-based remediation plan. • Group cyber incident response playbooks, including ransomware, EPR outage, pathology outage, imaging outage and supplier compromise. • Cyber resilience testing aligned to EPR, LIMS, PACS, pathology, radiology, e-prescribing and shared infrastructure dependencies. • Supplier cyber assurance process for critical systems and system/regional shared services.	*Oversight, monitoring and challenge functions* • Group Digital Oversight Committee or equivalent to review cyber risk, technical debt and security control convergence. • Group Risk and Assurance Committee to receive a consolidated cyber risk profile. • Group Information Governance / Security Forum to monitor policy, DSPT, IG training, data breach trends and cyber control compliance. • Finance/capital governance review of unfunded cyber remediation and deferred technical debt. • Clinical safety oversight where cyber risks affect clinical systems, medical devices or critical pathways. • Regular review of supplier cyber risk for critical clinical and corporate systems.	*Independent assurance: audit, regulator, peer review* • Independent Group-wide cyber maturity review against NHS CAF / DSPT / NCSC-aligned controls. • Internal Audit review of cyber governance and technical debt risk management. • Independent review of privileged access, endpoint protection, backup resilience and restore capability. • Tabletop exercise or live simulation of a major cyber incident affecting one or more COs. • Post-exercise assurance report to the Group Board. • Independent assurance on supplier cyber risk management for critical third parties.

Gaps in Controls and Assurance

Cyber risk remains high because CO risk registers identify material exposure from technical debt, unsupported infrastructure, inconsistent tooling, supplier vulnerabilities and constrained specialist cyber capacity. The Group does not yet have a fully consolidated cyber risk and technical debt heatmap across RUH, GWH and SFT, this is in progress. Cyber controls exist at Group Digital services, convergence of cyber tooling, identity controls, endpoint controls, USB/device controls, medical and IoT device security, supplier assurance and cyber incident response arrangements is not yet complete. Legacy infrastructure, including unsupported servers and bespoke systems, remains an active source of risk and capital constraints may delay remediation. Business continuity plans for

extended cyber outage scenarios require further testing across shared clinical dependencies, including EPR, pathology, radiology, imaging, e-prescribing and regional services.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group business continuity plans reviewed and strengthened for extended cyber outage scenarios, starting with Pathology LIMS and Integrated EPR	Group CDIO / CO COO	November 2026	Not started
Consolidate RUH, GWH and SFT cyber and digital risk registers into a single Group cyber risk and technical debt heatmap, showing highest-risk assets, unsupported systems, supplier risks and clinical service dependencies.	Group CDIO	August 2026	*In progress*
Agree Group cyber security operating model, including accountability, escalation, incident command, cyber on-call arrangements and relationship with CO teams	Group CDIO	November 2026	*In progress*
Agree Group cyber control baseline, including MFA, privileged access management, patching, endpoint protection, logging/monitoring, USB/device controls, backup resilience and incident response standards.	Group CDIO	October 2026	*Planned*
Complete risk-based remediation plan for unsupported infrastructure, legacy applications and high-risk clinical systems, prioritised by patient safety, cyber exposure and business continuity impact.	Group CDIO	December 2026	*In progress*
Complete supplier cyber assurance review for all critical systems and high-impact third parties, including regional dependencies and clinical networks.	Group CDIO	October 2026	*In progress*
Complete Group cyber incident tabletop exercise, including ransomware and extended outage scenario affecting EPR, LIMS or imaging.	Group CDIO	November 2026	*In Progress*
Report cyber training, phishing simulation, MFA coverage, patch compliance, unsupported asset reduction and cyber incidents quarterly to Group Digital Oversight Committee and Group Risk and Assurance Committee.	Group CDIO	October 2026	*In progress*

Note on this template: *Good practice (HM Treasury Orange Book; GGI BAF guidance) distinguishes between controls -the measures in place to manage a risk -and assurances -the evidence that those controls are working effectively. In this Initial BAF, controls and assurances are combined within each line of defence for simplicity during the transition period. They will be separated when the Initial BAF is superseded by a mature Group BAF in early 2027.*

BSW Hospitals Group Board

Agenda item	Item 8.1.4
Report title	Board Oversight of Maternity and Neonatal Services
Date of meeting	2nd July 2026
Sponsor	
Prepared by	Chief Nursing Officers / Directors of Midwifery
Approval Process: (where has this paper been reviewed and approved)	

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*	
☐ Developing an engaged workforce	☐ Making our teams diverse and inclusive
☒ Making our services safer	☒ Improving timely access to our services
☒ Improving the experience of those who use our services	☐ Improving our financial sustainability
☒ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R8 [	Reducing Avoidable Harm

KEY MESSAGES

This paper sets out how BSW Hospitals Group will discharge its Board-level responsibilities for the oversight of maternity and neonatal services. It translates the national framework for Board accountability into the Group's governance architecture, taking account of the fact that the Group Board holds oversight of three Care Organisations (COs), each with its own Maternity and Neonatal service.

