Bundle BSW Group Board 26 June 2026

4.3.a Group People Report - Staff Survey - Appendix A - GWH Staff Survey Slides
Item 4.3a Appendix A READING ROOM GWH Staff Survey Slides

4.3.a Group People Report - Staff Survey - Appendix B - RUH Staff Survey Slides
Item 4.3a Appendix B READING ROOM RUH Staff Survey Slides

4.3.a Group People Report - Staff Survey - Appendix C - SFT Staff Survey Slides
Item 4.3a Appendix C READING ROOM SFT Staff Survey Slides

6.1 Group Risk Register - BSW GRR Controls Analysis June 2026
Item 6.1 READING ROOM BSW GRR Controls Analysis June2026
Item 6.1 READING ROOM GRR June 2026 v2

8.1.1 BSW Risk Management Policy FINAL v1.0
Item 8.1.1 READING ROOM BSW Risk Management Policy FINAL v1.0

8.1.5 BSW Group Data Sharing Agreement v.03_JH
Item 8.1.5_READING ROOM 20260527_BSW Group DSA v0.3_JHBI

8.1.6 Group Board Cycle of Business 2026 v7
Item 8.1.6 READING ROOM Group Board Cycle of Business 2026 v7 - For July Bd

8.1.8 Statutory Responsibilities - Appendix - Board Roles 10.06.26
Item 8.1.8 Appendix READING ROOM Board Roles 100626

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2025 Staff Survey Results

Great Western Hospitals NHS Foundation Trust

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Headline Findings

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GWH 2025

Participation

3,638 staff responded

66% response rate

(71% 2024)

National 2025: 49% (51% 2024)

Questions

(significance vs 2024)

54% improve

41% decline

5% unchanged

Successes

Top 5 scores vs Sector Average	Org	IQVIA Avg
My organisation takes positive action on health and well-being. Agree (Q11a)	61.3%	54.5%
The opportunities for flexible working patterns. Satisfied 9Q4d)	61.2%	56.4%
I look forward to going to work. Often (Q2a)	55.3%	51.7%
As soon as I can find another job, I will leave this organisation. Disagree (Q26c)	60.3%	56.8%
I can approach my immediate manager to talk openly about flexible working. Agree (Q6d)	73.0%	70.3%

Most improved scores	2024	2025
Can eat nutritious and affordable food while working. Agree (Q22)	52.3%	55.3%
Last time you experienced physical violence at work, did you or a colleague report it. Yes (Q13d)	65.2%	68.1%
On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours. 0 hours (Q10c)	50.6%	53.2%
My immediate manager asks for my opinion before making decisions that affect my work. Yes (Q9c)	58.0%	60.4%
I am able to make suggestions to improve the work of my team / department. Agree (Q3d)	69.0%	71.4%

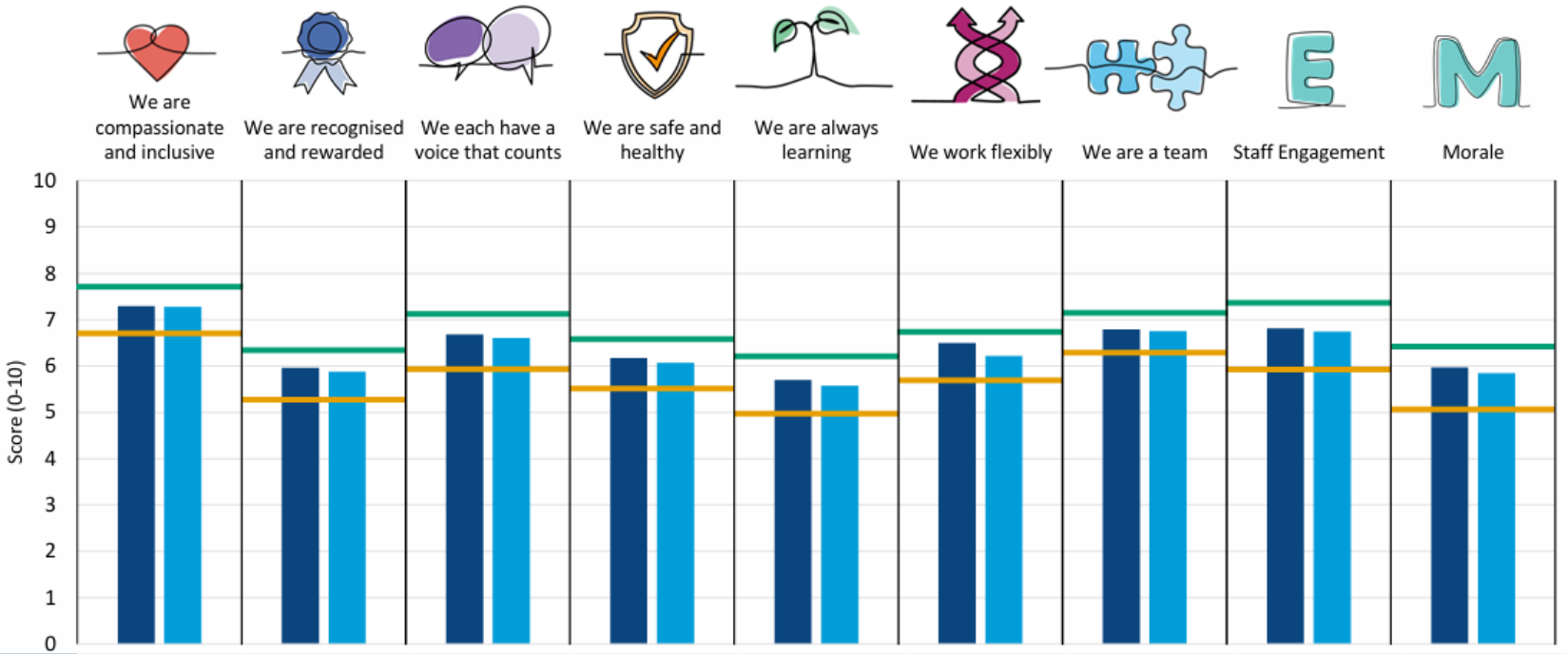
Challenges

Bottom 5 scores vs Sector Average	Org	IQVIA Avg
If a friend or relative needed treatment would be happy with the standard of care by organisation. Agree (Q25d)	59.3%	62.2%
In the last month have you seen any errors, near misses/incidents that could have hurt staff/patients/service users. No (Q18)	61.9%	64.7%
I have unrealistic time pressures. Rarely (Q5a)	22.9%	25.5%
The last time you experienced physical violence at work, did you or a colleague report it. Yes (Q13d)	68.1%	70.7%
On average, how many additional PAID hours do you work per week over and above contracted hours. 0 hours (Q10b)	64.1%	66.6%

Most declined scores	2024	2025
There are opportunities for me to develop my career in this organisation. Agree (Q24b)	55.7%	52.3%
Have you felt pressure from your manager to come to work? No (Q11e)	79.8%	77.7%
I am confident that my organisation would address my concern. Agree (Q20b)	57.3%	55.4%
My organisation takes positive action on health and well-being. Agree (Q11a)	62.3%	61.3%

Headline Findings

Promise and Themes



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.29	5.96	6.68	6.17	5.69	6.49	6.79	6.81	5.96
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	3628	3629	3592	3604	3470	3605	3625	3629	3632

- All people promise and themes in line with 2024 and above sector average.
- Morale and Staff Engagement remain key performance indicators for the organisation. Both theme scores are significantly better than sector scores.

Southwest Ranking

2025 Survey

Rank	Acute and Acute & Community Trusts South West Region inc. OUH	Response Rate	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale	Total Score
1	University Hospitals Bristol and Weston NHS Foundation Trust	61%	7.61	6.18	6.91	6.30	5.92	6.57	7.07	7.07	6.15	59.8
2	North Bristol NHS Trust	56%	7.55	6.14	6.87	6.28	5.95	6.47	6.89	7.09	6.17	59.4
3	Somerset NHS Foundation Trust	46%	7.50	6.21	6.81	6.29	5.78	6.54	6.96	6.94	6.13	59.2
4	Dorset County Hospital NHS Foundation Trust	43%	7.40	6.05	6.76	6.09	5.70	6.49	6.87	6.92	5.91	58.2
5	Royal Devon University Healthcare NHS Foundation Trust	33%	7.52	6.13	6.71	6.17	5.34	6.40	6.91	6.85	6.01	58.1
6	**Great Western Hospitals NHS Foundation Trust**	66%	7.29	5.96	6.68	6.17	5.69	6.49	6.79	6.81	5.96	57.8
7	University Hospitals Dorset NHS Foundation Trust	55%	7.39	5.95	6.72	6.14	5.56	6.29	6.80	6.83	5.93	57.6
8	**Salisbury NHS Foundation Trust**	53%	7.31	5.93	6.69	6.14	5.55	6.29	6.74	6.87	5.87	57.4
9	**Royal United Hospitals Bath NHS Foundation Trust**	52%	7.39	5.96	6.63	6.01	5.50	6.29	6.86	6.83	5.84	57.3
10	Torbay and South Devon NHS Foundation Trust	36%	7.31	5.96	6.57	6.01	5.37	6.33	6.73	6.72	5.82	56.8
11	University Hospitals Plymouth NHS Trust	48%	7.20	5.82	6.53	6.02	5.53	6.36	6.70	6.60	5.83	56.6
12	Gloucestershire Hospitals NHS Foundation Trust	50%	7.08	5.72	6.30	6.00	5.45	5.99	6.61	6.43	5.73	55.3
13	Royal Cornwall Hospitals NHS Trust	50%	7.05	5.64	6.27	5.79	5.04	5.89	6.62	6.27	5.57	54.1

- Ranked 6th across Southwest Acute and Acute & Community Trusts (9th in 2024)
- Highest response rate across southwest benchmarking group

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Results by People Promise & Theme

2025 Staff Survey

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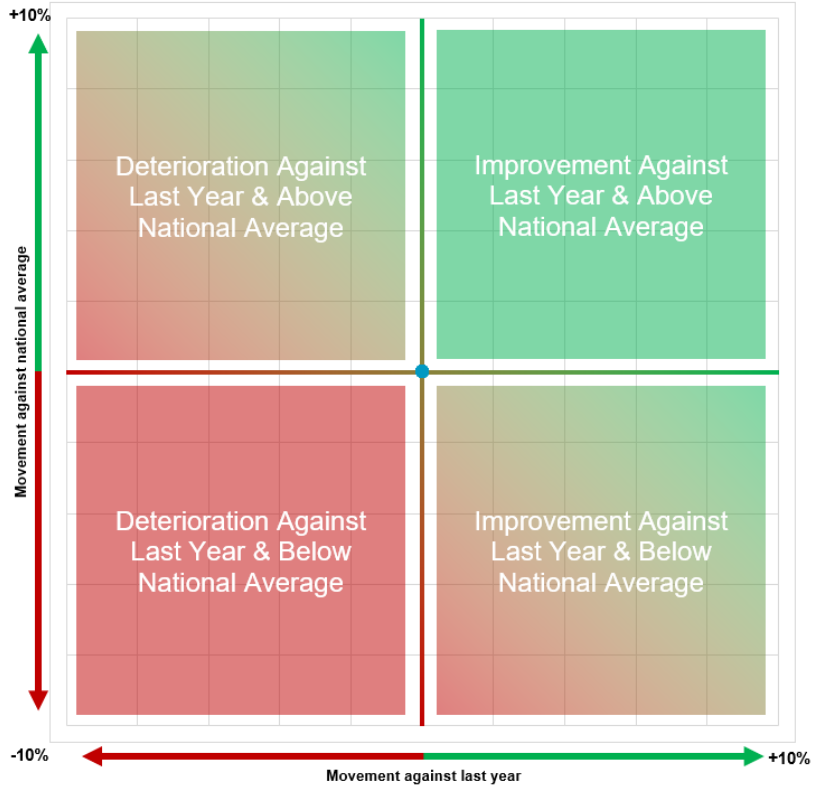
Using This Report

2025 Staff Survey

Great Western Hospitals NHS Foundation Trust

From the 2021 survey onwards, questions in the NHS Staff Survey have been aligned to the People Promise which is comprised of seven elements:

- This report breaks down performance against these People Promise elements as well as two historic 'themes' reported in previous years (Engagement and Morale).
- A quadrant graph has been created for each promise/theme, showing the relevant group of questions and their performance against last year and the national average.
- For 2025 reporting, all methodology (positive or negative scoring) continues to be aligned with the national methodology.
- Positively scored questions are denoted with a (+) and a higher result than last year/national average is good.
- Negatively scored questions are denoted with a (-) and a higher result than last year/national average is bad.



Positive/negative reporting

Variance to last year's results for GWH

Variance to national average

	Theme	Question Number	Question	2023 Result	Variance to 2022	National Average	Variance to National Average
+	Sub-Theme	ex1	Example Question 1 (Strongly Agree/Agree) Positive Reporting: Higher than LY/Average is good	67.5%	1.3%	65.0%	2.5%
-	Sub-Theme	ex2	Example Question 2 (Disagree/Strongly Disagree) Negative Reporting: Higher than LY/Average is bad	9.3%	-9.3%	9.0%	-0.3%

We are compassionate and inclusive

Great Western Hospitals NHS Foundation Trust

2025 Staff Survey

Compassionate Leadership

- Redesigned leadership programmes are streamlined for shorter delivery and broader MDT participation, offering increased capacity and improved attendance. Initial cohorts are fully booked with positive early feedback.

- Participation in the Active Bystander and Radical Candour programmes continues to grow, helping to extend impact across the organisation.

- The leadership conference in June 25 centred on anti-racism and system leadership and incorporated discussion on development of the behaviours.

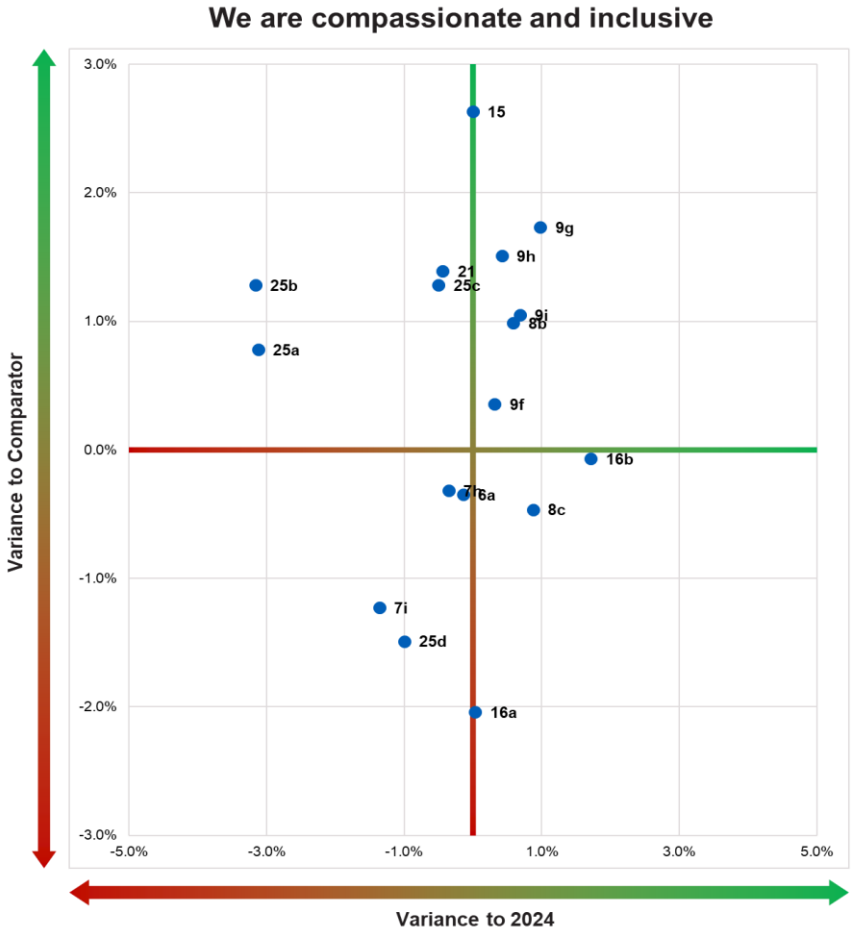
Compassionate Culture

- Scores indicate that staff have an understanding of the Trust's values, though these are not yet consistently reflected in everyday behaviours. This is in line with the early stage of the 2025 behaviours soft launch. New and planned initiatives to embed behaviours further in 2026/7 include:- themed e-cards; self and peer assessment tool; meeting role cards; visible displays; STAR champion engagement group; civility handbook; behaviour resource toolkits.

- Never OK campaign: This collaboration with Wilts Police included national press and local radio coverage with representatives from the police force and Swindon Town football club sharing experiences with staff. A focussed task group created an action plan to raise awareness and improve response to incidents.

- EDI: Sustainable strategies based on education, support, and challenge of behaviours that do not align with STAR values shaped initiatives in 2025/6 with a holistic approach to addressing unprofessional behaviours through virtual reality based training; equipping individuals and 65 EDI champions with tools and techniques in emotional resilience and self-advocacy; and promotion of a mentorship programme. Network leads meet with the board annually, and lived experience used to shape programmes.

- Care of patients (Q25a) is the breakthrough focus in 2026.