The recent published Ockenden Report (Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust June 2026) reinforces the Boards responsibility for active oversight of Perinatal safety and not delegate to a sub committee. The report states that it is essential to close the gap between what women, families and staff are reporting and what the board is hearing. The recommendations set out in the paper below will be reviewed against the learning highlighted in this report and be strengthened accordingly.

RECOMMENDATION

The Group Board is asked to:

1. Note the proposed architecture for maternity governance within the BSW Hospitals Group and the ongoing work led by the Directors of Midwifery with the Chief Nursing Officers to ensure robust escalation, learning and insights into perinatal services across the group.

APPENDICES

1. Purpose

This paper sets out how the BSW Group Board will discharge its responsibilities for oversight of maternity and neonatal (perinatal) services across the three Care Organisations.
It proposes a governance framework that ensures:

- clear visibility of performance and risk across all services
- effective escalation and management of safety concerns
- consistent learning and improvement across the Group

The paper seeks Board approval for the proposed governance architecture, including the establishment of a Group Perinatal Committee and associated reporting arrangements. New or emerging risks will be escalated in a timely manner through the BSW Groups risk management framework.

2. The National Framework

The Board's responsibilities in relation to perinatal services are set by two principal national frameworks.

The Perinatal Quality Oversight Model (PQOM), published by NHS England in August 2025, requires Boards are accountable for the routine oversight of maternity and neonatal services. This means the Board must be able to demonstrate that:

- it understands the current position across all services
- it is sighted on risks
- it is assured that appropriate action is being taken

The Maternity Incentive Scheme (MIS), Safety Action F, published by NHS Resolution (Year 8, March 2026), requires Boards to routinely review comprehensive assessments of maternity and neonatal quality. This is a compliance requirement with direct financial implications.

These obligations are not triggered by a risk score. They are standing governance requirements that apply regardless of current performance. A maternity service with green indicators still carries the Board's full oversight obligation. This distinction matters how the Group designs its oversight model.

3. The BSW Context

BSW Hospitals Group comprises of three Care Organisations, each operating its own perinatal service and serving distinct local populations across the BSW geography. The Group Board holds Board-level accountability for all three.

This creates both greater complexity and opportunity. The complexity lies in maintaining meaningful oversight across all services without overwhelming the Board with operational detail, while the opportunity is the ability to identify variation, share learning, and drive consistent improvement across the Group.

The governance framework must therefore be designed to manage this balance effectively: ensuring that detailed operational scrutiny and performance management are undertaken at Care Organisation level, whilst Group-level reporting is focused on synthesis, comparison, and assurance, enabling the Board to maintain a clear, accurate and actionable understanding of maternity safety and quality across the system

4. The Governance Architecture for Maternity

The Group's approach to perinatal oversight operates across five distinct levels. These are not alternatives to one another: they are interdependent components of a single system. The key principle is that the engine of assurance sits at Care Organisation level; each level above receives, synthesises and scrutinises rather than duplicating what sits below it.

A summary of the architecture is below.

Level	Role
Care Organisation Quality and Safety Committee (monthly)	Full monthly Maternity and Neonatal scrutiny: safety data, incidents, workforce, risks. Executive-led. The operational engine of maternity governance in the Group.
Group Perinatal Committee (monthly to bi monthly when established)	Monthly Group level synthesis, Executive and Non Executive Perinatal Safety champions. The purpose is the synthesis and oversight of maternity and neonatal safety and quality. Its role is to triangulate intelligence across the three Care Organisations, identify variation and emerging risks, and coordinate Group-wide learning and improvement.
Group Executive Committee (monthly)	Receives escalations from Care Organisation Quality and Safety committee, Managing Directors report and receive outputs from Group Perinatal Committee, confirms that material issues are being managed, and escalate any concerns to the Risk and Assurance Committee (RAC) and Group Board Chair as appropriate.
Risk and Assurance Committee	Will receive exception escalations, scrutinise whether the Group Perinatal Committee and Care Organisation Quality and Safety Committee processes are functioning effectively, and hold perinatal services within the Group Risk Register and Board Assurance Framework.
Group Board	Quarterly comprehensive cross-Care Organisation assurance report. Immediate notification of serious incidents, MOSS alerts and regulatory concerns.
Immediate: outside the reporting cycle	Any MOSS alert, serious incident, or material regulatory concern at any of the three Care Organisation perinatal services is notified immediately to the Group Board Chair and Chief Executive. The RAC Chair is informed in parallel. The Group Board receives a formal update at its next scheduled meeting.

4.1 Board-level Maternity and Neonatal Safety Champions

The Executive Maternity Safety Champion role sits with the Chief Nursing Officers in each of the 3 Care Organisations. The role leads, promotes, and oversees maternity safety and quality and champions at Board level as well as working closely with the Non Executive Director safety champion.

The Group has appointed three NED maternity and Neonatal Safety champions, one for each Care Organisation. NHS England's guidance on maternity safety champions (NHS Improvement, 2018) describes the board-level champion as a conduit between the board and the obstetric and midwifery champions at clinical level. The role is explicitly a floor-to-board connection: ensuring that clinical intelligence from the maternity team reaches Board level, and that Board priorities are understood by clinical leaders. Champions are expected to monitor safety and outcomes, ensure the Board receives regular updates, and maintain active links with the risk manager and governance leads.

Within a Group model, this role becomes particularly important. As Non-Executive Directors do not routinely sit on Care Organisation committees, maternity safety champions are a key mechanism for maintaining a direct line of sight to the operational reality of individual services. Through regular engagement with clinical teams, site visits and direct feedback, champions provide an additional layer of insight to complement formal reporting and assurance processes. This strengthens the overall governance framework by ensuring that Board oversight is informed not only by formal reports, but also by real-time clinical insight, supporting earlier identification of risks and a more informed and confident Board assessment of maternity safety and quality across the Group.

Each Non Executive Maternity and Neonatal Safety Champion's connection to their Care Organisation Perinatal Service operates through three routes provided for in the Group Assurance Manual: regular direct engagement with the Head of Midwifery/ Director of Midwifery, Clinical Director and maternity safety champions at their Care Organisation; go-and-see visits and attending the Group Perinatal Committee.

At Group Board, the three NED champions collectively provide the perinatal services perspective in the quarterly review. They bring intelligence from their Care Organisation relationships to bear on the Group-level assurance picture, identify where comparative data prompts questions, and act as the Board's early warning mechanism for concerns not yet at formal escalation thresholds.

A robust induction and brief terms of reference for the NED champion role (based on national guidance) will be developed to support this.

4. Risk Integration

Perinatal Services are held within the Groups risk management framework and escalated from Care Organisation Quality and Safety Committee. Perinatal Services carries inherent reputational, regulatory and legal exposure for the Group regardless of current performance indicators. Perinatal risks of concern are escalated to the Care Organisation Quality and Safety Committee to the Management Committee through to the Group Executive Committee.

Work is underway to ensure the Perinatal Services risks are sufficiently reflected on the Care Organisation Risk Register and Board Assurance Framework.

5. Alert, Advise, Assure

The Directors of Midwifery are reviewing how to incorporate the Alert, Advise, Assure framework into the PSOM summary slide to ensure concerns that need reviewing or escalation are addressed.

6. Next steps

1. Finalise the Group Perinatal Committee Design including Terms of Reference and forward planner.
2. Ensure the new Non Executive Maternity and Neonatal Safety Champions are fully inducted in the local Care Organisations to support the ward to board visibility.
3. Review each Care Organisations Risk Register to ensure Perinatal Services risks are sufficiently reflected and escalate to Group Risk Register and Board Assurance Framework.
4. Work with Experts from the National Perinatal Oversight / Maternity Intensive Support team to review governance structure and areas for improvement.
5. Review the governance structure against the learning from the Ockenden report.

BSW Hospitals Group Board

Agenda item	8.1.5
Report title	Group Data Sharing Agreement
Date of meeting	02 July 2026
Sponsor	Jonathan Hinchliffe Group CDIO
Prepared by	Graeme Temblett-Willis, Group DPO
Approval Process: (where has this paper been reviewed and approved)	Information Governance Steering Group, Digital Services Management Board

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
BAF R1	Becoming an effective Group
BAF R3	Delivering Digital Maturity
BAF R4	Transforming models of Care
BAF R7	Improving Value and Productivity
BAF R10	Cyber Security

KEY MESSAGES

Lead with the headline. The Board should know the key message within the first two sentences. Three to four short points is usually enough. State the position the Board needs to reach, what has changed since the last update, and what is being asked of the Board. Avoid restating background. For assurance reports, the full Alert, Advise, Assure analysis sits in the main body of the report in the executive summary.