We are compassionate and inclusive

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2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are compassionate and inclusiv	Compassionate culture	6a	I feel that my role makes a difference to patients / service users (Agree/Strongly agree).	Higher = better	87.9%	88.0%	-0.1%	88.2%	-0.3%
We are compassionate and inclusiv	Compassionate culture	25a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	Higher = better	72.4%	75.5%	-3.1%	71.6%	0.8%
We are compassionate and inclusiv	Compassionate culture	25b	My organisation acts on concerns raised by patients / service users (Agree/Strongly agree).	Higher = better	69.4%	72.6%	-3.2%	68.1%	1.3%
We are compassionate and inclusiv	Compassionate culture	25c	I would recommend my organisation as a place to work (Agree/Strongly agree).	Higher = better	59.1%	59.6%	-0.5%	57.8%	1.3%
We are compassionate and inclusiv	Compassionate culture	25d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	Higher = better	59.3%	60.3%	-1.0%	60.8%	-1.5%
We are compassionate and inclusiv	Compassionate leadership	9f	My immediate manager works together with me to come to an understanding of problems (Agree/Strongly agree).	Higher = better	69.2%	68.9%	0.3%	68.9%	0.4%
We are compassionate and inclusiv	Compassionate leadership	9g	My immediate manager is interested in listening to me when I describe challenges I face (Agree/Strongly agree).	Higher = better	72.8%	71.8%	1.0%	71.1%	1.7%
We are compassionate and inclusiv	Compassionate leadership	9h	My immediate manager cares about my concerns (Agree/Strongly agree).	Higher = better	71.2%	70.8%	0.4%	69.7%	1.5%
We are compassionate and inclusiv	Compassionate leadership	9i	My immediate manager takes effective action to help me with any problems I face (Agree/Strongly agree).	Higher = better	67.8%	67.2%	0.7%	66.8%	1.0%
We are compassionate and inclusiv	Diversity and equality	21	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) (Agree/Strongly agree).	Higher = better	70.3%	70.7%	-0.4%	68.9%	1.4%
We are compassionate and inclusiv	Diversity and equality	15	Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation (Yes).	Higher = better	55.7%	0.0%	0.0%	53.1%	2.6%
We are compassionate and inclusiv	Diversity and equality	16a	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (Yes).	Lower = better	10.6%	10.6%	0.0%	8.6%	-2.0%
We are compassionate and inclusiv	Diversity and equality	16b	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (Yes).	Lower = better	8.8%	10.5%	1.7%	8.7%	-0.1%
We are compassionate and inclusiv	Inclusion	7h	I feel valued by my team (Agree/Strongly agree).	Higher = better	68.5%	68.9%	-0.4%	68.9%	-0.3%
We are compassionate and inclusiv	Inclusion	7i	I feel a strong personal attachment to my team (Agree/Strongly agree).	Higher = better	61.7%	63.0%	-1.4%	62.9%	-1.2%
We are compassionate and inclusiv	Inclusion	8b	The people I work with are understanding and kind to one another (Agree/Strongly agree).	Higher = better	69.5%	68.9%	0.6%	68.5%	1.0%
We are compassionate and inclusiv	Inclusion	8c	The people I work with are polite and treat each other with respect (Agree/Strongly agree).	Higher = better	69.2%	68.4%	0.9%	69.7%	-0.5%

We are recognised and rewarded

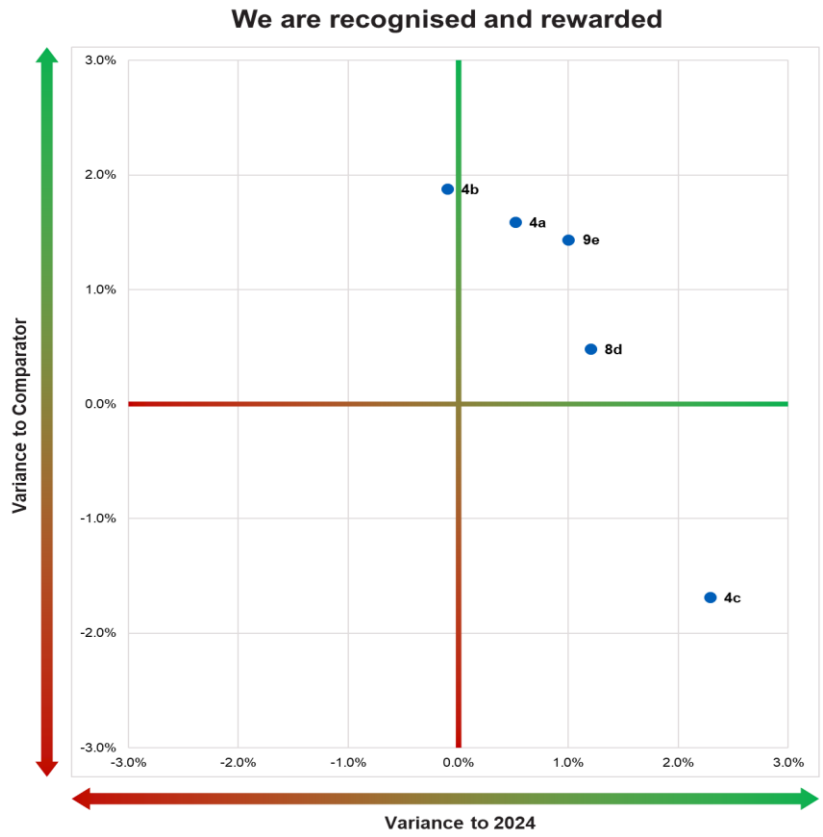
2025 Staff Survey

Reward

- There were 3 major strike periods by medical colleagues in July, Oct, and Dec 2025. Satisfaction with level of pay increases from 46% to 52% in the medical and dental staff group.
- A Gender Pay Gap workshop with the Women's Network invited members to share ideas about what the care organisation can do to reduce the gap, which is mainly driven by the medical and dental staff group. Feedback will inform the Medical Workforce Strategy in the spring of 2026.

Recognition

- Quarterly in-person long service awards ceremonies continue to thrive with 15+ staff receiving awards each time. New in 2025: being accompanied by family members/colleagues.
- 340 nominations received for the Staff Excellence awards, the event welcoming up to 500 staff members. Awards will be aligned to Behaviours in July 26.
- A monthly social media campaign was introduced in autumn 2025 celebrating good news stories and staff achievements. Introduced in response to Pulse feedback and as a positive reinforcement of peer-to-peer recognition. Further opportunities are provided through Hidden Hero (there were 158 presentations in 2025), star of the month, long-service (82 awards in 2025) and e-cards.
- The Trust's fifth annual 'Great West Fest' took place in September, offering an opportunity for 4,500 staff and families to attend.



We are recognised and rewarded

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2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are recognised and rewarded	-	4a	The recognition I get for good work (Satisfied/Very satisfied).	Higher = better	53.3%	52.8%	0.5%	51.7%	1.6%
We are recognised and rewarded	-	4b	The extent to which my organisation values my work (Satisfied/Very satisfied).	Higher = better	43.8%	43.9%	-0.1%	41.9%	1.9%
We are recognised and rewarded	-	4c	My level of pay (Satisfied/Very satisfied).	Higher = better	29.8%	27.5%	2.3%	31.5%	-1.7%
We are recognised and rewarded	-	8d	The people I work with show appreciation to one another (Agree/Strongly agree).	Higher = better	66.1%	64.9%	1.2%	65.6%	0.5%
We are recognised and rewarded	-	9e	My immediate manager values my work (Agree/Strongly agree).	Higher = better	73.1%	72.1%	1.0%	71.6%	1.4%

We each have a voice that counts

2024 Staff Survey

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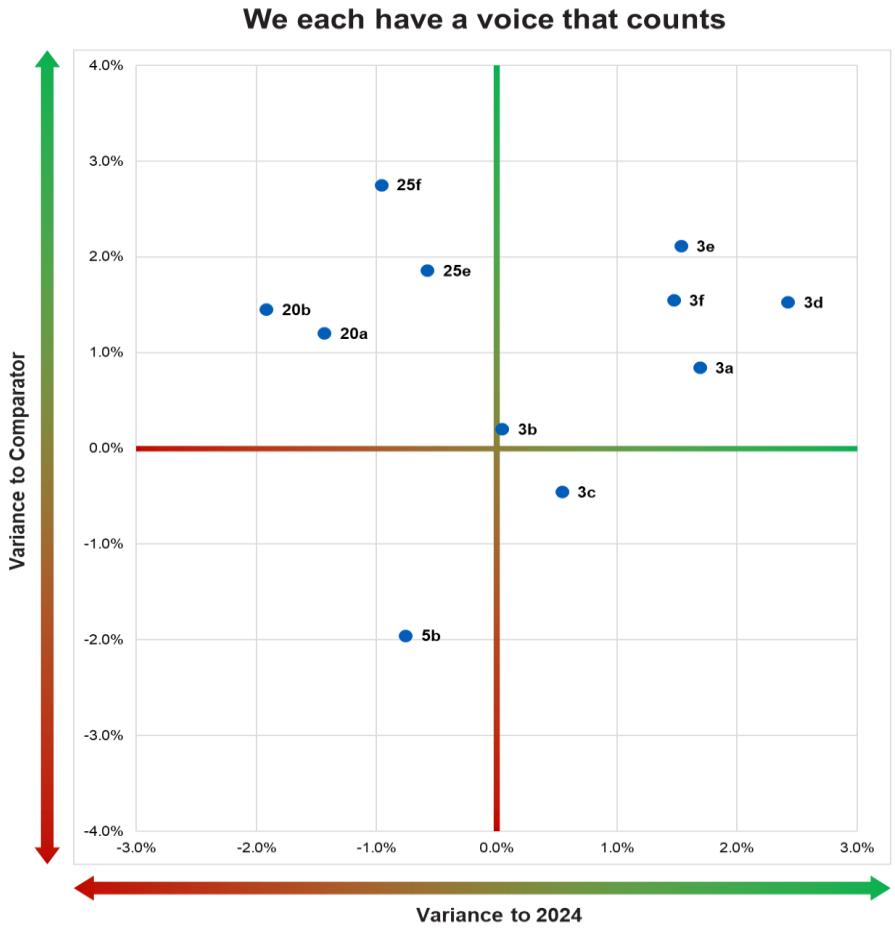
Highlight

- 635 staff shared 5,200 contributions to the ‘Lets Talk Behaviours’ big conversation on-line platform, helping to shape the Trust behaviours aligned to STAR values.

Raising Concerns

- GWH scores above sector average for all FTSU-related questions.
- New FTSU operating model embedded, strengthening governance, consistency, Guardian independence, and alignment with BSW-wide practice for improved system-level approach.
- Improved FTSU Guardian visibility and proactive engagement with staff and leaders, including strengthened Senior Leadership involvement and clearer accountability.
- Analysis of FTSU-related questions highlights specific teams low scoring themes: organisational responsiveness, awareness of routes for raising concerns, feeling listened to (feedback loop), local leadership behaviours (accepting poor behaviours as norm).
- Active bystander provides a framework for people to speak up and address poor behaviours.
- Improvement evidenced in staff feeling able to raise concerns and confidence that they will be addressed



We each have a voice that counts

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2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We each have a voice that counts	Autonomy and control	3a	I always know what my work responsibilities are (Agree/Strongly agree).	Higher = better	87.6%	85.9%	1.7%	86.8%	0.8%
We each have a voice that counts	Autonomy and control	3b	I am trusted to do my job (Agree/Strongly agree).	Higher = better	90.1%	90.0%	0.0%	89.9%	0.2%
We each have a voice that counts	Autonomy and control	3c	There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	Higher = better	72.1%	71.5%	0.5%	72.5%	-0.5%
We each have a voice that counts	Autonomy and control	3d	I am able to make suggestions to improve the work of my team / department (Agree/Strongly agree).	Higher = better	71.4%	69.0%	2.4%	69.9%	1.5%
We each have a voice that counts	Autonomy and control	3e	I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	Higher = better	51.7%	50.2%	1.5%	49.6%	2.1%
We each have a voice that counts	Autonomy and control	3f	I am able to make improvements happen in my area of work (Agree/Strongly agree).	Higher = better	56.1%	54.6%	1.5%	54.5%	1.5%
We each have a voice that counts	Autonomy and control	5b	I have a choice in deciding how to do my work (Often/Always).	Higher = better	49.4%	50.2%	-0.8%	51.4%	-2.0%
We each have a voice that counts	Raising concerns	20a	I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	Higher = better	71.0%	72.5%	-1.4%	69.8%	1.2%
We each have a voice that counts	Raising concerns	20b	I am confident that my organisation would address my concern (Agree/Strongly agree).	Higher = better	55.4%	57.3%	-1.9%	53.9%	1.5%
We each have a voice that counts	Raising concerns	25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	Higher = better	60.7%	61.3%	-0.6%	58.9%	1.9%
We each have a voice that counts	Raising concerns	25f	If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	Higher = better	48.9%	49.9%	-1.0%	46.2%	2.8%

We are safe and healthy

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2024 Staff Survey

Burnout

- GWH scores positively in the top 20% against the sector for staff reporting burnout as a result of work.
- Sickness absence and associated temporary cover has a high impact on staff morale and engagement. The Trust has achieved a 0.4% reduction in rolling 12 month average since April 25, reflecting the work of a Trust-led Attendance programme.

Health & Safety Climate

OHWB team work collaboratively on key topics and as part of the Trust Attendance and Never OK campaign working groups supporting areas of high need. This has included:-

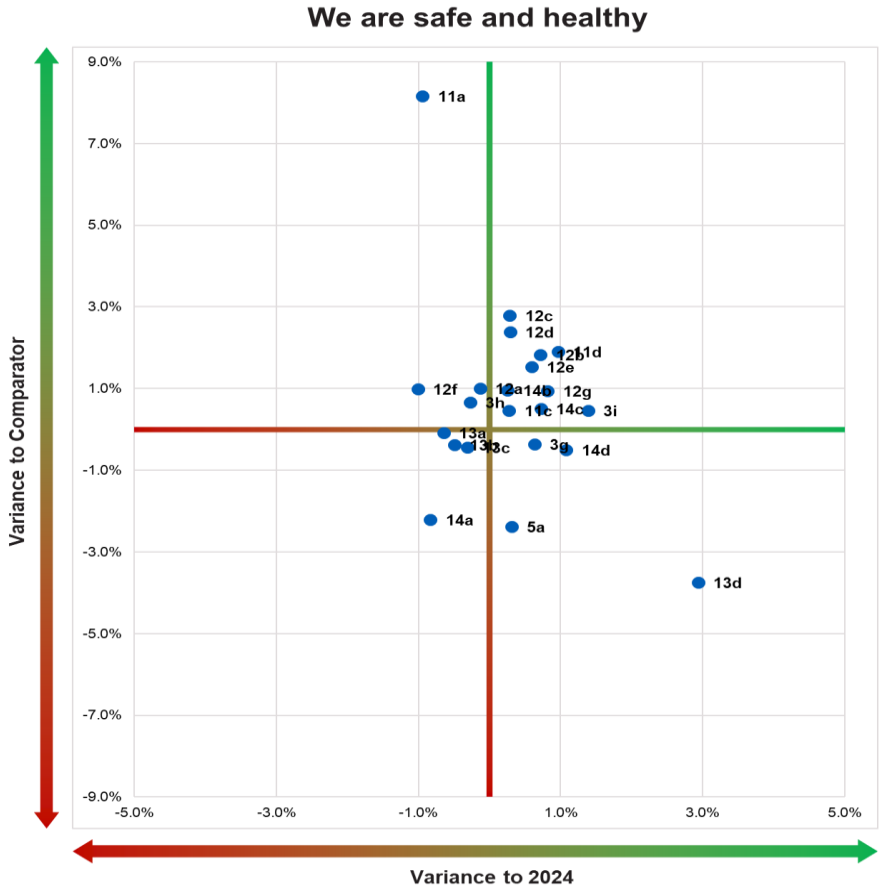
- Promotion and growth of H&WB local champions;
- Proactive physiotherapy approach to support staff with MSK conditions, with bespoke in-reach departmental groups, joint training sessions, and trust wide preventative workshops.

Continued embedding of preventative psychological support mechanisms for all staff, including compassion skills teaching, as well as responsive interventions as needed, such as TRiM (trauma risk management).

Enhanced training for managers to support their team's wellbeing proactively and compassionately via Mental Health Skills for Managers training course and Expectations of Line Managers programme.

2025 saw an increase in numbers of staff accessing Vivup and another great year in numbers of staff accessing the flu campaign.

- Improved scores in all divisions for staff reporting violence, a positive reflection of the Never OK awareness campaign.



We are safe and healthy

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2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are safe and healthy	Health and safety climate	3g	I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	Higher = better	45.8%	45.1%	0.6%	46.1%	-0.4%
We are safe and healthy	Health and safety climate	3h	I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	Higher = better	54.5%	54.8%	-0.3%	53.8%	0.7%
We are safe and healthy	Health and safety climate	3i	There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	Higher = better	31.8%	30.4%	1.4%	31.3%	0.5%
We are safe and healthy	Health and safety climate	5a	I have unrealistic time pressures (Never/Rarely).	Higher = better	22.9%	22.6%	0.3%	25.3%	-2.4%
We are safe and healthy	Health and safety climate	11a	My organisation takes positive action on health and well-being (Agree/Strongly agree).	Higher = better	61.3%	62.3%	-0.9%	53.2%	8.2%
We are safe and healthy	Health and safety climate	13d	The last time you experienced physical violence at work, did you or a colleague report it (Yes).	Higher = better	68.1%	65.2%	2.9%	71.9%	-3.7%
We are safe and healthy	Health and safety climate	14d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it (Yes).	Higher = better	52.4%	51.3%	1.1%	52.9%	-0.5%
We are safe and healthy	Burnout	12a	How often, if at all, do you find your work emotionally exhausting (Often/Always).	Lower = better	34.1%	33.9%	-0.1%	35.1%	1.0%
We are safe and healthy	Burnout	12b	How often, if at all, do you feel burnt out because of your work (Often/Always).	Lower = better	30.3%	31.0%	0.7%	32.1%	1.8%
We are safe and healthy	Burnout	12c	How often, if at all, does your work frustrate you (Often/Always).	Lower = better	34.3%	34.6%	0.3%	37.1%	2.8%
We are safe and healthy	Burnout	12d	How often, if at all, are you exhausted at the thought of another day/shift at work (Often/Always).	Lower = better	27.0%	27.3%	0.3%	29.4%	2.4%
We are safe and healthy	Burnout	12e	How often, if at all, do you feel worn out at the end of your working day/shift (Often/Always).	Lower = better	42.0%	42.6%	0.6%	43.5%	1.5%
We are safe and healthy	Burnout	12f	How often, if at all, do you feel that every working hour is tiring for you (Often/Always).	Lower = better	20.0%	19.0%	-1.0%	21.0%	1.0%
We are safe and healthy	Burnout	12g	How often, if at all, do you not have enough energy for family and friends during leisure time (Often/Always).	Lower = better	28.9%	29.7%	0.8%	29.9%	0.9%
We are safe and healthy	Negative experiences	13a	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (One or more times).	Lower = better	14.7%	14.1%	-0.6%	14.7%	-0.1%
We are safe and healthy	Negative experiences	13b	In the last 12 months how many times have you personally experienced physical violence at work from managers (One or more times).	Lower = better	1.1%	0.6%	-0.5%	0.8%	-0.4%
We are safe and healthy	Negative experiences	13c	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues (One or more times).	Lower = better	2.2%	1.9%	-0.3%	1.8%	-0.4%
We are safe and healthy	Negative experiences	14a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public (One or more times).	Lower = better	26.8%	26.0%	-0.8%	24.6%	-2.2%
We are safe and healthy	Negative experiences	14b	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers (One or more times).	Lower = better	8.2%	8.5%	0.3%	9.2%	1.0%
We are safe and healthy	Negative experiences	14c	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues (One or more times).	Lower = better	17.4%	18.1%	0.7%	17.9%	0.5%
We are safe and healthy	Negative experiences	11b	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities (Yes)?	Lower = better	40.8%	0.0%	-40.8%	40.7%	-0.1%
We are safe and healthy	Negative experiences	11c	During the last 12 months have you felt unwell as a result of work related stress (Yes).	Lower = better	41.8%	42.1%	0.3%	42.3%	0.5%
We are safe and healthy	Negative experiences	11d	In the last three months have you ever come to work despite not feeling well enough to perform your duties (Yes).	Lower = better	54.2%	55.1%	1.0%	56.1%	1.9%

We are always learning

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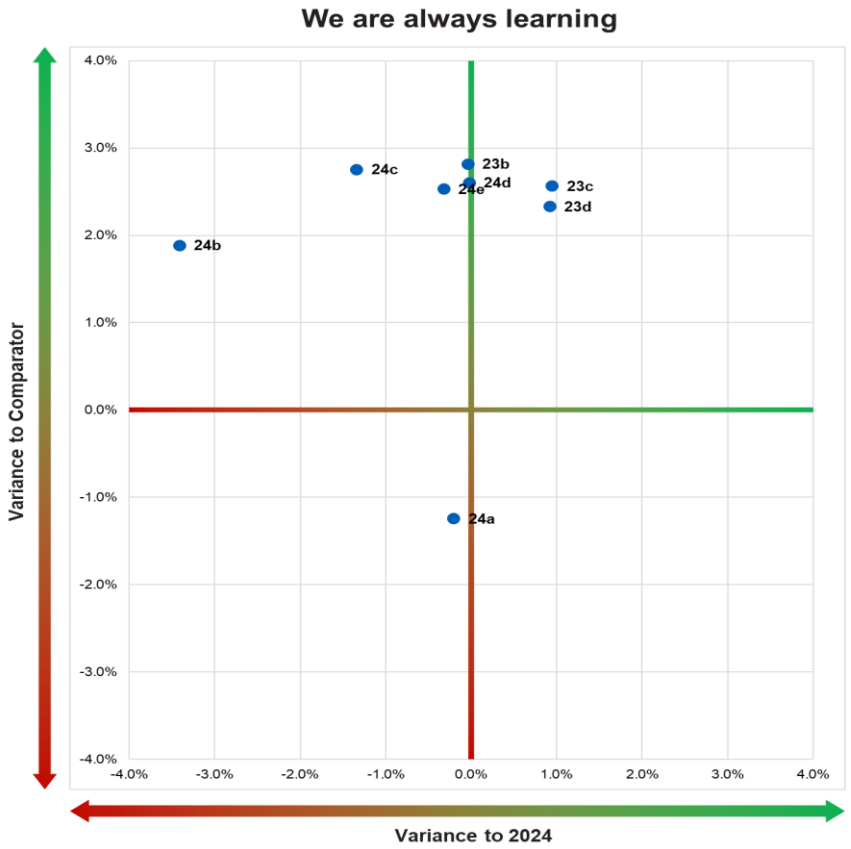
2025 Staff Survey

Development

- OD prospectus launched in 2025.
- EOLM has been successful with 97% of target audience (current managers) attending. This is being extended to Clinical Leads April 26.
- Apprenticeships focus in 2025 to make best use of available funding and GWH has exceeded 200 learners on program for the first time.
- Scope for Growth uptake continues to increase and extended to include medical colleagues. Year 1 target of 110 met, stretch target of 220 now in place for 206/7.
- CPD funding sustained this year.
- Satisfaction with career development is impacted by Estates and Administrative staff groups, reflecting the organisation restrictions on recruitment and Corporate re-design work in these functions.