The paper presents the BSW Group Data Sharing Agreement (Joint Controller Agreement) for approval, establishing the formal data protection governance arrangements between Royal United Hospitals Bath NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust as constituent organisations of the BSW Hospitals Group.

The Agreement is required as part of the Group operating model, the Trusts jointly determine the purposes and essential means of processing personal and special category data for defined Group-level functions. These include shared digital platforms and data services, performance and quality oversight, operational planning and reporting, analytics, population health management, system transformation and statutory NHS reporting. Under Article 26 of UK GDPR, such arrangements require a formal Joint Controller Agreement that clearly sets out the respective responsibilities of each organisation.

The paper confirms that each Trust remains an independent legal entity and Data Controller for data originating from its own clinical care activities, while acting jointly with the other parties where data is processed for agreed Group-level purposes. The Agreement sets out the scope of processing, lawful basis, governance arrangements, responsibilities for data quality and access, arrangements for data subject rights, security measures, incident management, use of processors, transparency, retention, liability, review and termination.

The Agreement strengthens the Group's information governance framework by ensuring that shared data processing is underpinned by clear accountability, appropriate safeguards, compliance with UK GDPR and the Data Protection Act 2018, and alignment with NHS Data Security and Protection Toolkit requirements. It also provides a consistent basis for managing privacy risks, data access, breach response and assurance across the BSW Hospitals Group.

The Board is asked to note the requirement for the Joint Controller Agreement,

RECOMMENDATION

The Group Board is asked to:

1. Endorse the Group Data Sharing Agreement (Joint Controller Agreement) recognise its role in enabling lawful and transparent Group-level data processing and endorse the Agreement for adoption across the BSW Hospitals Group.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

BSW Hospitals Group Board

Agenda item	8.1.8
Report title	Board Statutory Responsibilities
Date of meeting	2nd July 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Simon Hackwell, Project Governance lead
Approval Process: (where has this paper been reviewed and approved)	n/a

☐ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk R1	**Becoming an effective group**

KEY MESSAGES

As part of the new governance arrangements a list of statutory or mandated duties (including those contained as NHSE guidance) has been prepared along with the appropriate Board member who carries the responsibility.

RECOMMENDATION

The Group Board is asked to:

Note the current allocation of responsibilities against the Board's statutory duties.

APPENDICES

To help manage the volume of information the following items have been placed in the reading Room for this Board meeting:

- Statutory Responsibilities

BSW Group Board

Agenda item	Great Western Hospital Board Assurance Report 9.1a
Report title	Quality and Safety Committee (Q&SC), GWH
Date of meeting	2 July 2026
Sponsor	
Prepared by	Claudia Paoloni, NED Chair of Q&SC
Approval Process: (where has this paper been reviewed and approved)	Q&SC

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☒ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

- Sustained operational pressure at front doors of Organisation, high bed occupancy and ongoing use of escalation areas, including corridor care.
- Good oversight of issues, mitigating systems and processes in place
- Continues to be some outcome metrics outside acceptable parameters

RECOMMENDATION
The Group Board is asked to: **Receive and review the report**

APPENDICES	
None	

Assure

- Following an NHFD alert in 2024 identifying Excess mortality, a comprehensive review and subsequent BOA peer review visit (sept/oct 2025) established key system -wide improvements required across the hip fracture pathway. Following a focused MDT programme (HipQIP) driving delivery of 5 priority actions , alongside wider set of recommendations with oversight through Divisional and Trust governance structures, significant improvement has been achieved:

  Mortality reduced from 11% to 5.4% now below national average and time to surgery 31.7 hrs , again below the national average.

  Ongoing improvement work to the service continues.

- Trustwide improvement continues to focus on communications for patients. The National campaign on "what matters to you" is being adopted at GWH from week commencing 22nd June 2026.
- GWH has achieved significant and measurable improvement in reduction of falls and falls with harm. 186 fewer falls compared with the previous 12 month reporting period, additionally a sustained decrease in moderate, severe and above severity harms overall, demonstrating the positive impact of targeted interventions and strengthened clinical practice. The focus for next 12 months is on deconditioning prevention, continence and enhanced therapeutic observations and care.
- Maternity services have been awarded UNICEF UK BFI Gold accreditation placing the Trust amongst just 11 maternity units in England.
- Despite operational pressures, safer staffing processes remain robust. Safer Staffing Reports overall fill rates across the Trust for nursing and midwifery that provide 24 hour care were within the permitted ranges, assuring that there were sufficient nursing and midwifery staff to deliver safe and effective care to patients.

- The research and innovation annual report was received and demonstrated good engagement and capability in delivering complex and commercial research.

    - Good commercial interventional performance
    - More complex research portfolio
    - Strengthening clinical reputation
    - Financially running in a positive position supporting financial sustainability
- CQC preparedness report-Trust is now operating in a mature but pressured system where policies and processes are in place. Trust has made significant progress in strengthening safety systems and culture. The challenge remains to ensure resilience and consistency of the systems now in place.
- The annual Quality Report final version was approved.
- Annual learning from deaths report: Mortality rates for the Trust are within expected levels with no national concerns. From Structured Judgement Reviews analysis-End of Life Care is generally good, majority of care is timely, appropriate and compassionate.

Advise

- Ongoing attention required for infection prevention and control measures. Bacteraemia rates for MSSA and E.Coli remain elevated. Mitigations include new alcohol gel and dispense supplier, additional training in hand hygiene and IPC protocols and there is work to refresh the IPC strategy. Catheter care and related infections continues to be an area of extended review and new approach required as improvements are not as expected.
- National Cancer plan represents an ambitious transformation of NHS cancer services, setting a target of 75% 5 year cancer survival by 2035 and requires all Trusts to meet cancer waiting time standards by March 2029 alongside strengthened expectations on accountability. GWH has strong starting point but critical gaps requiring urgent action are:
    - No designated Lead Accountable Executive Officer for cancer
    - No formal Cancer board at Executive/NED level
    - Incomplete CNS workforce
    - Outstanding STT pathways: upper GI, lung and gynaecology

  GWH will deliver six workstreams addressing : Governance and accountability, Performance and diagnostics, Workforce and personalised care, digital and data, CYP and rare cancers

- Increased maternity theatre activity (~50% LCSC rate and more all day lists) is not currently matched by Association for Perioperative practice compliant staffing levels, presenting ongoing pressure in maternity staffing and service delivery. No safety incidents have been reported to date

- Medical staffing in maternity services is non compliant with Tier 2 medical staffing at night and weekends, according to the revised British Association of Perinatal Medicine Local Neonatal Unit/Special Care Unit workforce standards (Nov 25)
- Rates of Post partum haemorrhage ≥ 1500ml per 1000 births remain above national average , however six month rolling average remains stable with no evidence of upward trend and remain within statistical control limits.
- Received Learning from deaths report demonstrates better engagement with clinicians on review or mortality, but ongoing operational pressures does impede attendance to meetings and further alignment required between mortality reviews and wider patient safety issues, including thematic reviews focused on deteriorating patients and discharge processes to better understand and address risks.

Alert

- Learning From deaths report: Mortality reviews found some repeated issues: poor documentation, delays in diagnosis and treatment, inconsistent out-of-hours reviews and delays in recognising a deterioration or starting palliative care. Operational pressures e.g ED overcrowding and unclear team responsibilities , impacted care in some cases.
- Also noted was a higher than expected pneumonia mortality rate, which is being investigated.
- Maternity: ongoing challenges in meeting neonatal cot capacity due to workforce constraints with a recognized gap between current staffing establishment and increasing service demand. The misalignment has been confirmed and draft plan in place to address through targeted recruitment, skill mix review and use of regional escalation pathways. Interim mitigation measures are in place.
- Maternity: two recent home births, one attended by independent midwife and one by GWH midwives, both outside standard guidance and resulted in poor outcomes for the babies. Both cases have been referred to maternity and Neonatal Safety Investigations for review. MDT planning meetings for women choosing to birth outside guidance is now in place, alongside continued monitoring to promote safe and individualized care planning.
- Stroke performance: Unit has SNAPP rating E, and remains an area of focus for the Trust. A comprehensive improvement programme is in place with enhanced executive oversight, strengthened governance arrangements and external clinical support. Progress has been made in several priority areas, notably time to scan which is now A rating. And time for SALT assessment rating C. Medical workforce sustainability, particularly substantive Consultant recruitment remains the principal challenge. Therapy work force numbers have improved but out of hours and weekend cover limited.

BSW Hospitals Group Board

Agenda item	9.2a
Report title	Alert, Advise and Assure Report – RUH Audit & Risk Committee
Date of meeting	2 July 2026
Sponsor	Paul von der Heyde, BSW Hospitals Group Chair
Prepared by	Joy Luxford, Non-Executive Director
Approval Process: (where has this paper been reviewed and approved)	

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

The Audit and Risk Committee provides assurance that the control environment is improving but not yet fully embedded, with no matters requiring escalation. External audit identified no material concerns, with ongoing focus on financial sustainability and governance.

The Board is asked to note the Committee's assurance and approvals, and to refer to the Alert, Advise and Assure sections for detail on key findings, areas of focus and positive assurance.