Appraisal

- Refreshed form now includes an individual evidenced based assessment against the Trust behaviours.
- A standardised process on ESR is helping to improve tracking and record keeping. The system transition to ESR has had an impact on KPI completion with support available via user guides and training.



We are always learning

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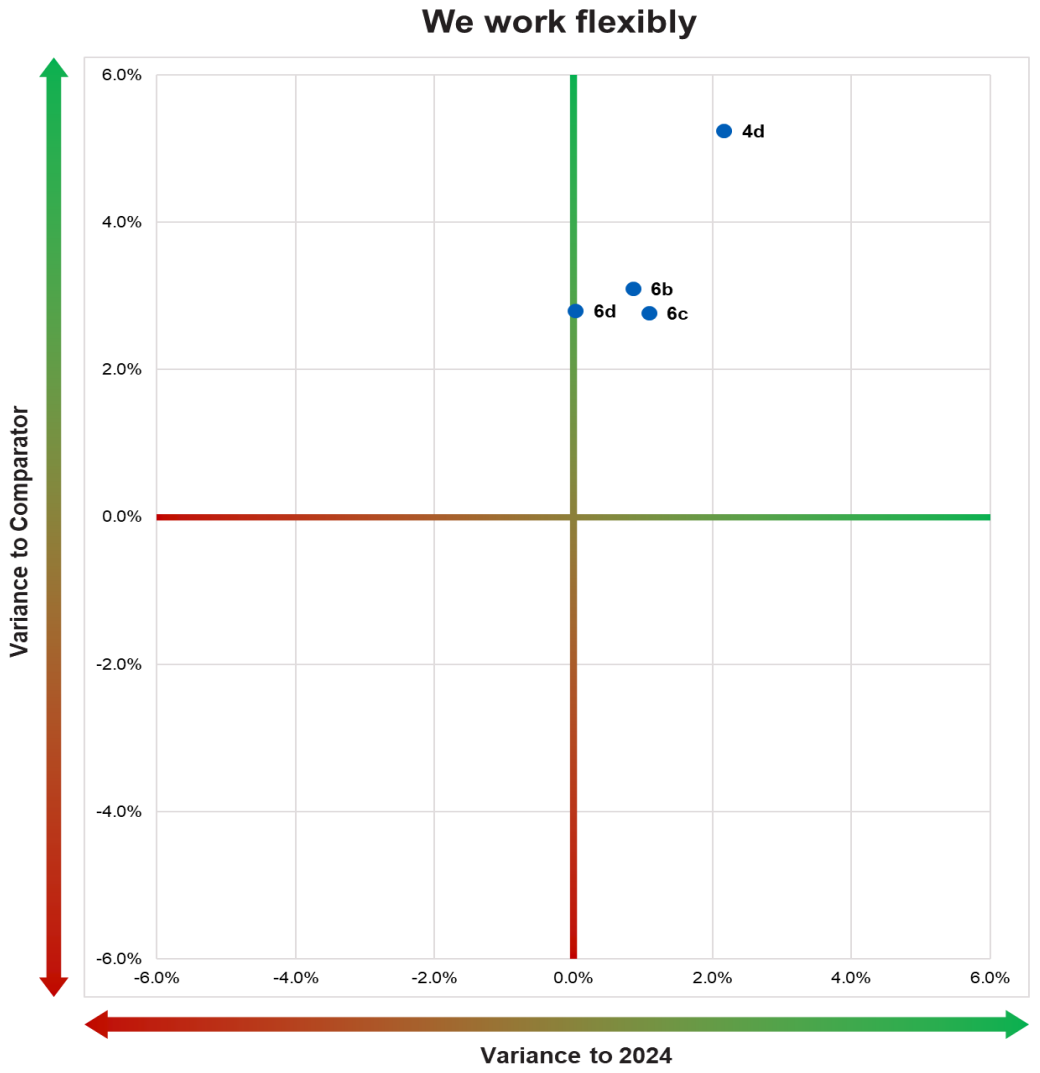
2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are always learning	Development	24a	This organisation offers me challenging work (Agree/Strongly agree).	Higher = better	66.3%	66.5%	-0.2%	67.5%	-1.2%
We are always learning	Development	24b	There are opportunities for me to develop my career in this organisation (Agree/Strongly agree).	Higher = better	52.3%	55.7%	-3.4%	50.4%	1.9%
We are always learning	Development	24c	I have opportunities to improve my knowledge and skills (Agree/Strongly agree).	Higher = better	70.2%	71.5%	-1.3%	67.4%	2.8%
We are always learning	Development	24d	I feel supported to develop my potential (Agree/Strongly agree).	Higher = better	56.7%	56.7%	0.0%	54.1%	2.6%
We are always learning	Development	24e	I am able to access the right learning and development opportunities when I need to (Agree/Strongly agree).	Higher = better	60.0%	60.3%	-0.3%	57.4%	2.5%
We are always learning	Appraisals	23b	It helped me to improve how I do my job (Yes, definitely).	Higher = better	28.0%	28.1%	0.0%	25.2%	2.8%
We are always learning	Appraisals	23c	It helped me agree clear objectives for my work (Yes, definitely).	Higher = better	37.4%	36.4%	0.9%	34.8%	2.6%
We are always learning	Appraisals	23d	It left me feeling that my work is valued by my organisation (Yes, definitely).	Higher = better	35.4%	34.4%	0.9%	33.0%	2.3%

We work flexibly

2025 Staff Survey

- National results show We Work Flexibly remaining static at 6.31 whereas GWH improves vs 2024 to 6.5.
- The application process for Agenda for Change flexible working requests was launched on ESR during the survey period.
- Expectations of the Line Manager promotes awareness and a standardised approach when staff submit a request. 1:1 and appraisal templates support continuous, open discussions between staff and managers, helping to balance individual working patterns with service requirements.



We work flexibly

2025 Staff Survey

Great Western Hospitals NHS Foundation Trust

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We work flexibly	Flexible Working	4d	The opportunities for flexible working patterns (Satisfied/Very satisfied).	Higher = better	61.2%	59.0%	2.2%	55.9%	5.2%
We work flexibly	Support for work-life balance	6b	My organisation is committed to helping me balance my work and home life (Agree/Strongly agree).	Higher = better	51.3%	50.5%	0.9%	48.2%	3.1%
We work flexibly	Support for work-life balance	6c	I achieve a good balance between my work life and my home life (Agree/Strongly agree).	Higher = better	58.3%	57.2%	1.1%	55.5%	2.8%
We work flexibly	Support for work-life balance	6d	I can approach my immediate manager to talk openly about flexible working (Agree/Strongly agree).	Higher = better	73.0%	73.0%	0.0%	70.2%	2.8%

We are a team

2025 Staff Survey

Great Western Hospitals NHS Foundation Trust

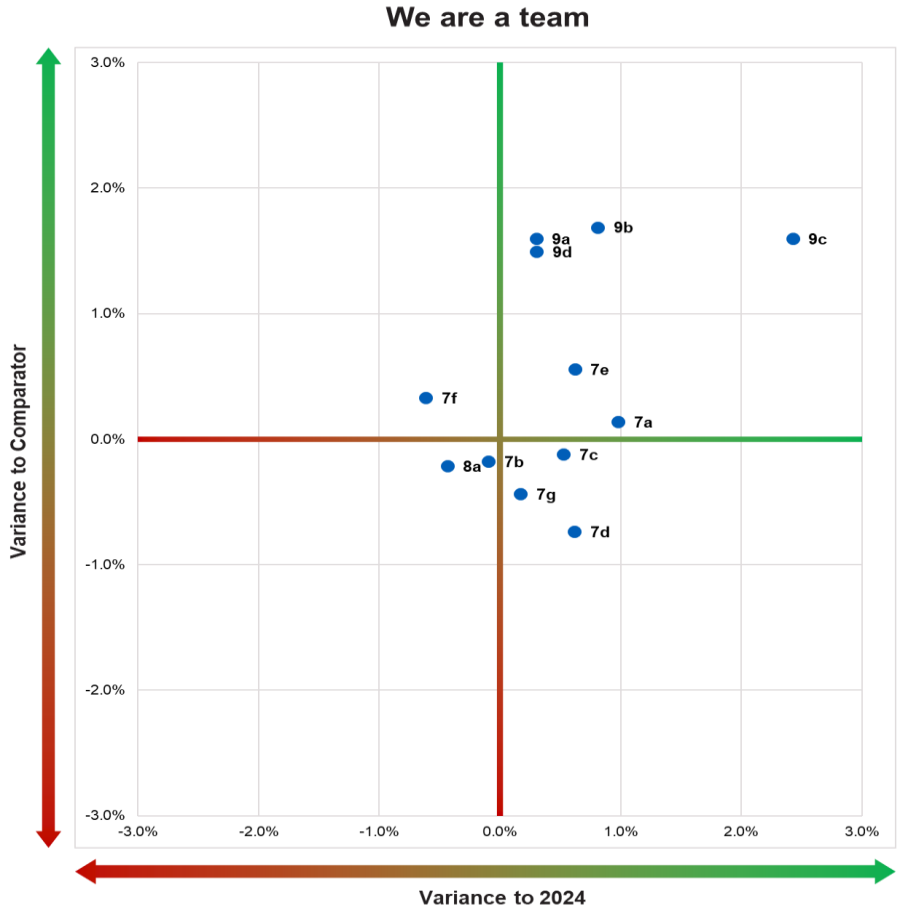
Team working
Encouraging to see results broadly consistent with the previous year, despite significant team moves during 2025 including TUPE transfer to HCRG; Pathology and Maternity services transferring to FaSS division; bed reconfiguration phase 2 transferring Gastro to S&PC, and Saturn moving to Medicine as a Respiratory speciality ward.

- There has been increased uptake of the TED tool with ownership and management of the process being embedded into the line manager role with OD support and guidance.

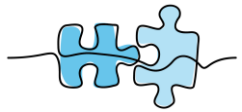
  642 responses through 122 surveys were completed in 2025 (28 previous year when introduced). Running a TED project is also now integrated into leadership programmes as part of the course. Positive teamworking outcomes are evidenced, for example in the newly-formed team Saturn.

- Trust countermeasures focussed on hotspot teams and themes to improve respect between colleagues under the improving together approach. This has resulted in a 0.5% improvement in Q7c vs 2024.

- Cara Charles-Barks (CEO) and Lisa Thomas (MD) introduced regular Group and Trust staff forums during 2025. These provide an opportunity for staff to come together and receive updates on projects, performance, and priorities, and questions from staff are invited. Face-to-face listening sessions were also introduced, hosted by members of the Exec team to hear and respond to matters affecting staff.



We are a team



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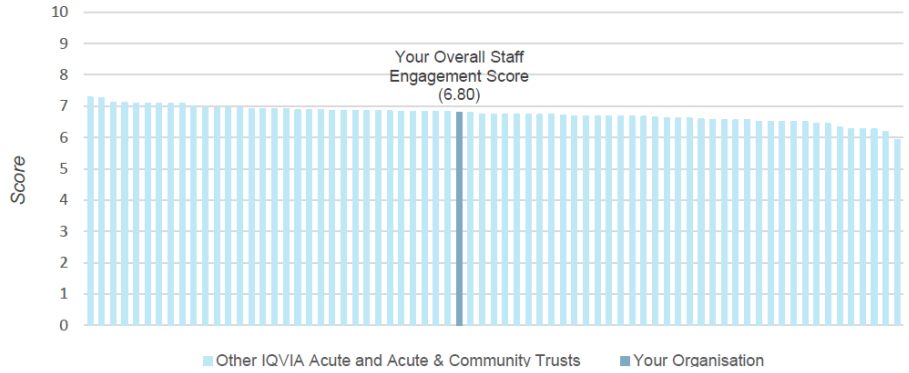
2025 Staff Survey

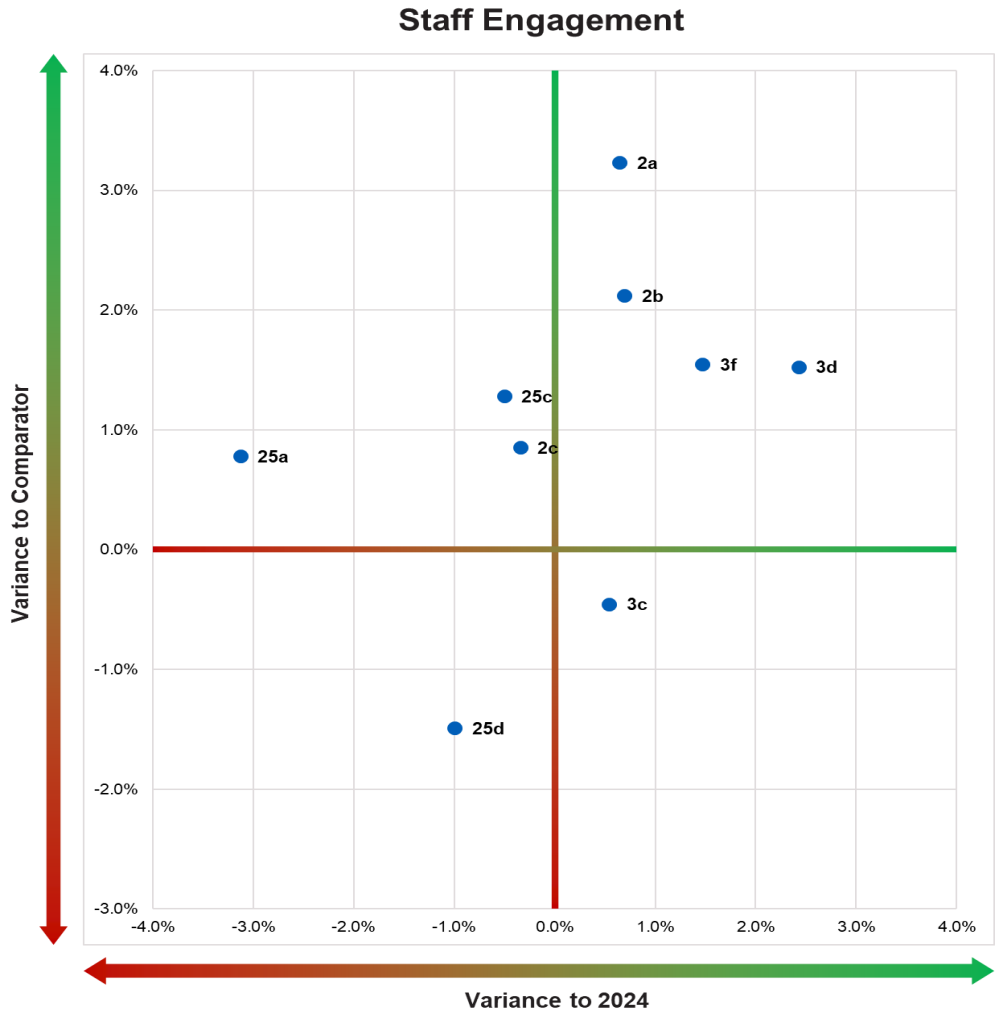
Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are a team	Team working	7a	The team I work in has a set of shared objectives (Agree/Strongly agree).	Higher = better	73.7%	72.7%	1.0%	73.5%	0.1%
We are a team	Team working	7b	The team I work in often meets to discuss the team's effectiveness (Agree/Strongly agree).	Higher = better	61.6%	61.7%	-0.1%	61.8%	-0.2%
We are a team	Team working	7c	I receive the respect I deserve from my colleagues at work (Agree/Strongly agree).	Higher = better	70.3%	69.8%	0.5%	70.4%	-0.1%
We are a team	Team working	7d	Team members understand each other's roles (Agree/Strongly agree).	Higher = better	70.4%	69.8%	0.6%	71.2%	-0.7%
We are a team	Team working	7e	I enjoy working with the colleagues in my team (Agree/Strongly agree).	Higher = better	80.1%	79.5%	0.6%	79.5%	0.6%
We are a team	Team working	7f	My team has enough freedom in how to do its work (Agree/Strongly agree).	Higher = better	58.8%	59.5%	-0.6%	58.5%	0.3%
We are a team	Team working	7g	In my team disagreements are dealt with constructively (Agree/Strongly agree).	Higher = better	55.6%	55.4%	0.2%	56.0%	-0.4%
We are a team	Team working	8a	Teams within this organisation work well together to achieve their objectives (Agree/Strongly agree).	Higher = better	53.1%	53.5%	-0.4%	53.3%	-0.2%
We are a team	Line management	9a	My immediate manager encourages me at work (Agree/Strongly agree).	Higher = better	73.3%	73.0%	0.3%	71.7%	1.6%
We are a team	Line management	9b	My immediate manager gives me clear feedback on my work (Agree/Strongly agree).	Higher = better	67.1%	66.3%	0.8%	65.4%	1.7%
We are a team	Line management	9c	My immediate manager asks for my opinion before making decisions that affect my work (Agree/Strongly agree).	Higher = better	60.4%	58.0%	2.4%	58.8%	1.6%
We are a team	Line management	9d	My immediate manager takes a positive interest in my health and well-being (Agree/Strongly agree).	Higher = better	71.2%	70.9%	0.3%	69.7%	1.5%

Staff engagement

2025 Staff Survey

- Nationally the Motivation sub theme is at it's lowest level for 5 years. Staff engagement at GWH is unchanged from 2024 and scores 6.81 vs 6.87 nationally.
- Decline in all 3 Advocacy questions, including the Trust pillar metric "I would recommend my organisation as a place to work." The breakthrough focus will therefore move to Q25a (Care of patients is top priority) in 2026/7 to drive greater progress towards the pillar matric goal. GWH is currently 59.1% with a goal of achieving 2% above national average which was 58.05% in 2025.
- GWH vs sector:





Staff engagement

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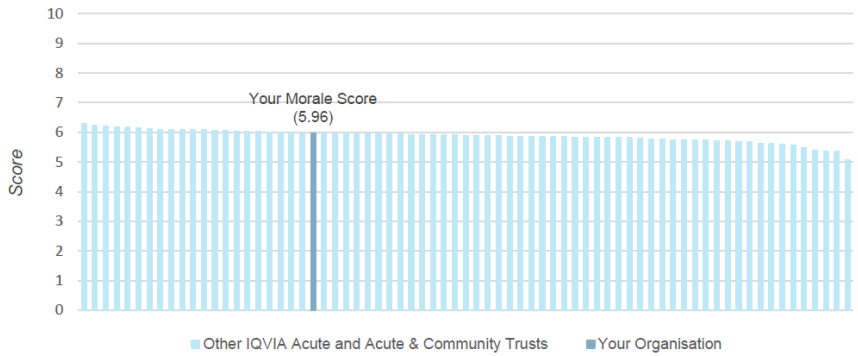
2025 Staff Survey

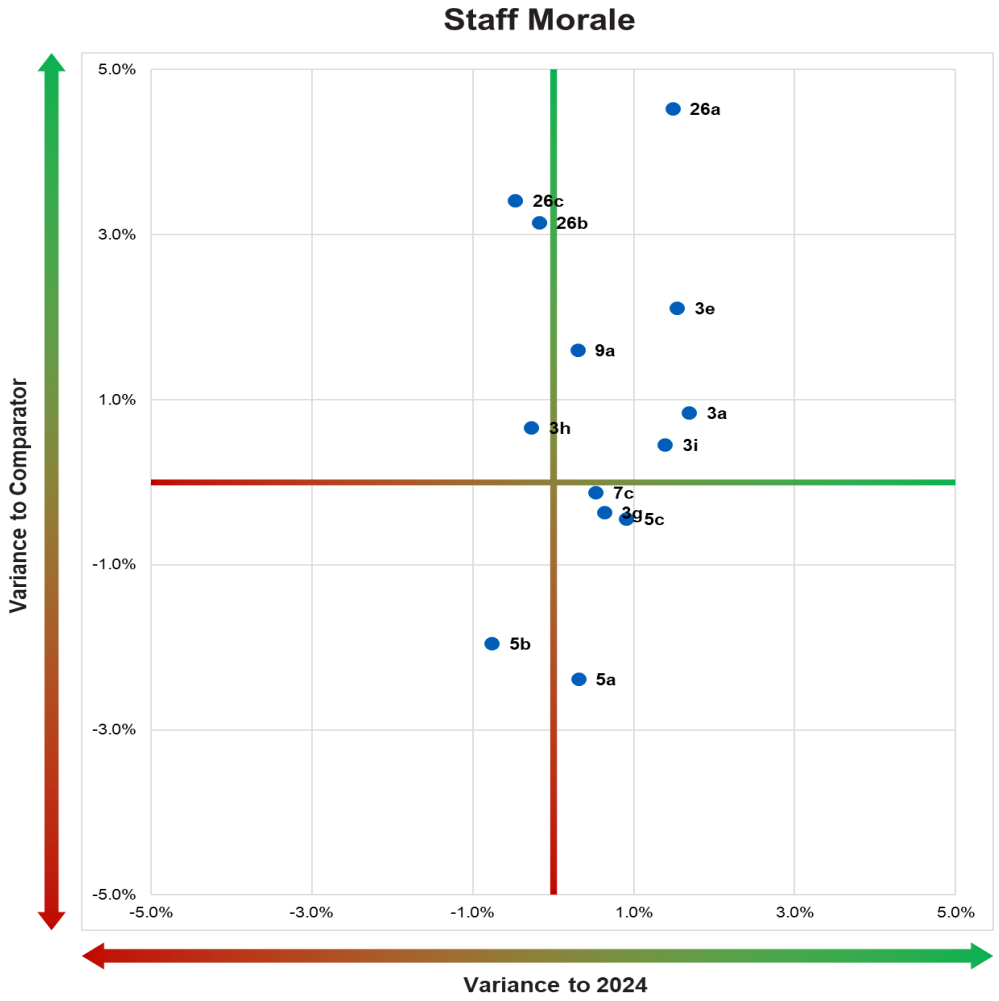
Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
Staff Engagement	Motivation	2a	I look forward to going to work (Often/Always).	Higher = better	55.3%	54.6%	0.6%	52.0%	3.2%
Staff Engagement	Motivation	2b	I am enthusiastic about my job (Often/Always).	Higher = better	68.2%	67.5%	0.7%	66.1%	2.1%
Staff Engagement	Motivation	2c	Time passes quickly when I am working (Often/Always).	Higher = better	70.9%	71.2%	-0.3%	70.0%	0.9%
Staff Engagement	Involvement	3c	There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	Higher = better	72.1%	71.5%	0.5%	72.5%	-0.5%
Staff Engagement	Involvement	3d	I am able to make suggestions to improve the work of my team / department (Agree/Strongly agree).	Higher = better	71.4%	69.0%	2.4%	69.9%	1.5%
Staff Engagement	Involvement	3f	I am able to make improvements happen in my area of work (Agree/Strongly agree).	Higher = better	56.1%	54.6%	1.5%	54.5%	1.5%
Staff Engagement	Advocacy	25a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	Higher = better	72.4%	75.5%	-3.1%	71.6%	0.8%
Staff Engagement	Advocacy	25c	I would recommend my organisation as a place to work (Agree/Strongly agree).	Higher = better	59.1%	59.6%	-0.5%	57.8%	1.3%
Staff Engagement	Advocacy	25d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	Higher = better	59.3%	60.3%	-1.0%	60.8%	-1.5%

Morale

2025 Staff Survey

- The Morale score is similar to last year and remains above 2022 and 2021.
- Nationally, the ‘Work pressure’ sub-score is at its lowest level since 2023 with less than half of staff say they are able to meet all of the conflicting demands on their time at work, which has been the case since 2021.
- GWH also has less than half (45.8%) of staff reporting being able to meet all conflicting demands, although this is a marginal (0.7%) improvement vs 2024.
- Stressors overall are in line with sector and again marginally improve vs 2024. Relationships and respect both improve and are linked to the Trust 2025/6 breakthrough objective.
- GWH position vs sector - Morale:





Morale

2025 Staff Survey

NHS
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Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
Staff Morale	Thinking about leaving	26a	I often think about leaving this organisation (Agree/Strongly agree).	Lower = better	25.3%	26.8%	1.5%	29.8%	4.5%
Staff Morale	Thinking about leaving	26b	I will probably look for a job at a new organisation in the next 12 months (Agree/Strongly agree).	Lower = better	17.9%	17.7%	-0.2%	21.1%	3.1%
Staff Morale	Thinking about leaving	26c	As soon as I can find another job, I will leave this organisation (Agree/Strongly agree).	Lower = better	13.4%	12.9%	-0.5%	16.8%	3.4%
Staff Morale	Work pressure	3g	I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	Higher = better	45.8%	45.1%	0.6%	46.1%	-0.4%
Staff Morale	Work pressure	3h	I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	Higher = better	54.5%	54.8%	-0.3%	53.8%	0.7%
Staff Morale	Work pressure	3i	There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	Higher = better	31.8%	30.4%	1.4%	31.3%	0.5%
Staff Morale	Stressors	3a	I always know what my work responsibilities are (Agree/Strongly agree).	Higher = better	87.6%	85.9%	1.7%	86.8%	0.8%
Staff Morale	Stressors	3e	I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	Higher = better	51.7%	50.2%	1.5%	49.6%	2.1%
Staff Morale	Stressors	5a	I have unrealistic time pressures (Never/Rarely).	Higher = better	22.9%	22.6%	0.3%	25.3%	-2.4%
Staff Morale	Stressors	5b	I have a choice in deciding how to do my work (Often/Always).	Higher = better	49.4%	50.2%	-0.8%	51.4%	-2.0%
Staff Morale	Stressors	5c	Relationships at work are strained (Never/Rarely).	Higher = better	44.0%	43.1%	0.9%	44.4%	-0.4%
Staff Morale	Stressors	7c	I receive the respect I deserve from my colleagues at work (Agree/Strongly agree).	Higher = better	70.3%	69.8%	0.5%	70.4%	-0.1%
Staff Morale	Stressors	9a	My immediate manager encourages me at work (Agree/Strongly agree).	Higher = better	73.3%	73.0%	0.3%	71.7%	1.6%

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Responding through Improving Together

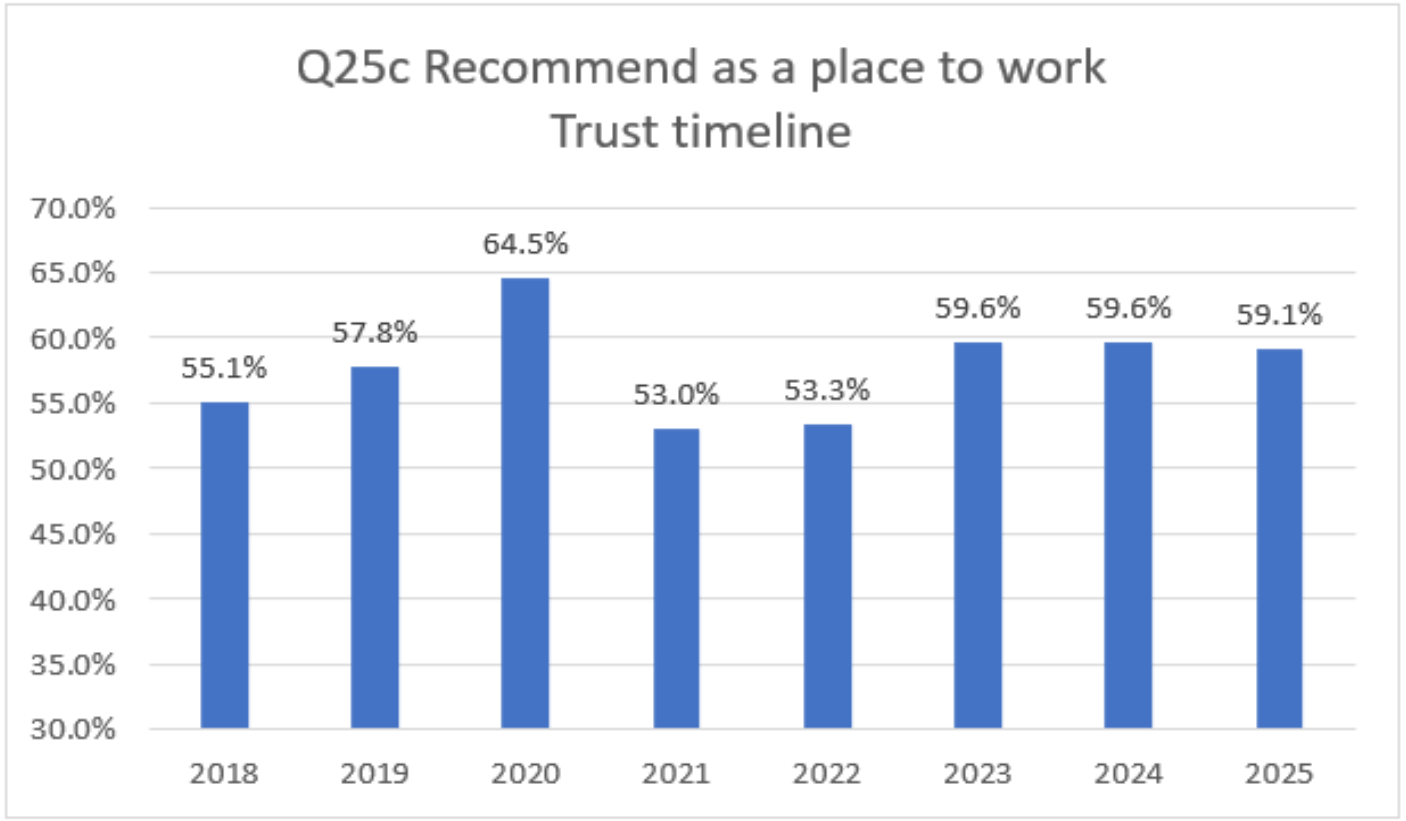
2025 Staff Survey Trust Breakthrough Metric

Together we are Great

2025 Survey Trust Position – Pillar Metric

Great Western Hospitals NHS Foundation Trust

Pillar Metric	To achieve an improvement target of 2% above national average in the national staff survey question 'I would recommend my organisation as a place to work'	2025 Survey



Target: 60%
(IQVIA benchmark 57.8%
National average 58.05%)

Gap: 1%

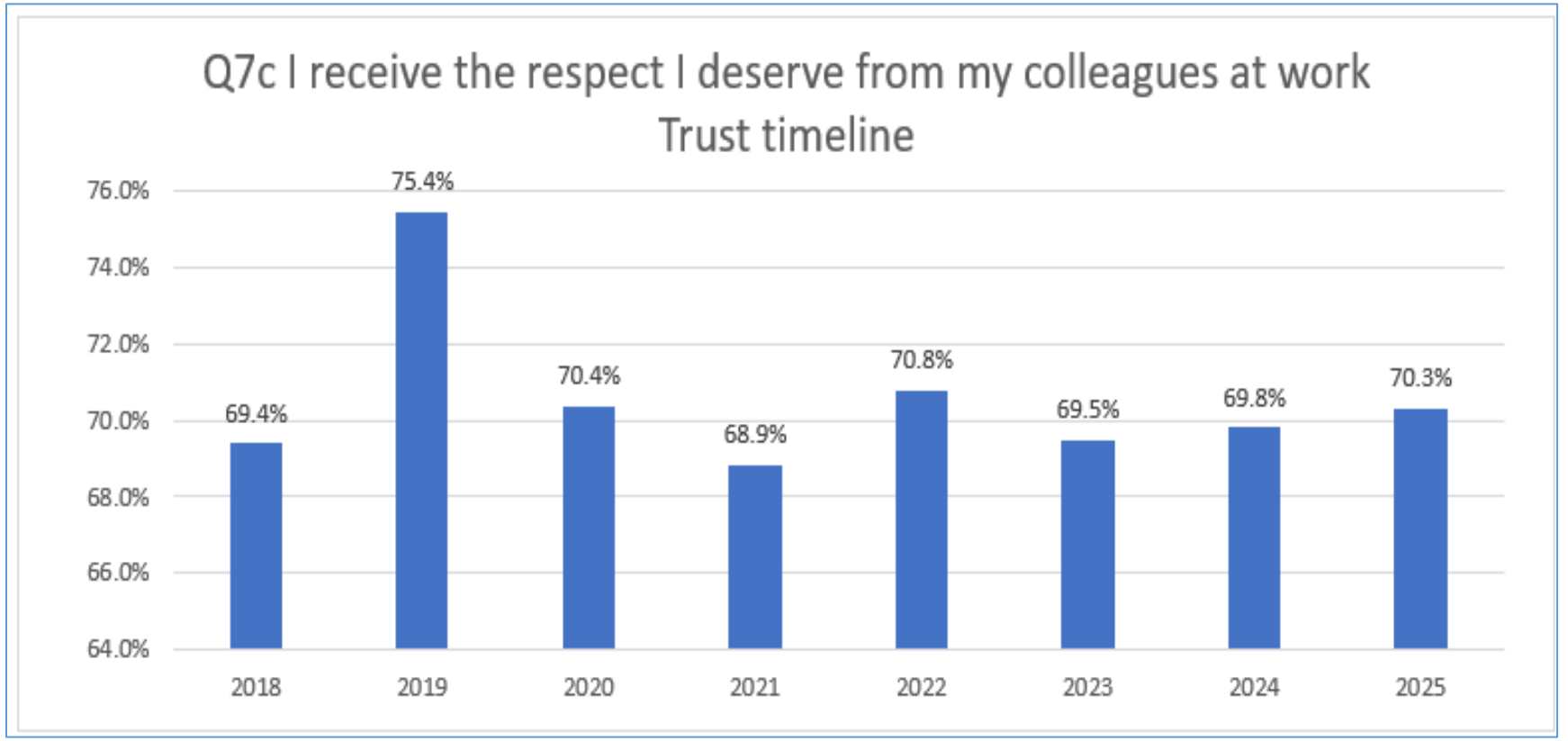
Service | Teamwork | Ambition | Respect

Key: Pulse Survey Annual Staff Survey

2025 Survey Trust Position –Breakthrough Objective

Great Western Hospitals NHS Foundation Trust

Breakthrough Objective	To reach a target score of 75% in the annual 2025 staff survey national staff survey question 'I receive the respect I deserve from my colleagues at work'	2025 Survey



Target: 75%
(IQVIA benchmark 70.9%

Gap: 4.7%

Service | Teamwork | Ambition | Respect

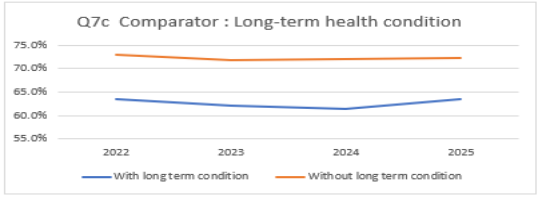
Key: Annual Staff Survey

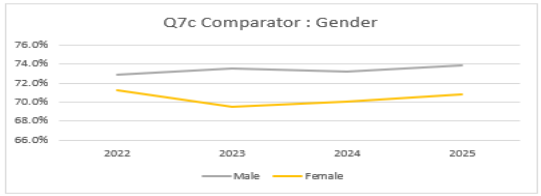
2025 Breakthrough Objective Stratified Data

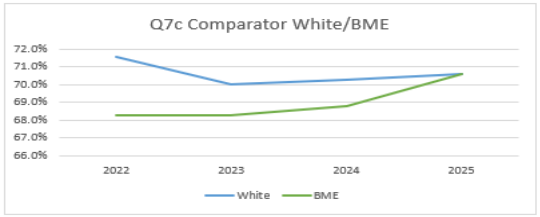
I receive the respect I deserve from colleagues at work Q7c Stratified Data

Great Western Hospitals NHS Foundation Trust

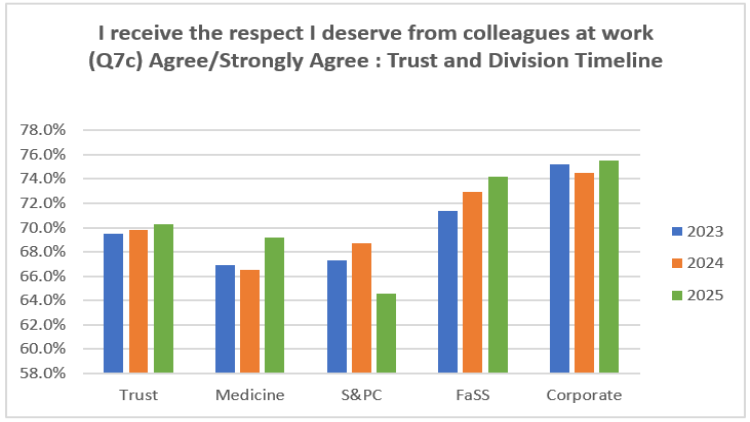
Protected Characteristics





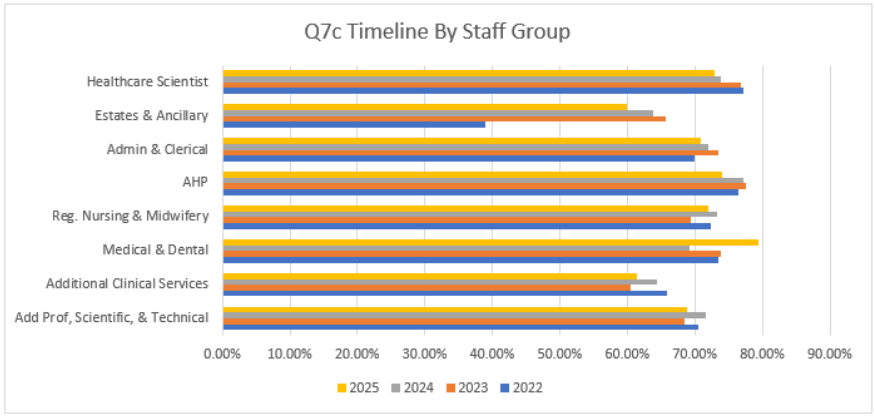


Reduced disparity across key protected characteristic groups with particular progress in equity of experience between white and BME colleagues.