RECOMMENDATION

The Group Board is asked to:

1. Note the report

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

Key discussion points and matters to be escalated from the meeting
ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy
• Nothing to raise.
ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance
• As with the previous reports, the Audit Committee will continue to maintain oversight of key Internal Audit Actions arising throughout the prior year and to encourage the implementation of lessons learnt from the FY25/26 audit processes.
ASSURE: Inform the Board where positive assurance has been achieved
Annual Report and Accounts 25/26 - External Audit • The Auditors presented their ISA260 Audit report which did not identify any material concerns. On the Value for Money Statement, they did understandably raise Financial Sustainability as a matter for concern due to the ongoing financial and cash challenges facing the Trust. This is a common position across similar NHS Trusts and well understood at a National level; that context and commentary was included within their report. They also raised governance as a matter for concern primarily due to the recent CQC findings in UEC, we expect this to be resolved during the year as the action plans are completed in line with board discussions. • The auditors drew our attention to the MEA (Modern Equivalent Asset) valuation, which was a significant area of focus and audit work. In conclusion, they were comfortable that the approach taken was within a reasonable range. But given the significance of the assumptions made included a section for formal sign off in the letter of representation. The committee took assurance from the work done by the finance team and auditors around MEA valuation and were satisfied to include these within the letter of representation. **Internal Control 25/26 - Internal Audit (annual opinion)** • During 2025/26 KPMG completed nine reviews. Based on the controls reviewed, the following conclusions have been drawn: o Governance (amber-red) : Overall findings on design showed the need to improve the design and implementation of controls. o Risk management and control (amber-green): Overall findings on design show some controls to be effectively designed with

some exceptions. KPMG testing showed some controls to be operating effectively, and others could be more consistently applied.
    - Financial reporting and management (amber-green): Overall findings on design show some controls to be effectively designed with some exceptions. KPMG testing showed some controls to be operating effectively, and others could be more consistently applied.
    - Data captured and used by the organisation (amber-red): Overall findings on design showed the need to improve the design and implementation of controls.
- These findings are aligned to expectations and consistent with upward reports throughout the year and speaks to an improving but not yet embedded, effectively designed or operating environment.

Internal Control 25/26 - Internal Audit (deep dive reports)

- The Internal Audit report on Controlled Drugs was given an assurance rating of 'Significant Assurance with minor improvement opportunities', or amber / green.
- The Internal Audit report on Data Security & Protection Toolkit (25/26) was given an assurance rating of 'Significant Assurance with minor improvement opportunities, or amber / green.

Local Counter Fraud

- The Local Counter-Fraud Service Annual report 25/26 was given an overall rating of green (10 green and 2 amber).

RISK: Advise the Board which risks were discussed and if any new risks were identified

- To improve 3rd party assurance from External (Deloitte) and Internal (KPMG) Auditors, there remains a need for clarity around our financial sustainability plans, Cost Improvement Plans, Cash management and to ensure internal control gaps and recommendations are addressed quickly and maintained.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

- The Committee would like to commend the outstanding work by the Finance, Governance and Estates Team in an effective and efficient audit process. The External Auditors (Deloitte) emphasised the improvements made year on year and so this success should be celebrated.
- The Committee would like to congratulate the whole team involved in the Data Security & Protection Audit for the significant improvement made year-on-year.

APPROVALS: Decisions and Approvals made by the Committee
• Under RUH Board delegation, the Committee approved the Annual Governance Statement and Financial Statements FY25/26 for signing and delegated approval for any last-minute immaterial changes to the Group CFO /material changes to the Chair of Audit and Group CFO. This was given due to the tight timescales for submission and because the external audit fieldwork had not quite finished at the time of the committee meeting. No material changes are expected. The final version should be shared with NHSE by the 26 June 2026 deadline. • The Committee approved the Internal Audit Plan 26/27 (aligned to group expectations), noted the Internal Audit Annual Report, 2 internal audit reports and Local Counter Fraud Annual Report mentioned above. • The Committee also noted progress into financial grip and control and reports on debtors, creditors, salary over/under payments, as well as losses and special payments.

BSW Hospitals Group Board

Agenda item	9.2 aii
Report title	Alert, Advise and Assure Report – RUH People Committee
Date of meeting	2 July 2026
Sponsor	Paul von der Heyde, BSW Hospitals Group Chair
Prepared by	Paul Fairhurst, Non-Executive Director
Approval Process: (where has this paper been reviewed and approved)	

☒ **FOR ASSURANCE**	☐ **FOR DECISION**	☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

The People Committee provides assurance that the principal workforce risks within its remit are understood and subject to active oversight, with no matters requiring escalation for Board action. The Committee's key areas of focus were sickness absence, appraisal compliance and workforce planning. Sickness absence remains structurally elevated, with anxiety, stress and depression accounting for a significant proportion of absence, and the Committee noted the need for a coordinated organisation-wide response through the Healthier Workforce Programme.