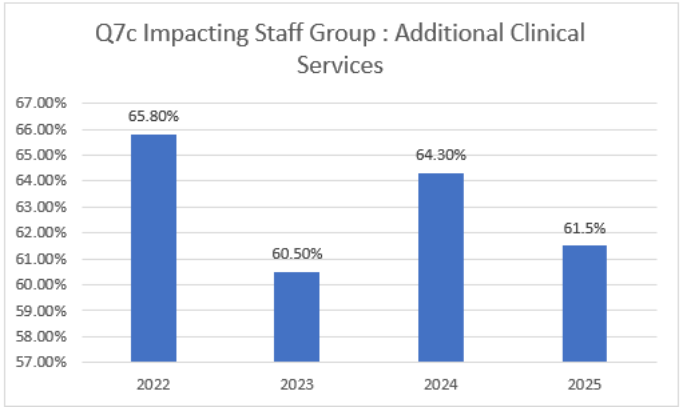


Positive 3-year trajectory at Trust level. S&PC are a focus division with a 4% decline against 2024.

Survey Highlights



Significant improvement in Medical & Dental staff group. All other staff groups decline.



Impacting staff group of Additional Clinical Services (predominantly unregistered nursing)

Improving Together | A3

Great Western Hospitals NHS Foundation Trust

Metric Breakthrough metric - Staff Survey 'Care of patients / service users is my organisation's top priority' Q25a

Lead(s) Claire Warner, Site People Services Director

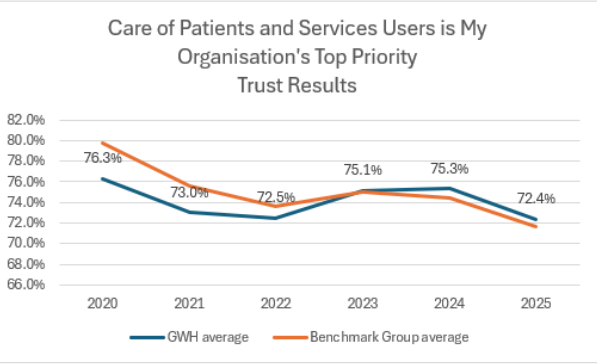
Step 1: Problem Statement

Staff feedback shows a steady decline over the past 5 years in the belief that the organisation prioritises the care of patients and service users.

This trend suggests a growing gap between our stated values and staff experience, risking reduced engagement, impact on quality of care, and reduced number of colleagues recommending the organisation as a place to work.

Step 2: Current Situation

Target: 77% **Gap: 5%**

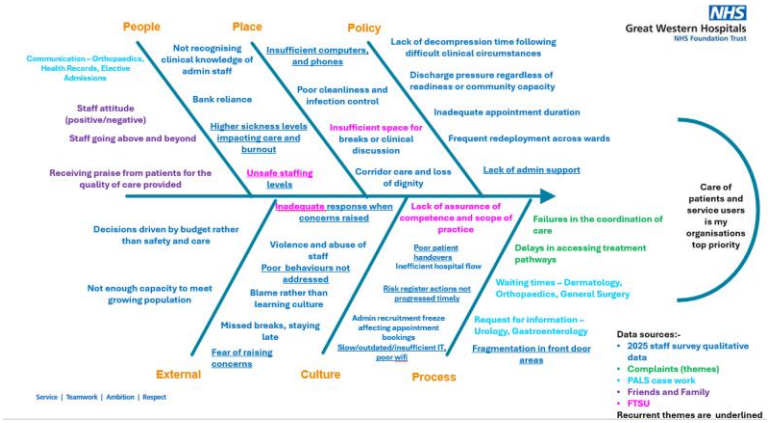


Step 3: Vision & Goals

We strive to be an organisation where every decision, action, and improvement is grounded in delivering outstanding, compassionate care; a place where colleagues feel confident that the needs of patients and service users are always highest priority.

Goal: Achieve a 5% improvement in the number of staff perceiving care as a top priority (Q25a).

Step 4: Root Cause / Gap Analysis



Priority themes influencing staff perception:-

1. Staffing shortages and unsafe staffing levels
2. Poor safety culture (fear, blame, speaking up)
3. Communication failures

Step 5: Countermeasures

Concern	Cause	Countermeasure
Staff believe current staffing levels are insufficient, creating a perception that patient care quality and safety are being compromised.	Gap between staffing reality and staffing experience —staff feel unsafe because key conditions around communication, workload, and support are missing.	Increase staff confidence that patient care remains safe by making staffing decisions transparent, predictable, and visibly supported.
Staff report a poor safety culture, characterised by fear of retaliation when speaking up, experiences of bullying or discrimination, a *blame-not-learning* mindset, and a general discouragement from raising safety issues. These conditions undermine psychological safety, reduce incident reporting, and increase the risk of harm to patients and staff.	Staff have witnessed or experienced poor behaviours and negative consequences after raising concerns. A lack of feedback and acknowledgement of concerns becomes a deterrent to speaking up.	Embed speaking-up behaviours across all teams by modelling psychological safety and reinforcing expected behaviours. Strengthen feedback loops by routinely communicating patient-experience improvements to administrative teams and ensuring they see the impact of their contributions.
Difficulties in navigating pathways for patients and managing next step expectations has a negative impact on the prioritisation of care.	Staff do not always have access to clear, up-to-date, or standardised information about patient pathways.	Provide staff with clear, accessible, and consistently updated pathway information. Integrate this work with the *What Matters to Me* project to ensure staff consistently apply and reinforce patient-care prioritisation in day-to-day practice.

Step 6: Actions

- 30 Apr: top 3 impacting priority areas identified based on data analysis
- 30 Apr: Q1 Pulse survey 17.3% response rate (965 number of staff)
- May: Analysis of Pulse results

Step 7: Progress & Benefits

- Top 3 priority themes identified
- Countermeasure aligned to priority themes agreed at TMC away day with engaged leads

Step 8: Insights

- Staff in administrative and clerical roles are more likely to feel that patient care is not consistently treated as a top priority.
- Corporate division shows the greatest decline 2025 vs 2024 and are below Trust average.
- S&PC also show a significant decline compared to the previous year.

Priority themes

Co-creation of trust-wide countermeasures for q25a

Great Western Hospitals NHS Foundation Trust

Staffing shortages & unsafe staffing levels	• Present across all staff groups, comment themes of reduced time per patient, missed care, delays, corridor care • Free text mentions reliance on temporary staff and recruitment constraints, with admin shortages delaying referrals, bookings, and flow • *Q25a ↓ care not seen as top priority (capacity undermining care)* • *Q25b ↓ organisation not acting on patient concerns* • *Q11e ↓ pressure to come to work*
Lack of organisational responsiveness to concerns	• Comments state concerns raised not acted on, slow response to known risks, and risk-register actions not followed • Repeated escalation without resolution • *Q25b ↓ organisation acts on concerns* • *Q20b ↓ confidence unsafe practice would be addressed* • *Q19d ↓ feedback on changes made after incidents*
Poor safety culture (fear, blame, speaking up)	• Within comments, reference to fear of retaliation when speaking up, bullying/discrimination, a 'blame not learning culture', and staff discouraged from raising safety issues • *Q20a ↓ feeling safe to speak up on clinical practice* • *Q20b ↓ confidence unsafe practice would be addressed* • *Q19c ↓ organisation takes action on errors not happening again*
Leadership credibility & disconnect from frontline	• Free text themes of 'detached leadership', decisions being made without front-line feedback, and a finance/KPI driven decision making process over patient care • *Q25a ↓ organisation prioritises patient care* • *Q25b ↓ organisation acts on concerns* • *Q7i ↓ reduced team attachment (proxy for leadership impact)*
Communication failures & fragmented pathways	• Comment themes of poor handovers, fragmented care pathways, and delays/duplications between teams • General lack of coordination across services, and poor communication across staff groups • *Q19d ↓ lack of feedback loops* • *Q19c ↓ weak communication of learning/actions taken*

Countermeasures

Great Western Hospitals NHS Foundation Trust

Countermeasure No.	Concern	Cause	Countermeasure	Owner	Due Date	Status
1	Staff believe current staffing levels are insufficient, creating a perception that patient care quality and safety are being compromised.	Gap between staffing reality and staffing experience —staff feel unsafe because key conditions around communication, workload, and support are missing.	Increase staff confidence that patient care remains safe by making staffing decisions transparent, predictable, and visibly supported.	Chris Bull/Vicky Treadwell (Head of Business Partnering)		
2	Staff report a poor safety culture, characterised by fear of retaliation when speaking up, experiences of bullying or discrimination, a *blame-not-learning* mindset, and a general discouragement from raising safety issues. These conditions undermine psychological safety, reduce incident reporting, and increase the risk of harm to patients and staff.	Staff have witnessed or experienced poor behaviours and negative consequences after raising concerns. A lack of feedback and acknowledgement of concerns becomes a deterrent to speaking up.	Embed speaking-up behaviours across all teams by modelling psychological safety and reinforcing expected behaviours. Strengthen feedback loops by routinely communicating patient-experience improvements to administrative teams and ensuring they see the impact of their contributions.	Sonia Maciver, Freedom to Speak Up Guardian Amanda Wylie		
3	Difficulties in navigating pathways for patients and managing next step expectations has a negative impact on the prioritisation of care.	Staff do not always have access to clear, up-to-date, or standardised information about patient pathways.	Provide staff with clear, accessible, and consistently updated pathway information. Integrate this work with the *What Matters to Me* project to ensure staff consistently apply and reinforce patient-care prioritisation in day-to-day practice.	Chris Bull Supported by Tim Edmonds, Vicky Treadwell		

Actions

Countermeasure No.	Action	Owner	Due Date	Status
	Add questions to Q1 Pulse survey to provide further insights.	Angela Morris	31 March 2026	Completed
	Engage with senior leaders at TMC away day.	Amanda Wylie/OD team	30 Apr 2026	Completed
	Receive actions escalated by divisions as sitting outside of their control and requiring Trust level action. Divisions to design local countermeasures and escalate areas requiring support to the Trust-wide meeting 28 May.	Claire Warner	28 May 2026	In progress
1	Create and implement a structured approach that supports staff in recognising how their roles contribute to the overall patient experience.	Vicky Treadwell supported by Corporate Heads of Service	31 July 2026	Planned

Actions

Great Western Hospitals NHS Foundation Trust

Countermeasure No.	Action	Owner	Due Date	Status
1	Implement standardised communication that clearly explains how patient care is prioritised during staff redeployment, addressing expectations for both the departing and receiving wards.	Chris Bull	End of August	
2	Using the TMC Away Day as the starting point, ensure that all actions agreed by the Trust Management Committee are clearly recorded, formally agreed with named ownership and timescales, and then actively tracked through to completion.	Nic Green/Claire Warner	End of July	
2	Audit the consistency of Datix feedback/learning response to all staff groups. Where gaps, review mitigation to ensure feedback loop is consistent and clear	tbc	End of August	
2	Team leaders to introduce a standard process for giving regular improvement feedback to teams that receive mainly negative interactions.	Vicky Treadwell	End of July	

Actions

Great Western Hospitals NHS Foundation Trust

Countermeasure No.	Action	Owner	Due Date	Status
2	Freedom to speak up to join Staff Survey Task and Finish group and develop clear a clear action plan to raise speaking up within the organisation and incorporating feedback loop for learning	Sonia Maciver and Chris Bull (Action plan with deliverable by end of June)	Action plan end of June	
3	Identify opportunities to include an A&C representative on and patient improvement initiative.	Chris Bull	End of August	
3	Reflect the friends & family voice within comms, amplify the voice of patients, use patient forum, link with Patient Experience project.	Chris Bull Supported by Madeline Goodwin	End of July	

Driver Metric 2026/7

Great Western Hospitals NHS Foundation Trust

Timeline

• w\c 20 Apr	Go & See visits to impacting areas.
• 23 Apr	Receive escalations for Trust level countermeasures from divisions via staff survey working group. Maintain engagement and momentum with division survey leads through monthly meetings.
• 30 Apr	Co-creation of countermeasures at TMC away day.
• May	Update A3 with agreed countermeasures and engage with responsible leads to agree measurable outcomes and actions. Review against Group countermeasures to identify shared learning and resource opportunities.
• June-Mar	Implement focussed actions in focus areas with on-going PDSA review and response. Provide monthly progress update to TMC.
• July	Build insights into impacting themes through bespoke additional questions in Q2 Pulse survey.
• Sept	Launch of 2026 annual survey.

BSW HOSPITALS GROUP

NHS

RUH Staff Survey 2025

People Committee Update

NHS
Great Western Hospitals
NHS Foundation Trust

NHS
Royal United Hospitals Bath
NHS Foundation Trust

NHS
Salisbury
NHS Foundation Trust

Group Staff Survey summary

Summary of Group Staff Survey Response rates

Trust	2024	2025	% to LY
Great Western Hospitals NHS Foundation Trust	70.9%	**66.0%**	-4.9%
Royal United Hospitals Bath NHS Foundation Trust	54.3%	**52.1%**	-2.1%
Salisbury NHS Foundation Trust	59.1%	**52.4%**	-6.6%
BSW Hospitals Group Total	61.5%	**56.8%**	-4.7%

Shared themes across group:

In terms of the group themes areas requiring improvement are:

- Development (we are always learning)
- Compassionate culture (we are compassionate and inclusive)

WRES/WDES metrics from the staff survey continue to highlight a disparity in experience at all three care organisations.

All Care organisations saw a reduction in ‘recommendation as a place to work metric’.

Positive theme of engaging staff opinions, suggestions and improvements – highlighting impact of improving together.

Group Opportunities:

- A3 lens on the feedback from care organisations to understand root causes of areas of decline.
- Continued alignment and learning from each other within EDI, to ensure impactful schemes are replicated. For example, GWH work on discrimination has show impact in survey metrics
- Learning/education review underway across group to look at offering, impact and how we learn from best practice.
- Ambition for 2026 Staff Survey, triangulated data to be available on Power BI, a coordinated approach support by a Group Staff Experience and Engagement forum involved Care Organisation People Partners.

Care Organisation Actions:

- Divisional People Partners have worked at a care organisational level with specialities to create and support bespoke actions plans. This work is support by Care Organisation Leadership.
- Focused work - breakthrough objectives programmes at care organisations.
- Example workstreams from 2025 feedback: team recognition programmes, work on ‘additional hours’, focused work on violence and aggression, A3’s on supporting work-life balance.

Largest declines to last year

	#	Question	+/-	+/-	2025 Survey				2025 Variance to Group			2025 Variance to LY			
					Group	GWH	RUH	SFT	GWH	RUH	SFT	Group	GWH	RUH	SFT
Development	24b	There are opportunities for me to develop my career in this organisation (Agree/Strongly agree).	Higher = better	+	**50.6%**	52.3%	49.2%	49.9%	1.7%	-1.3%	-0.7%	-4.6%	-2.5%	-5.1%	-6.9%
Compassionate culture & advocacy	25a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	Higher = better	+	**71.2%**	72.4%	69.5%	71.7%	1.2%	-1.7%	0.5%	-4.3%	-2.9%	-5.5%	-4.6%
Unlinked	19c	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again (Agree/Strongly agree).	Higher = better	+	**64.3%**	67.5%	61.6%	62.9%	3.2%	-2.7%	-1.4%	-3.2%	-1.7%	-4.7%	-3.0%
Compassionate culture	25b	My organisation acts on concerns raised by patients / service users (Agree/Strongly agree).	Higher = better	+	**67.8%**	69.4%	66.3%	67.6%	1.6%	-1.6%	-0.2%	-3.0%	-2.3%	-2.9%	-3.9%
Compassionate culture & advocacy	25c	I would recommend my organisation as a place to work (Agree/Strongly agree).	Higher = better	+	**59.6%**	59.1%	60.2%	59.5%	-0.5%	0.6%	-0.1%	-3.0%	-0.1%	-3.3%	-7.2%
Development	24c	I have opportunities to improve my knowledge and skills (Agree/Strongly agree).	Higher = better	+	**68.2%**	70.2%	65.8%	68.3%	2.0%	-2.3%	0.2%	-2.9%	-0.3%	-4.2%	-5.2%
Raising concerns	20b	I am confident that my organisation would address my concern (Agree/Strongly agree).	Higher = better	+	**53.3%**	55.4%	51.9%	52.1%	2.1%	-1.4%	-1.2%	-2.7%	-1.6%	-2.9%	-3.8%
Development	24d	I feel supported to develop my potential (Agree/Strongly agree).	Higher = better	+	**54.9%**	56.7%	53.1%	54.6%	1.8%	-1.8%	-0.2%	-2.5%	0.7%	-3.1%	-6.6%
Development	24e	I am able to access the right learning and development opportunities when I need to (Agree/Strongly agree).	Higher = better	+	**57.9%**	60.0%	55.4%	58.3%	2.0%	-2.5%	0.4%	-2.4%	0.7%	-4.6%	-4.2%
Compassionate culture & advocacy	25d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	Higher = better	+	**62.2%**	59.3%	66.1%	61.3%	-2.9%	3.9%	-1.0%	-2.4%	-1.0%	-3.8%	-3.4%

RUH 2025 Survey Highlights

From our People Promise themes we have seen 2 minor improvements, around 'working flexibly' in a 'safe and healthy' way. Four scores remain static, and 3 have declined from 2024: these include 'having a voice', 'always learning' and 'staff engagement'.