The Committee received assurance on the actions being developed to improve appraisal compliance, strengthen accountability and ensure the appraisal process is meaningful and embedded. Workforce planning remains under pressure, with the April position above plan in both WTE and financial terms, driven by bank usage, and with agency usage improved but still above target. Assurance was received in relation to the Cleaning Department sickness deep dive, Staff Survey response planning and the revised Fit and Proper Person Test SOP.

The Board is asked to note the Committee's assurance, areas of continued monitoring and the detail set out in the Alert, Advise, Assure and Risk sections.

RECOMMENDATION

The Group Board is asked to:

1. Note the report

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	

Key discussion points and matters to be escalated from the meeting
ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy
• **Sickness absence:** the overall rate fell in March (five-month downward trajectory) but mainly due to seasonal factors and targeted interventions. Overall rates remain structurally elevated. Anxiety Stress & Depression accounts for almost a third of absences (unprecedentedly high levels). The overarching insight from the Staff Survey and divisional/ Group feedback is that sickness absence is increasingly systemic (sustained workforce pressure, inconsistent management practice, fragmented processes and data) and less driven by individual health factors. A more coordinated, organisation-wide response is required to deliver a sustainable reduction. A 2026/27 Breakthrough Objective is reduction to 4.8%, supported by delivery of the Healthier Workforce Programme (a 2026/27 Corporate Project/ core component of the emerging People Strategy), which brings together initiatives on wellbeing, management capability, culture, and system improvement. The Committee discussed risks to Programme delivery including data quality, systems effectiveness and capacity to train ~900 managers. The Committee also discussed the formation of a group to improve insight coordination across the Staff Survey, local A3s, forthcoming Mattering data, and feedback from Staff Governors, Staff Side and the FTSU Guardian. Programme updates will come to the People Committee and the Engine Room. Reporting to Group is to be determined. • **Appraisals:** compliance has slightly improved (notably Surgery) but overall rates have plateaued well beneath the 90% target. The Committee was reassured that countermeasures are being developed to address continued Corporate team compliance declines. The Committee discussed efforts to ensure the RUH approach is meaningful and fully embedded, including through strengthened prioritisation, clearer accountability, consistent leadership and through Group-level work to simplify policy and process. A Trust appraisal window remains under consideration for 2027/28 • **Workforce Planning:** April position was 61 WTE and £1.1m over plan, driven by bank usage (heightened activity levels). Agency improved but remains is over target. The Committee was advised that workforce elements of CIP schemes are in development with HR/ Finance. Detailed plans should be available in early July. The Committee requested confirmation on delivery reporting internally. The Committee was reassured that the digital/ AI workforce planning will be included in the 10-year workforce strategy (and specifically covered in future updates to the Committee).

<table>
<tr><td>ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance</td></tr>
<tr><td>

Turnover (ongoing monitoring): remains low, minimal variation. The drivers remain unclear (PRMs are seeking to better understand the causes). The Committee noted Staff Survey insights regarding lack of development opportunities and noted the external NHS labour market constraints.
Mandatory Training (ongoing monitoring): overall compliance continues to improve. Oliver McGowan Training was paused but has restarted (although with a limited course offering). A business case for a Group approach is progressing. RUH now employs the previous lead trainer and is exploring regional delivery.
Violence and aggression (ongoing monitoring): governance is moving to Estates & Facilities (Health & Safety) through the corporate services redesign. An impact report will be presented to the Committee in September.
AHP Strategy 2025-28 (development): The strategy was reviewed (including plans, actions and key risks) and will proceed to MEC for approval. The Committee was assured that the AHP voice is included in the clinical transformation/ service redesign and that AHP leads are aligned across Group.

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<tr><td>ASSURE: Inform the Board where positive assurance has been achieved</td></tr>
<tr><td>

Cleaning Department: Sickness Deep Dive: identified systemic issues (strength of leadership, support to leaders, consistent and fair management practices and improved recognition and communication) and clear opportunities for improvement. Targeted actions are underway to support improved wellbeing and reduce absence.
Staff Survey: as previously reported, 2025 results show strong performance in compassion, inclusion and team working, and small improvements in flexible working and health and wellbeing. Concerns include a 3.4% reduction in staff recommending the Trust as a place to work; lower engagement/ voice/ feeling valued; limited learning and career progression; and persistent inequalities for some staff groups. The Committee reviewed Divisional response plans and Trust-level actions and was assured as to the prioritisation of workload pressures, wellbeing, and engagement and development. The Committee discussed the rapidly changing operating context and was assured that whilst the Staff Survey data is dated, the plans reflect real time insights. The alignment to the Healthier Workforce Programme and efforts to collaborate, align and shared learning across Group were noted. The potential use of AI to triangulate safety, quality, performance and Staff data was noted.
Fit & Proper Person Test: The Committee was assured that a revised SOP clarifies the process, roles, responsibilities and secure document management following the introduction of new Group-level director roles. An internal audit will review compliance; any identified gaps will be resolved within 3 months.

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RISK: Advise the Board which risks were discussed and if any new risks were identified
• **Board Assurance Framework:** the Board has resolved not to undertake a further detailed refresh ahead of transition to the Group BAF. Risks within the Committee's remit remain appropriate. Some details require update, but the Committee was assured as to the adequacy of controls, assurances mitigating actions. • **Risk Register:** A new draft risk on violence and aggression is going through the approval process (rated 12). The Committee considered a new risk related to the issues addressed in Lord Mann's review of antisemitism and other forms of racism.
CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding
• None
APPROVALS: Decisions and Approvals made by the Committee
• None

BSW Hospitals Group Board

Agenda item	9.3 a
Report title	SFT Audit Committee Assurance Report.
Date of meeting	2nd July
Sponsor	Richard Holmes, Chair Audit Committee
Prepared by	Richard Holmes
Approval Process: (where has this paper been reviewed and approved)	

☐ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

STRATEGIC ALIGNMENT (*Tick all priorities that this paper materially supports)*

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

Following delegation granted to it by the SFT Board on Monday 15th June, the SFT Audit Committee (18th June) "Approved the Annual Accounts for Signing."

An email from the Chair of the Audit Committee, Richard Holmes, to Paul von der Heyde and Cara Charles-Barks is copied in appendix a.

RECOMMENDATION

The Group Board is asked to:

1. Note the report

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix a	Email text (18/06/26) from Chair Audit Committee, Richard Holmes, Non-Executive Director

Email (18/06/26) from Chair Audit Committee, Richard Holmes, Non-Executive Director to Paul von der Heyde and Cara Charles-Barks.

'Paul and Cara

I am sure that you will be both pleased and relieved to know that, following delegation granted to it by the SFT Board on Monday, the SFT Audit Committee this morning "Approved the Annual Accounts for Signing."

The Auditors presented the report of their audit which did not identify any material concerns. During the audit there were some cerebral discussions about the technical accounting treatment of CDEL expenditure, where SFT Management eventually accepted the auditors proposed treatment and amended the accounts accordingly, but this had a £nil impact on the accounts themselves. The auditors also identified a few transactions that they considered could have been treated differently, but as these were not considered material they were simply highlighted for information with the accounts not being adjusted.

There remain one or two trivial and immaterial matters just to be closed out - an inevitable feature of the complexity and tight timescales of this process. Once this has happened and as a condition precedent to the signing, Audit Committee is requiring Simon as CFO to write explicitly to confirm a) that the matters are closed, that b) they have not had a material impact on the accounts, and c) that the Auditor's opinion is unchanged and remains unqualified, save for the fact that they are unsurprisingly raising Financial Sustainability as a matter for concern within their Value for Money review due to the ongoing financial challenges facing the Trust. Whilst this is a common position across similar NHS Trusts, and well understood at a National level, the Auditors were not prepared to include commentary to that effect in their report, which was a disappointment.

The Auditors were given the opportunity to raise any matters with the NEDs in private, but they declined the offer. Always a good sign!

As a practical reminder, the deadline for the report and accounts to be signed and submitted is 26 June. Simon is leading the logistic effort to ensure that both of your signatures are captured and appended to the appropriate pages of the Annual Report and Accounts, and subsequently to submit them. You will no doubt be required to sign not only the SFT accounts, but also the GWH and RUH accounts in the same way and within the same timescales, but I have to leave that to others to advise.

In summary, as far as can be expected but with the exception of the Auditor's value for money comment regarding financial sustainability, the accounts are 'clean' and the Board can therefore be assured that the systems and processes to capture and record financial transactions during the year, and to prepare the annual accounts within SFT are appropriately designed and operated, so as to give a 'true and fair' view of the Trust's financial position as at 31 March 2026.

Well done and many thanks to Simon and Jennie and the Finance Team, and to Kylie and the Governance team for getting us here so successfully and after loads of hard work and late nights.

Best regards, and Thank you

Richard Holmes

Non-Executive Director and Chair, Audit Committee'