Compassion and inclusion remains the highest of our outcomes, potentially a positive result of our well-established 'safe and inclusive working environment' and 'Kindness and Civility' programmes.

The 2025 results show decreases across our Vision/Pillar metrics, with a 3.4% decline in the organisation being recommended as a place to work. This is likely to be a reflection of the operational and financial pressures with which the organisation is currently grappling, alongside a wider social narrative around NHS productivity and expenditure.

Question	Metric type	2024 Result	**2025 Result**	% to LY	Comparator
I would recommend my organisation as a place to work….	Pillar	63.6%	**60.2%**	-3.4	*56.3%*
Organisation acts fairly towards career progression	Pillar	Not available	**50.9%**	-	*53.3%*
Not experienced discrimination from Manager/team leader or other colleagues	Pillar	91.7%	**91.6%**	-0.1	*91.2%*
Satisfied with extent organisation values my work	Breakthrough	42.9%	**41.6**	-1.3	*41.9%*

Comparator score is the average response for Picker

	2024	**2025**		*Comparator*
We are compassionate and inclusive	7.4	**7.4**	→	*7.3*
We are recognised and rewarded	6.0	**6.0**	→	*5.9*
We each have a voice that counts	6.7	**6.6**	↓	*6.6*
We are safe and healthy	6.0	**6.1**	↑	*6.1*
We are always learning	5.6	**5.5**	↓	*5.6*
We work flexibly	6.2	**6.3**	↑	*6.2*
We are a team	6.8	**6.8**	→	*6.7*
Staff engagement	6.9	**6.8**	↓	*6.7*
Morale	5.9	**5.9**	→	*5.8*

Successes and challenges for RUH

Most improved:

Reporting and reduction in negative experiences: In 2025/26 we worked to further embed our Violence Prevention and Reduction Policy, and to increase reporting using Report+Support.

Most Declined:

There is an emergent theme around availability and support for developing in role/skills and broader career development. This is almost certainly related to the temporary challenges in releasing colleagues from duties and obtaining funding for bespoke programmes of development.

Positive outliers:

We are above the Picker average on various measures, related to colleagues being polite and civil to eachother, being able to make impactful suggestions, making Reasonable Adjustments and feeling confident that the organisation provides good patient care.

Negative outliers:

We are currently falling below the Picker average in terms of learning from incidents and taking action following reporting. Colleagues continue to struggle to meet conflicting demands (resulting in unpaid overwork), which again is likely to be related to the current sustainability context.

Most Improved Scores	Org 2025	Org 2024
Last experience of physical violence reported	73.7%	69.4%
Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	46.8%	42.6%
Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76.7%	73.7%
In last 3 months, have not come to work when not feeling well enough to perform duties	47.2%	44.4%
Achieve a good balance between work and home life	55.5%	52.9%

Top 5 scores vs Organisation Ave	Org	Picker
If friend/relative needed treatment would be happy with standard of care provided by organisation	66.1%	60%
Disability: organisation made reasonable adjustment(s) to enable me to carry out work	78.2%	73.1%
Colleagues are understanding and kind to one another	73.4%	68.5%
Able to make suggestions to improve the work of my team/dept	74.6%	69.9%
Colleagues are polite and treat each other with respect	74.1%	69.6%

Most Declined Scores	Org 2025	Org 2024
Care of patients/service users is organisation's top priority	69.5%	75.1%
There are opportunities for me to develop my career in this organisation	49.2%	54.7%
Able to access the right learning and development opportunities when I need to	55.4%	60.3%
Organisation ensure errors/near misses/incidents do not repeat	61.6%	66.4%
Have opportunities to improve my knowledge and skills	65.8%	70.5%

Bottom 5 scores vs Organisation Ave	Org	Picker
Feedback given on changes made following errors/near misses/incidents	53%	59.3%
Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	46.8%	52.3%
Organisation ensure errors/near misses/incidents do not repeat	61.6%	65.7%
Able to meet conflicting demands on my time at work	43%	46.5%
Last experience of harassment/bullying/abuse reported	50.4%	53.7%

WRES and WDES for RUH

24% of respondents have a disability

This is an increase from 23.6% in 2024

21.4% of respondents are Global Majority

This is a decrease from 21.5% in 2024

Question	Trust	White staff	BME staff	Without a long-term condition	With a long-term condition
q16a: Not experienced discrimination from patients/service users, their relatives or other members of the public	91%	96%	73%	90%	91%
q16b: Not experienced discrimination from manager/team leader or other colleagues	92%	94%	82%	93%	88%

We have seen a very slight decline in response rates for colleagues from the Global Majority, which is likely related to our overall response rate reduction.

Despite an overall response rate reduction, we have seen a slight increase in responses from colleagues with a disability and/or a long-term health condition. This may be linked to the 2024/25 Breakthrough Objective focus on programmes such as Working with Cancer, reasonable adjustments and improving accessibility.

The ENABLE network remains our most engaged and active staff network.

For Reference 2025: Q31b: Organisation made reasonable adjustments to enable me to carry out my work (78.2%, up 0.8% from 2024 and 5.1% higher than the Picker average)

Staff with a Disability

- Disabled staff report generally strong manager support and team cohesion, and high levels of trust and clarity in roles, indicating a solid foundation for inclusion.
- Despite good access to adjustments, experience gaps remain, with disabled staff reporting lower scores in job satisfaction, feeling valued, wellbeing, and involvement in change compared to non-disabled staff. Variation across divisions indicates inconsistent delivery of adjustments and support, requiring more targeted action.

Staff from the Global Majority

- Global Majority staff often report stronger engagement indicators, including higher enthusiasm, trust in their role, and access to development opportunities.
- There is lower confidence that the organisation will act on concerns, alongside ongoing exposure to harassment or discrimination from patients/public.
- Persistent issues exist around pay satisfaction, work-life balance, and workload, which are consistently lower across Global Majority groups

RUH – Next Steps

- The RUH has seen in an increase in sickness absence and the staff survey provides further context around our colleagues health and well-being and key areas for improvement.

- Staff comments highlight that while wellbeing offers (like classes, hubs, and events) are appreciated, **core working conditions** are the biggest determinants of wellbeing. This impacts the absence rates and willingness for staff to return to work after sickness.

- Ongoing improvements to appraisals through enhancing their value to individuals and their teams, will continue. This will strengthen our position regarding staff feeling the organisation values their work.

Divisional Response Plans

Surgery Divisional Priorities

- **Leading on deep dive into MSK sickness**
- Data analysis done reviewing MSK and Back problem sickness absence against staff survey and training compliance. Hot spot areas identified: theatres, T&O and General surgery. Next steps is to link in with hot spot areas and discuss the data, in addition discussing findings at healthier workforce group

- **Embed learning from cases and situations**
- Fully recruit to patient safety team
- Re introduce safety briefings which shares learning of cases

- **Improve the culture of the division to report harassment and abuse.**
- Embedding and raising the profile of the policy - discuss the policy in divisional board
- Tea trolley discussions
- Go and see visits
- Civility saves lives campaign in theatres

	Comparator (Organisation Overall)	Surgical Division 2024	Surgical Division 2025	Variance
Description	n = 3335	n = 779	n = 727	
In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	61.7%	64.8%	55.5%	-9.3%
Organisation ensure errors/near misses/incidents do not repeat	61.6%	68.9%	61.7%	-7.3%
Last experience of harassment/bullying/abuse reported	50.4%	53.8%	46.6%	-7.2%
Feel organisation would address any concerns I raised	46.9%	48.2%	41.6%	-6.6%
Feedback given on changes made following errors/near misses/incidents	53.0%	59.1%	53.5%	-5.6%

Detailed action plans for each speciality have been done and actions will be monitored through PRMs.

Urology

- Workload, Time Pressures
- Work – Life balance
- Emotional Exhaustion and Burnout
- Career Progression
- Retention
- Speaking up and Patient Safety

Surgery Management

- increasing confidence that the divisional team will address concerns about unsafe clinical practice.
- To continue to embed improving together
- To improve on providing clear feedback
- OD programme to improve working relationships and capacity planning.

Pathology

- Improving working relationships within the team
- Encourage speaking up

Ophthalmology

- Improving opportunities for people to make changes to role and department
- Improve health and wellbeing of team including team dynamics.

OMFS	ENT	T&O	ICU
• Focus on Appraisal quality	• Workload, Time Pressures • Work – Life balance • Emotional Exhaustion and Burnout • Career Progression • Retention • Speaking up and Patient Safety	• Improve staff relationships to ensure everyone treats each other with respect. • Deep dive MSK injuries, often linked to manual handling and work demands.	• Reducing discrimination • Acts fairly on career progression

FASS Staff Survey – Actions Summary

Divisional Priorities:

Wellbeing & burnout - investment in services (e.g. haem and onc) and HR support on sickness

Appraisals - the value for individuals beyond the proforma tick box

By Exception - working relationships & working as a team

Oncology:
Area of focus: Wellbeing, value, listening culture, work life balance.
Actions:
- Implement consistent use of TOIL to recognise additional hours worked.
- Improvement in break culture and planning and monitoring.
- Directorate meeting repurposed to celebrate achievements and gather feedback from colleagues.
- Charity support for Café in DCC footprint
- Facilitate access to 1:1 and group sessions re reflection and resilience.

Breast Unit:
Area of focus: Improving appraisal quality, have a voice to make improvements at work, improve working relationships.
Actions:
- Re train staff who undertake appraisals.
- Re instate improvement huddles
- Away days being booked in with one in July.

Paediatrics and NICU:
Area of focus: Lack of supplies and equipment, violence and aggression, recognition and value, flexible working
Actions:
- Surveyed team, identified lack of medical consumables. Reviewing availability and solutions.
- Reviewing violence and aggression findings from previous work at departmental meeting to agree additional actions.
- Focus on appraisal and line manager feedback quality.
- Reviewing current shift patterns and flexibility available to colleagues across teams.

FASS Management Team:
Area of focus: Fairness, understanding role
Actions:
- Escalation of banding review
- Divisional finance session – complete
- 121 support and new starter expectations

Gynaecology:
Area of focus: Emotional exhaustion, burnout, harassment from patients, appraisal quality and quantity.
Actions:
Actions to Follow

Fatigue Services:
Area of focus: Materials to do my job, career progression, encourage raising concerns and share actions taken to address concerns.
Actions:
- Encourage CPD funding uptake
- Re share how to order stock and supplies
- Follow up on Datix submissions

Sexual Health:
Area of focus: Harassment and bullying from colleagues, errors, near misses and incidents and the treatment of staff that are involved.
Actions:
Actions to follow

Pharmacy:
Area of focus: Stress and burnout, kindness and civility, health and wellbeing.
Actions:
- A3 developed for departmental sickness rates.
- Use A3 thinking to address concerns around kindness and civility.
- Restart health and wellbeing departmental survey in order to understand and improve wellbeing.

Maternity Services:
Area of focus: Health and wellbeing, working as a team, Learning and development opportunities, have a say in what happens at work
Actions:
- Day in the life of different roles to improve understanding of different roles and responsibilities.
- Health and wellbeing board in coffee room
- Management leadership development opportunities and training.
- Re launch specialist interest group which focuses on sharing ideas and opportunities.

Radiology:
Area of focus:
Conflicting demands, time pressures, relationships, team working, managerial support
Actions:
- Acute team huddles between the MDT to prioritise work and ease facilitate work across the MDT.
- Quality improvement away afternoons for consultants.

Medical Physics:
Area of focus: Bullying and harassment amongst colleagues and from patients and relatives, appraisal quality and colleagues' perception of appraisal value.
Actions:
- Raising awareness within affected teams of Trust resources to tackle B&H and encouraging colleagues to come forward.
- All line managers to attend Trust appraisal training.
- Medical Physics appraisal survey to gather additional feedback on appraisals regarding what would make them more valued by the team.

Medicine Division Staff Survey Update - Actions

2025/26 Area of Focus: Violence and aggression experienced by colleagues from patients and relatives.

Q	Description	Comparator (Organisation	Emergency Medicine Divisio	Medical Division
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	86.0%	52.6%	77.0%
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76.7%	30.9%	67.2%
q14d	Last experience of harassment/bullying/abuse reported	50.4%	59.1%	53.2%

- Colleagues within the division experience higher levels of violence and aggression than elsewhere in the Trust. This is attributable to the services that sit within the division.
- However, the divisions response, tolerance and support provided when violence and aggression occurs is within out control.

Question		Organisation	Global Majority	White
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	86.0%	77.0%	82.0%
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76.7%	68.0%	78.0%
q14d	Last experience of harassment/bullying/abuse reported	50.4%	77.0%	72.0%

- Violence, aggression and harassment from service users is not experienced evenly by our colleagues based on ethnicity. Colleagues from the global majority are 5% more likely to experience violence and 10% more likely to experience harassment from patients, relatives and service users.
- However, global majority staff are more likely to report their experiences of violence.

Analysis and Actions:

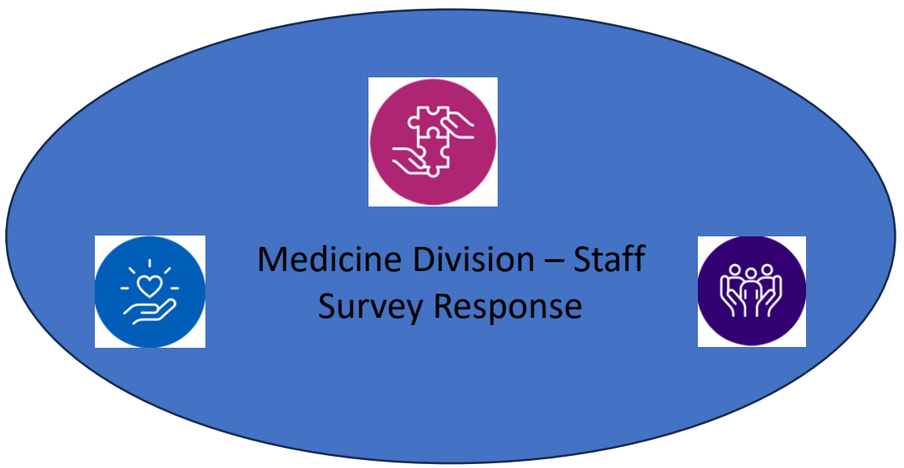
- Divisional hot spots for V&A are Parry, Haygarth, ED, Acute Med, OPU. Yet Parry and Haygarth in particular show low levels of reported violence (Datix).
- Analysis of security information shows Trust policy not routinely followed through the verbal and formal warnings.
- The division will be setting up a governance meeting with the areas of highest violence and aggression to review incidents, share learning and ensure appropriate processes are followed when violence occurs.
- Re-launch of Trust Violence Prevention and Reduction Policy in areas outlined above.
- Highlight discrepancy in experience of global majority colleagues as part of relaunch with ward teams and encourage action when V&A is reported.

Staff Survey – Specialty Analysis and Actions Summary

Acute Medicine:
Area of focus: Effective team working, burn out, value, conflicting demands, flexible working.
Actions:
- Listening events on SDEC and MSS re bed management and departmental procedures. Development of internal processes and SOP.
- Additional managerial support for MAU during absence.
- Recruitment to consultant vacancies.
- Trial of self rostering for M&D staff to commence September 26.
- Changes to SDEC shift pattern.

Dermatology:
Area of focus: Workload, burnout, recognition, value, appraisal, work-life balance and wellbeing.
Actions:
- Workload and job plan review addressing capacity gaps.
- Introduce local recognition programme linked to patient outcomes, service impact and feedback.
- Implement team forum and collect and respond to feedback – "you said we did".
- Appraisal to focus on staff development, career pathways and meaningful objectives/development goals.

Emergency Department:
Area of focus: Burnout, exhaustion, time pressures, wellbeing, team working.
Actions:
- Regular team briefs, visible leadership presence, clear governance and standardised ways of working.
- Staff voice strengthened through listening events, drop-ins, clearer communications and "you said, we did" feedback.
- Education, supervision and CPD expectations clarified, particularly for UTC practitioners.
- Operational friction reduced through clearer roles (e.g. NIC), improved rostering processes, and agreed UTC streaming and exclusion criteria.
- Culture and behaviours reinforced through civility discussions, leadership involvement and visible Trust values.



Endocrine:
Area of focus: Wellbeing and fatigue, responding to concerns, career development, staffing availability.
Actions:
- Listening events to be undertaken re wellbeing an fatigue to understand needs across the dept.
- Improvement huddles re-instated to address staff feedback and concerns
- Protected time to attend relevant professional forums (e.g. admin forum), focus on appraisal quality.
- Skill mix reviews across departments to ensure best use of resource.
- Review of pathways and introduction of innovative solutions where appropriate (e.g. PIFU, groups clinics).

Cardiology:
Area of focus: Leadership and listening, operational friction, team culture.
Actions:
- Structured listening sessions across Cariology teams.
- "You said we did" tracker to describe and communicate actions.
- Review of non-value adding tasks.
- Implement protected time for delivery of core work (admin team).
- Huddles – recognition of improvements and high performance and sharing of positive feedback amongst team.

Hospital At Home:
Area of focus: Resources and staffing, workload and burnout, wellbeing and retention, harassment from patients and relatives.
Actions:
- MABO training for relevant staff members
- Service identity development and recognition within the organisation.
- Focus on wellbeing and staff development through appraisal cycle.
- Weekly team meetings with wellbeing discussions and opportunity for escalation of concerns.

Staff Survey – Specialty Analysis and Actions Summary

Neurology:
Area of focus: Violence and aggression from patients, welllbeing, learning availability, acting on concerns.
Actions:
- Re-launch V&A policy and post incident support for those affected by violence and aggression.
- Protect CPD time and encourage use of CPD funding, protect supervision time.
- Share feedback from directorate governance processes with the team and outline actions taken.
- Embed regular staff engagement forums and feedback via “you said we did”.

OPU:
Area of focus: Time pressure and staffing availability, effectiveness of team managers.
Actions:
- Bed base review to align demand with capacity (UEC Strategy).
- Leadership development for managers through Trust leadership offering.
- Focus on sickness management to reduce sickness absence, support colleagues and increase wellbeing amongst colleagues.

Rheumatology:
Area of focus: Safety and wellbeing, recognition, engagement and feedback to colleagues.
Actions:
- Introducing regular wellbeing check ins, particularly for clinical staff.
- Review of job plans and clinic intensity following demand increase.
- Formalise departmental recognition through celebration of excellence and team achievements.
- Use MDT and team meetings to discuss staff survey outcomes and actions, feed back changes via you said we did.

Stroke:
Area of focus: Safety and wellbeing, workforce capacity and resourcing, speaking up and recognition.
Actions:
- Strengthen use of violence reduction policy through re-training, incident follow up and security support.
- Ensure a leader always present to support staff following a serious incident.
- Review skill mix and resource deployment across the MDT.
- Formalise departmental celebrations and awards.
- Share staff survey feedback and actions with team.

Therapies:
Area of focus: Adequate materials and supplies, burnout, conflicting demands, learning and development opportunities, recognition.
Actions:
- Focus groups to identify opportunities and act re materials and supplies.
- AHP Job planning project to clarify roles, responsibilities to help meet conflicting demands and burnout.
- Review NHS recognition framework and map current standards to identify opportunities.

Respiratory:
Area of focus: Workload, burnout, exhaustion, harassment and discrimination from patients and relatives, management feedback and involvement in decision making.
Actions:
- Recruitment to consultant vacancies and current ward establishment.
- Delivery of MABO training and re-launch of Trust V&A policy amongst relevant teams.
- Feedback on individual and departmental performance included in 1:1.

Gastroenterology
Area of focus: Time pressure and conflicting demands, burnout, ward processes, leadership and development.
Actions:
- Comprehensive ward action plan developed to support ward team, focussing on leadership, rostering, people management and communication .

Estates and Facilities Staff Survey Action Plan

Priority 1: Workforce Capacity & Workload

- Recruitment and retention plan- Cleaning recruitment plan and recruitment replace process efficiencies.
- Workload and process review- CSR/ SLA's being created with Trust.
- Improved rota and capacity management- Oncall review and rostered periods.

Priority 2: Wellbeing & Burnout

- Wellbeing programme- Wider Trust review and Department plans linked to Divisional BTO.
- Manager training- People Hub training and support.
- Reduction in unpaid additional hours- review workload/ capacity ratio on department level.

Priority 3: Engagement & Recognition

- "You Said – We Did" framework- Department/Directorate Staff Survey action plans
- Staff involvement in decisions- Increased team meetings, Manager 121's
- Recognition programme- Facilities newsletter, Employee of the month and E&F Forum.

	Estates and Facilities Division (2025)	Estates and Facilities Division (2024)	
Last experience of harassment/bullying/abuse reported	57.5%	43.84%	13.66% ↑
Teams within the organisation work well together to achieve objectives	54.6%	43.88%	10.72% ↑
Staff involved in an error/near miss/incident treated fairly	54.7%	45.50%	9.2% ↑

	Estates and Facilities Division (2025)	Estates and Facilities Division (2024)	
In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	54.3%	70.65%	-16.35% ↓
Don't work any additional paid hours per week for this organisation, over and above contracted hours	60.8%	70.59%	-9.79% ↓
Organisation acts fairly: career progression	41.8%	51.09%	-9.29% ↓

Corporate Division

Priority 1: Rebuild Engagement & Sense of Purpose

Priority 2: Improve Cross-Division Working

Priority 3: Strengthen Speak-Up Culture & Trust

Priority 4: Enhance Career Development & Learning

		Locality 1	Comparator (Organisation Overall)	Corporate Division
Section	Q	Description	n = 3335	n = 453
YOUR MANAGERS	q9a	Immediate manager encourages me at work	73.7%	76.8%
	q9b	Immediate manager gives clear feedback on my work	65.5%	70.4%
	q9c	Immediate manager asks for my opinion before making decisions that affect my work	62.6%	69.0%
	q9d	Immediate manager takes a positive interest in my health & well-being	73.3%	78.1%
	q9e	Immediate manager values my work	75.1%	80.8%
	q9f	Immediate manager works with me to understand problems	71.5%	77.7%
	q9g	Immediate manager listens to challenges I face	74.7%	78.3%
	q9h	Immediate manager cares about my concerns	74.4%	78.5%
	q9i	Immediate manager helps me with problems I face	69.0%	73.2%
YOUR ORGANISATION	q25a	Care of patients/service users is organisation's top priority	69.5%	67.7%
	q25b	Organisation acts on concerns raised by patients/service users	66.3%	61.3%
	q25c	Would recommend organisation as place to work	60.2%	51.0%
	q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	66.1%	61.9%
	q25e	Feel safe to speak up about anything that concerns me in this organisation	61.1%	56.1%
	q25f	Feel organisation would address any concerns I raised	46.9%	42.7%
	q26a	I don't often think about leaving this organisation	43.3%	37.8%
	q26b	I am unlikely to look for a job at a new organisation in the next 12 months	53.3%	44.2%
	q26c	I am not planning on leaving this organisation	59.2%	52.3%

Trust level Priorities 2026-27

Priority	Main Focus	NHS People Promise Alignment
Safe, Healthy & Respectful Workplace	Violence & aggression reduction, reporting, civility, inclusion	We are safe and healthy; We each have a voice that counts; We are always learning
Workforce Capacity, Workload & Wellbeing	Recruitment, workload and rota review, TOIL, burnout and MSK support	We are safe and healthy; We work flexibly; We are recognised and rewarded
Leadership, Engagement & Feeling Valued	Line management, staff voice, recognition, fairness and role clarity	We each have a voice that counts; We are recognised and rewarded; We are a team; We are compassionate and inclusive

Actions

Action	Owner	Due Date	Status
Set up and map out Healthier Workforce Programme to enable improvement works around Workforce Capacity, Workload & Wellbeing	Matt Foxon/ Nick Horwood/ DDoNs	End of June 26	In progress
Freedom to speak up to join Staff Survey Task and Finish group and develop clear a clear action plan to raise speaking up within the organisation and incorporating feedback loop for learning	Amanda Wylie/ FTSU Guardian	TBC	Planned
Audit the consistency of Datix feedback/learning response to all staff groups. Where gaps, review mitigation to ensure feedback loop is consistent and clear	Jamie Caulfield/ Nick Horwood/ Fiona Barnard	End of September 26	Planned
Monthly Divisional Review of Staff Survey Improvement works/ BTO	Divisional Leads / People Partners	Feb 27	In progress
Review Discrimination and Poor Experience of Staff- focusing on WRES and WDES results	EDI Lead/ Head of Culture/ DPP's	Sep 26	Planned
Set up Your Voice Matters working group/network	EDI Lead / OD/ DPP's	Sep 26	Planned

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National Staff Survey 2025

Public Board Presentation

15th Jun 2026

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Results and Analysis

Public Board Presentation

15th Jun 2026

SFT Response Rate

Down 6% on 2024, but remains above national average

Salisbury NHS Foundation Trust

4667	4624	**53%**	48%	59%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (2472)	Average response rate for similar organisations	SFT previous response rate

By Staff Group we saw a significant reduction (>5%) from 2024 rates:

- Medical and Dentistry was 43.7% – down 8.7%
- Nursing and Midwifery was 60.7% – down 5.9%
- Additional Clinical Services was 40% - down 5.7%

Specific attention was paid to engaging Additional Clinical Services and Medical and Dental staff, historically the lowest engaging groups. Paper surveys were used for ACS and specific engagement through Resident Doctor and other medical forums was used in addition to routine advertising through comms bulletins

Staff Group	Eligible Sample	Respondents	Response Rate
ADMINISTRATIVE AND CLERICAL	1080	732	67.8%
ALLIED HEALTH PROFESSIONALS	276	186	67.4%
ESTATES AND ANCILLARY	287	182	63.4%
ADD PROF SCIENTIFIC AND TECHNIC	257	147	57.2%
NURSING AND MIDWIFERY REGISTERED	1369	740	54.1%
HEALTHCARE SCIENTISTS	87	44	50.6%
MEDICAL AND DENTAL	592	209	35.3%
ADDITIONAL CLINICAL SERVICES	676	232	34.3%

People Promise overview

The staff survey questions were aligned against the people promise pillars in 2021.

	2024	**2025**	*Comparator*
 We are compassionate and inclusive	7.4	**7.3**	7.3
 We are recognised and rewarded	6.1	**5.9**	5.9
 We each have a voice that counts	6.8	**6.7**	6.6
 We are safe and healthy	6.3	**6.2**	6.1
 We are always learning	5.7	**5.5**	5.6
 We work flexibly	6.4	**6.3**	6.2
 We are a team	6.9	**6.7**	6.7
 Staff engagement	7.1	**6.9**	6.7
 Morale	6.1	**5.9**	5.8

2024 survey results for SFT were the best experienced for a number of years. In 2025 these results have reduced across every category, but maintained broad parity against the average of comparator Acute Trusts in England.

A challenging financial position, increased operational activity, major NHS restructuring and external headwinds, including cost of living crisis have contributed to a general downturn in results not only in SFT, but across the NHS.

Free text comments on the survey identified that staff felt the impacts of the financial position and increased recruitment control keenly, which in turn led to an erosion of value felt by staff.

SFT saw a 0.2 value drop against ‘We are rewarded and recognised’, ‘We are always learning’ and We are a Team’, as well as for Staff Engagement and Morale.

‘We are always learning’ is the only category below the National Average.

Best and Worst scores

The tables below provide a snapshot of the questions which provided the best and worst responses to the survey and outlying performance against the National Average

NHS Salisbury NHS Foundation Trust

Top 5 scores vs Organisation Average	Org	Picker Avg
q3e. Involved in deciding changes that affect work	55.1%	48.7%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	49.9%	44.6%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	78.3%	73.1%
q3f. Able to make improvements happen in my area of work	58.5%	53.7%
q2a. Often/always look forward to going to work	56.6%	52.2%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q7d. Team members understand each other's roles	68.2%	71.2%
q19d. Feedback given on changes made following errors/near misses/incidents	55.7%	59.3%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	63.1%	66.8%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	48.0%	52.3%
q23a. Received appraisal in the past 12 months	82.3%	88.3%

Most improved scores	Org 2025	Org 2024
q23a. Received appraisal in the past 12 months	82.3%	80.0%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	86.8%	85.5%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	92.2%	91.1%
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	64.4%	63.4%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	49.9%	48.9%

Most declined scores	Org 2025	Org 2024
q26c. I am not planning on leaving this organisation	55.9%	61.4%
q24d. Feel supported to develop my potential	54.6%	61.1%
q3i. Enough staff at organisation to do my job properly	28.8%	35.4%
q24b. There are opportunities for me to develop my career in this organisation	49.9%	56.8%
q25c. Would recommend organisation as place to work	59.5%	66.9%

Vision metric - Staff Engagement

Increasing Staff engagement – remains above Picker average but fallen from 7.1 to 6.9

NHS Salisbury NHS Foundation Trust

	Motivation	Historical 2021	2022	2023	2024	2025	External Average	Organisation
q2a	Often/always look forward to going to work	52%	52%	58%	62%	**57%**	52%	**57%**
q2b	Often/always enthusiastic about my job	66%	66%	70%	73%	**68%**	66%	**68%**
q2c	Time often/always passes quickly when I am working	74%	75%	75%	75%	**72%**	70%	72%

	Involvement	Historical 2021	2022	2023	2024	2025	External Average	Organisation
q3c	Opportunities to show initiative frequently in my role	74%	74%	76%	78%	**74%**	72%	74%
q3d	Able to make suggestions to improve the work of my team/dept	72%	74%	75%	76%	**74%**	70%	**74%**
q3f	Able to make improvements happen in my area of work	52%	55%	58%	60%	58%	54%	**58%**

	Advocacy	Historical 2021	2022	2023	2024	2025	External Average	Organisation
q25a	Care of patients/service users is organisation's top priority	76%	70%	76%	76%	**72%**	70%	72%
q25c	Would recommend organisation as place to work	57%	51%	60%	67%	**59%**	56%	**59%**
q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	69%	56%	63%	65%	**61%**	60%	61%

While averages are falling nationally, SFT has seen a more significant fall in some key questions.

- Often/always looking forward to going to work has fallen at SFT by 5% - while average has fallen by 2%
- Would recommend organisation as a place to work has fallen at SFT by 8% - while national average fall is 3%
- Would be happy with standard of care provided has fallen at SFT by 4% - while national average fall is 1%.

Vision Metric – Staff Retention

Salisbury NHS Foundation Trust

Increasing staff retention – staff NOT thinking about leaving the organization has declined from 61% to 56% - remains 1% above Picker average

Thinking about leaving

		Historical					External	
		2021	2022	2023	2024	2025	Average	Organisation
q26a	I don't often think about leaving this organisation	40%	39%	43%	47%	**44%**	42%	44%
q26b	I am unlikely to look for a job at a new organisation in the next 12 months	49%	47%	51%	56%	**51%**	51%	51%
q26c	I am not planning on leaving this organisation	56%	55%	59%	61%	**56%**	55%	56%

All three staff survey questions relating to thinking about leaving scored significantly worse that in 2024. Notwithstanding these results, the answers have not generated significant action. Staff retention rates have continued to gradually improve, as measured through the IPR data. At the time of the survey in November 2025 retention was measured at 12.4% compared to a measure of 11.8% for May 25.

The current economic position, combined with uncertainty surrounding organisational change may also have a bearing on retention rates at SFT at this time.

Vision Metric – Staff Inclusion

NHS Salisbury NHS Foundation Trust

Staff are treated equitably – the measure is the People Promise compassionate culture – made up of a number of questions. The overall score has declined and is now at the national average

	Compassionate Culture	Historical 2021	2022	2023	2024	2025	External Average	Organisation
q6a	Feel my role makes a difference to patients/service users	88%	88%	88%	89%	87%	88%	87%
q25a	Care of patients/service users is organisation's top priority	76%	70%	76%	76%	72%	70%	72%
q25b	Organisation acts on concerns raised by patients/service users	68%	62%	69%	71%	68%	67%	68%
q25c	Would recommend organisation as place to work	57%	51%	60%	67%	59%	56%	59%
q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	69%	56%	63%	65%	61%	60%	61%

	Compassionate leadership	Historical 2021	2022	2023	2024	2025	External Average	Organisation
q9f	Immediate manager works with me to understand problems	65%	66%	68%	73%	69%	69%	69%
q9g	Immediate manager listens to challenges I face	67%	68%	72%	75%	72%	71%	72%
q9h	Immediate manager cares about my concerns	67%	68%	70%	74%	70%	70%	70%
q9i	Immediate manager helps me with problems I face	61%	62%	65%	70%	68%	67%	68%

	Diversity and equality	Historical 2021	2022	2023	2024	2025	External Average	Organisation
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	92%	94%	93%	91%	92%	91%	92%
q16b	Not experienced discrimination from manager/team leader or other colleagues	91%	92%	91%	92%	92%	91%	92%
q21	Feel organisation respects individual differences	67%	67%	71%	74%	72%	70%	72%

Vision metric – Staff Inclusion

Salisbury NHS Foundation Trust

	Inclusion	Historical 2021	2022	2023	2024	2025	External Average	Organisation
q7h	Feel valued by my team	68%	67%	71%	72%	70%	69%	70%
q7i	Feel a strong personal attachment to my team	62%	63%	66%	65%	63%	63%	63%
q8b	Colleagues are understanding and kind to one another	67%	69%	72%	72%	68%	69%	68%
q8c	Colleagues are polite and treat each other with respect	69%	70%	72%	73%	68%	70%	68%

Scores at SFT fell against most aspects of the Staff Inclusion vision metric – in some cases faster than the average. For example, *Colleagues are understanding and kind to one another* has fallen at SFT by 4% - the average is a 1% fall.

There was no significant change to answers within the Diversity and Equality sub-set, which demonstrated a small increase in response to the question relating to discrimination from service users and members of the public.

Our scores against questions relating to compassionate leadership and compassionate culture were all significantly lower than last year. This is a concern and will be addressed through actions at Trust and Divisional level and through the WRES/WDES action plans.

Strategic Initiative

Creating a Sustainable Workforce – staff feeling there were enough staff has fallen by 6% and is below the Picker average

		Historical					External	
		2021	2022	2023	2024	2025	Average	Organisation
q3i	Enough staff at organisation to do my job properly	20%	20%	29%	35%	29%	31%	29%

2024 saw a leap in this metric, but our 2025 results demonstrate a return to 2023 scores of 29%, likely due to concerns relating to the financial position of the Trust and the resultant workforce controls put in place. It is worth noting that at the time of the survey in Nov 2025, vacancies within the Trust were showing as -5%, indicating that there were more staff in post across the Trust than on the establishment.

It is nevertheless concerning that nearly two thirds of the organisation do not believe that there are routinely sufficient staff to manage work requirements.

Free Text Comments - Analysis

NHS Salisbury NHS Foundation Trust

The qualitative data from the 2025 staff survey reveals a profound sense of pride in clinical excellence and strong "on-the-ground" peer support, but there are systemic frustrations. The prevailing sentiment is negative, characterised by a perceived disconnect between senior leadership and frontline realities. The primary drivers of dissatisfaction are the current recruitment controls, the implementation of change programmes and a perceived "culture of favouritism."

Key themes from analysis include:

Workforce & Recruitment Strategy

- The "Admin Freeze" Paradox: Staff report that this is counter-productive, as clinicians (Bands 7/8) are now performing admin tasks, which is both cost-ineffective and risks clinical burnout.
- Skill Underutilisation: Suggestions the Trust is "blind" to the existing skills of its workforce (e.g., Band 3s with over-qualification), opting to hire externally rather than developing internal talent.
- International Staff Integration: Concerns were raised regarding the 2-week annual leave cap, which prevents international staff from visiting family, impacting retention and mental health.

Leadership and Management Culture

- Middle Management Bloat: A recurring theme is the perception of "too many layers" of management (specifically Matrons and middle managers) who are seen as duplicating work or "micromanaging" without adding clinical value.
- Transparency and Trust: Significant distrust exists regarding the merger with Bath and Swindon. Staff feel these decisions are "done unto them" rather than "with them."
- "Who You Know" Culture: There are explicit allegations of favoritism in promotions and training opportunities, with some staff describing the environment as "toxic" or "clique-driven."

Free Text Comments – Analysis (cont)

Salisbury NHS Foundation Trust

Operational Pressures & Safety

- Systemic Exhaustion: Staff describe "firefighting" and "panic" during OPEL 4 states. There is a specific concern regarding "boarding" patients in unsafe areas to meet management targets.
- Clinical/Management Disconnect: Clinical staff feel that managers do not understand the physical and emotional toll of their roles, citing examples like restrictive Christmas leave policies that do not apply to non-clinical management.

Infrastructure and Wellbeing

- Digital Inefficiency: IT systems are cited as a major drain on productivity, with staff arriving 15–20 minutes early just to log into essential applications.
- Basic Needs: There is high dissatisfaction with the removal of some food options (eg, M&S closure) and the quality/availability of the salad bar in "Springs."

The table to the right provides a summary of Key findings from the analysis of free text comments

Metric	Status	Key Driver
Peer Support	High	Strong bonds within immediate clinical teams.
Trust in SLT	Low	Lack of visibility and perceived financial-first focus.
Morale	Low	Burnout, recruitment freezes, and "goodwill" exhaustion.
Career Growth	Stagnant	Perceived lack of transparent pathways.

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Action Plans

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Trust Actions

Salisbury NHS Foundation Trust

Current Projects and workstreams in place as a result of previous Staff Survey and other identified requirements will be maintained and include

- **People Promise Projects** – IEN development; Recognition SOX and Awards Review; Reduce detriment after Speaking Up; Appraisals Update; Team Based Rostering; Licence to manage; Flexible Working group actions
- **WRES/WDES Action Plan** – Group Inclusion Questionnaire; Support for IEN; Enhance reach and impact of Networks; Promote Health Passport awareness and use; reduce relative likelihood of disabled staff entering formal capability/absence processes.
- **Gender Pay Gap** – Female staff seeking coaching/training to achieve promotion into top quartile.
- **Improving the Working lives of Doctors** – 10 Point Plan actions

Actions plans are being developed to address Compassionate Culture and Leadership issues through use of our Leadership Behavioural Framework and in house leadership programmes

The impact of financial planning is already being addressed through a new series of engagement with staff led by the MD, and improved communication through the CI/Transformation Cell

Corporate Services

Salisbury NHS Foundation Trust

Impacts

Turnover is showing an upwards trend in Corporate and is currently 14.48% which is the highest rate since Feb 2024, when it was as 12.64% (earliest data in report). The lowest rate was February 2025, just ahead of the CSR news landing.

A reliance on temporary, **fixed term contracts** is creating a more flexible but less permanent workforce, with potential for any investment in training and onboarding of FTC employees being lost at 6 -12 months as substantive vacancies are filled via the redeployment of displaced staff during the CSR change programme.

Sickness is higher than this time last year; March 2026 shows sickness absence at 3.55% for Corporate compared to 2.51% Mar 2025. Anxiety/stress/depression remains the highest reason for days lost by sickness (Corporate: 348 FTE days in Feb 2026) 5.55% for Facilities compared to 2.92% Mar 2025 and 6.90% for Estates compared to 3.50% Mar 2025.

Concern over **career development** opportunities and personal development training.

Corporate Teams Action Planning

Salisbury NHS Foundation Trust

Due to the current contextual complexities of Corporate there will be a collective focus on one shared area for improvement

"We are always learning"

This will mean that efforts can be shared and coordinated so that we are realising the benefits of a collective approach and reducing duplication in line with the current strategic vision being shared at Group.

With OD&L support, Corporate teams will be looking at the levers that would help with moving the dial on 'We are always learning' for their staff and how we can engage effectively with the differing employee personas within SFT.

The 2 days of Tent Talks provided an immediate and informal opportunity to promote learning at no added cost.

Medicine Division

Salisbury NHS Foundation Trust

Impacts

- Staff in the medicine division report that they experience a high level of burnout and are under extensive pressure in their work. They report that this leads to a higher number of negative incidents and experiences.
- Staff in the medicine division report that they don't feel they always work in a safe and healthy environment and that the health and safety culture could be improved.
- Although reports of appraisal compliance and learning culture is much greater in the medicine division compared to the organisation, staff continue to report that they don't feel that there is a learning culture across the team and appraisals are not completed.
- Overall, a morale score lower than the rest of the organisation

Medicine Division – Agreed Actions

NHS Salisbury NHS Foundation Trust

Medicine focusing on 3 main areas:

- Priority area 1: We are Safe and Healthy/Burnout
- Priority area 2: We are Safe and Healthy/Negative experiences at work
- Priority area 3: Morale/Communication

DMT agreed actions

1. **Wellbeing trolley** – staffed by DMT & volunteers, planned prgramme of areas to cover, wellbeing information packs and refreshments. Enables DMT and management teams to engage with staff informally, showing presence and care.

2. **Monthly e-bulletin: to all Division -** Content to include Divisional changes, DMT profile, achievements, Wellbeing quote with QR code, gym timetable.

3. **Monthly Cascade briefing on Teams** - Use Teams "townhall function" to support Q&A, 1st session in July after DPRM.

4. **Violence and Aggression Prevention and Response** – Staff Training

5. **Poster Campaign** - OH and Wellbeing posters on Burnout, Vivup posters in all areas

Medicine Division – Planned Actions

NHS Salisbury NHS Foundation Trust

Ref	Action
2026.NSS.1	Develop an appraisal programme to ensure tracking and compliance against appraisal target
2026.NSS.2	Provide specific resource to ED and Acute Medicine team to achieve appraisal compliance
2026.NSS.3	Develop engagement strategy for the division to improve communication across teams
2026.NSS.4	Develop rolling away-day programme for the Emergency Medicine, Acute Medicine, and Stroke teams and provide backfill
2026.NSS.5	Create career progression document outlining career pathway for each role in the division
2026.NSS.6	Refresh patient warning and exclusion policy and develop programme to manage and track compliance
2026.NSS.7	Develop model to support staff to raise concerns about patient behaviour and receive more timely feedback
2026.NSS.8	A review of nursing, medical, and admin staffing levels against demand to be completed to ensure that staffing levels are consistent across teams
2026.NSS.9	Productivity analysis to be developed for the division to ensure that teams with the highest levels of burnout are support
2026.NSS.10	Specific wellbeing support to be developed for ED, acute medicine, and stroke teams
2026.NSS.11	Estates review and regular walk-arounds to be completed to ensure environment meets required standards
2026.NSS.12	Feedback loop and ‘learning from incidents live bulletin’ to be developed to ensure staff get responses from incident reporting and learning is captured
2026.NSS.13	Consider ways to expand flexible working options including annualised hours contracts
2026.NSS.14	Introduce greater consistency of go-and-see
2026.NSS.16	Implement monthly wellbeing rounds and develop Schwartz rounds
2026.NSS.17	Review options for local peer-nominated recognition system
2026.NSS.18	Implement ‘stay interviews’ for staff to consider career options and plans

Surgery Division

Salisbury NHS Foundation Trust

Impacts

RECOGNITION – recognition for good work, manager / organisation values my work:

- Orthopaedics (Amesbury).
- Surgery Management and Support (all locality 3s).
- Urology (insufficient responses for locality 3 breakdowns).

LEARNING – feeling supported to develop my potential:

- GI Unit (Clinical Gastroenterology, Endoscopy Nursing).
- Plastics (Plastics Outpatients).
- Surgery Management and Support (Central Booking, Receptions, Central Admin).

MORALE – realistic time pressures, choice how to do my work, strained relationships at work:

- Plastics (Plastics Outpatients).
- Surgery Management and Support (Central Booking, Receptions, Surgery Management).
- Urology (insufficient responses for locality 3 breakdowns).

Surgery Division - Actions

Salisbury NHS Foundation Trust

Use clinical governance half days for go and sees to Plastics OP and Endoscopy Nursing to hear from staff what would make a difference to their feelings about support for career development.

A3 group to inform counter measures about improving appraisals and developmental 1:1s. Share monthly appraisal data to track progress with compliance and enable a trajectory to be built to enable a ‘return to green’ for medical and non-medical appraisals.

Socialise and use the Improving Together ‘Pink Ticket’ process to better recognise staff achievements at PRM and more widely.

Instigate a more rigorous role modelling of trust behaviours and values amongst the Division’s leadership teams, challenging poor behaviour in meetings and on the ‘shop floor’.

Speed up and streamline the Divisional decision-making processes in relation to Workforce Control, Temporary Staffing Management and Leave and absence decisions

FASS Division

Salisbury NHS Foundation Trust

Impacts

- Early work has identified Flexible Working as the key consideration within the staff survey results
- Immediate actions are to conduct facilitated listening events to further understand the issues raised by Staff in relation to staff survey data.

FASS Division - Actions

Salisbury NHS Foundation Trust

- FASS actions have been delayed by vacancies and sickness absence in DMT and wider leadership team. The return and employment of key staff has enabled work to be conducted in the last few weeks.
- FASS information session delivered in late April to be arranged in the second half of April
- 80% of specialities had completed their internal listening events by end May. Remaining areas are working on dates and event plans.
- Action plans to be submitted to DMT by the end of June
- Action plans, with updates will be included in PRM packs from July onwards.

BSW Hospitals Group

Controls Quality Analysis: Group Risk Register June 2026

Paper title	Controls Quality Analysis – BSW Hospitals Group Risk Register June 2026
Prepared for	Group Chief Risk Officer / Care Organisation Risk Leads
Author	Group Governance Project Lead
Date	June 2026
Classification	For Information and Action

Purpose and Framework

This report assesses the quality of control descriptions across all risks in the June 2026 Group Risk Register scoring 12 or above under the 5+5+5 model (residual score = Likelihood + Impact + Control Score). It follows the same structure as the May 2026 Controls Quality Analysis and should be read alongside the June GRR.

Each risk is assessed 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?

Verdicts are: Pass (controls meet the test), Partial (some controls meet the test but gaps remain), or Fail (controls do not meet the test as described).

The Score Alignment column assesses whether the stated control effectiveness score is consistent with the controls described. Aligned means the score is consistent with the controls as described. Optimistic means the score overstates the effectiveness of the controls described. Possible means the score is on the boundary and could be argued either way.

Section 2 of this report assesses the response to May 2026 feedback. This is kept separate from the substantive June assessment in Section 1.

Overall Picture

This report covers 42 risks scoring 12 or above across the three care organisations: 15 GWH, 17 RUH, and 10 SFT (of which two have a control score of tbc). Across all 42 risks, 14 Pass, 21 are Partial, and 7 Fail.

The seven Fail assessments are:

1. RUH-3289 (Working Capital): three entries, one of which is described as under development and one of which is a goal rather than a control. No operational controls managing the cash shortfall are described.
2. RUH-3314 (Hospital at Home): both controls relate to the governance decision around service discontinuation. No controls address patient safety during or after the transition.
3. RUH-3235 (Outdated Policies): two controls, one of which is a self-assessed gap. No controls describe the update backlog, priority review schedule, or governance oversight.
4. RUH-3273 (Electrical Infrastructure): the entry states that both listed assets do not address the capacity risk. Remaining controls are monitoring only.
5. GWH-1493 (Medical Leadership): three controls, none of which describe the divisional medical leadership development programme in sufficient specificity to be auditable.
6. SFT-6229 (DSU Infrastructure): unchanged from the May Fail. The entry acknowledges no systematic controls are in place. The ECC remains a planned capital solution.
7. SFT-8068 (Switchboard Lone Working): a single shift rota adjustment is the only control. No arrangements for overnight or weekend lone working coverage are described.

Notable improvements from May include GWH-1382 (Interventional Radiology, upgraded to Pass following addition of five new controls), GWH-1539 (Elective/RTT, upgraded to Pass following addition of corrective action controls), RUH-2110 (Backlog Maintenance, upgraded to Pass following description of prioritisation methodology), GWH-1576 (Financial Plan, recovered from Fail to Partial), and GWH-1577 (Clinical Environment, recovered from Fail to Partial).

Section 1 – Active Group Risk Register (Residual Score ≥ 12)

This section covers the 42 risks in the active register scoring 12 or above under the 5+5+5 model.

Summary

	Pass	Partial	Fail	Total
GWH	5	9	1	15
RUH	7	6	4	17
SFT	2	6	2	10
Total	**14**	**21**	**7**	**42**

Detailed Assessment

Risks are presented in care organisation order (GWH, RUH, SFT), then by residual score descending.

Great Western Hospitals NHS Foundation Trust (GWH)

Risk Ref	Risk Title	CO	Verdict	Score Alignment	Assessment
GWH-286	Utilities Site Infrastructure	GWH	**Partial**	Aligned	New risk. The Utilities Capacity Dashboard with named metrics (kVA headroom, MW output, water storage/pressure) is specific and auditable. Capital gate control with mandatory sign-off and embedded estates representation at Capital Group are preventative controls. Item 6 (WFP funding avenues) is a potential future action rather than a functioning control and should be flagged as such.
GWH-299	Estates Lifecycle Works	GWH	**Partial**	Aligned	EFM Board oversight and named escalation ownership are present, partially addressing the May finding. The specific protocol when P2G flags delayed or cancelled works — who receives the alert, within what timeframe, and what the response authority is — is still not described. May finding partially addressed; core gap persists.
GWH-1085	High Hospital Occupancy	GWH	**Pass**	Aligned	Controls are unchanged from May. The Handover Improvement Group (weekly, ToRs, reporting to UEC sub-committee), nerve centre for live patient placement, Emergency Zone Operational Group, NCTR improvement plan, and UEC/Flow Programme are specific and auditable. Item 11 ('New IFD area – not in place until September 2024') is now almost two years out of date and should be updated or removed. Control score of 3 remains credible.
GWH-1230	Legal Services Capacity	GWH	**Partial**	Aligned	New risk. Some controls are functioning: mutual aid from SFT or RUH addresses capacity gaps; external legal advice has a

					named approval gate (deputy exec or exec). The 0.4 WTE band 7 for ten weeks is a time-limited pending request, not a confirmed control. The trigger for activating mutual aid is not described. The weekly legal services meeting summary is monitoring rather than mitigation. The underlying staffing gap against rising demand has no structural control.
GWH-1267	Stroke Care	GWH	**Partial**	Aligned	Controls are unchanged from May. The SOP ringfencing two Falcon beds, Bournemouth predictor tool, bi-monthly SSNAP oversight (DDD/DD), weekly ED improvement huddles, and cross-divisional SSNAP recovery plan are specific and largely auditable. There is no description of the contingency when ringfenced beds cannot be maintained under capacity pressure. May finding not addressed.
GWH-1314	Paediatric Radiology – Suspected Abuse Cases	GWH	**Partial**	Aligned	The RUH referral pathway for child protection medicals is a new and practical addition. The primary SPA reporting arrangement ('tertiary centre reporting') remains unspecified — no named centre, no confirmed arrangement, no timeframe stated. TMC backup is explicitly noted as untested. Recruitment is listed without timeline. May finding partially addressed; primary specialist reporting gap persists.
GWH-1382	Interventional Radiology Service	GWH	**Pass**	Aligned	The June entry adds five controls not present in May: 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. These are specific, auditable, and act directly on the gap. Previously Partial.
GWH-1401	Building Safety Act	GWH	**Pass**	Aligned	New risk. Named external legal advisor (Bevan Brittan), a defined testing approach with the Building Safety Regulator, Building Control as the determining body, and co-ordinated BSR submissions via SERCO and THC covering named sites (IFD, UTC, BTC, GWH) are specific and auditable. The change in Serco's position (now acting as Principal Contractor) is relevant operational context.
GWH-1493	Clinical Medical Leadership Capacity	GWH	**Fail**	Aligned	New risk. Three controls are present: new CMO appointment, AMD and Exec leadership support, and training for clinical leaders commenced May 2026. The CMO appointment addresses executive leadership, not the divisional medical leadership capacity gap described in the risk. AMD and Exec support is not described with sufficient specificity. Training is noted without scope, cohort, or expected outcomes. None of the three controls pass the three-question test on specificity and auditability.
GWH-1539	Elective Activity and RTT Trajectory	GWH	**Pass**	Aligned	Improved from May. Plans on a Page when gaps or off-track trajectory are identified directly addresses the May finding that controls described monitoring without corrective action. The DD-led RTT recovery

					meeting, with named attendees and a defined function (working through action updates and escalating areas for support), adds decision-making authority to the oversight. Previously Partial.
GWH-1576	Capacity/Capability – Financial Plan	GWH	**Partial**	Aligned	Improved from May, which contained a single generic phrase. June includes five controls: named external provider (Hunter Healthcare), monthly ERM reviews linked to breakthrough objectives, defined savings targets with accountable owners, financial reporting mechanisms for forecasting, and corporate project oversight for prioritisation. The financial improvement programme board and its reporting route are not named, and a savings delivery trajectory is absent. Previously Fail.
GWH-1577	Suboptimal Clinical Environment	GWH	**Partial**	Aligned	Improved from May. The May entry was a single generic phrase; June includes six controls: IPC measures with audit, duty of candour and feedback mechanisms, health and safety risk assessment monitoring, divisional governance committee review, capital bids for named areas (maternity triage), and the Way Forward Programme capital masterplan. The specific improvement programme content — what aspects are being addressed, by whom, to what timeline — is not described. Previously Fail.
GWH-570	Surgical Assessment Unit – Patient Safety	GWH	**Partial**	Aligned	New risk. The three daily divisional huddles, 9am safety and quality meeting covering acuity and staffing allocation, and Matron of Day oversight are specific and auditable. Controls address day-to-day operational management but not the underlying demand growth. There is no escalation pathway to senior leadership when safety thresholds are breached, and no description of capacity decisions when SAU is full.
GWH-1608	PFI Expiry – Capital and Funding	GWH	**Partial**	Aligned	New risk. The Trust-approved PFI Expiry Capital and Betterment Plan with EFM Board prioritisation, active engagement with System/IPA/DHSC for central funding, and the resourced Programme Plan identifying critical activities and required capacity are specific and appropriately strategic. The charitable funds application is a pending action rather than a confirmed control. The fundamental capital funding gap is not resolved by the controls described.
GWH-1613	PFI Expiry – Capacity and Resourcing	GWH	**Pass**	Aligned	New risk. Named external support types (legal, commercial, technical, IPA/NISTA), escalation routes (Programme Board to EFM Board to FIDC), and integration with capital and financial planning are specific and auditable. The governance and external specialist framework is described with sufficient detail to be verifiable.

Royal United Hospitals Bath NHS Foundation Trust (RUH)

Risk Ref	Risk Title	CO	Verdict	Score Alignment	Assessment
RUH-3165	Delivery of Annual Financial Plan	RUH	**Pass**	Aligned	Maintained from May. Named percentage progress (37% green, 26 May 26) is a specific auditable data point. Turnaround team capacity reduction in 26/27 is acknowledged explicitly. Enhanced pay controls (VCARP), non-pay controls (No PO No Pay, discretionary spend limits), System Triple Lock, and BSW Group/ICS collaboration are specific and auditable.
RUH-3273	Future Site Development – Electrical Infrastructure	RUH	**Fail**	Possible	New to the active register. The entry notes that both the PV panels and the CHP facility do not address capacity issues. The two controls that do apply — all new projects running through the Electrical Senior Estates Officer, and electrical demand monitoring — are screening and monitoring controls only. There is no capital programme for substation upgrade, no interim capacity management protocol, and no timeline for an infrastructure solution. Control score of 4 is arguable given the entry explicitly states existing assets do not address the risk.
RUH-3289	Working Capital Cash Shortfall	RUH	**Fail**	Possible	Three entries: budget delivery, an internal control described as under development, and an application for Revenue Support PDC. Budget delivery is a goal, not a control. An undeveloped control is not a functioning control. The PDC application is a pending action. No operational controls managing the cash shortfall are described. Control score and residual should be reviewed against what is actually in place.
RUH-3314	Discontinuation of RUH Hospital at Home Service	RUH	**Fail**	Possible	Two controls: a business case written for MEC submission, and staff advised of cessation. Both relate to the governance decision, not the patient safety risk of service discontinuation. There are no controls describing patient transition arrangements, alternative pathway provision during any gap, or clinical safety arrangements for patients mid-treatment.
RUH-1977	Millennium Electronic Order Comms	RUH	**Partial**	Aligned	Trust policy, induction training, and phlebotomist-specific training are in place. The entry acknowledges that the lab comment workaround is unsustainable due to workload. There is no compliance audit, no monitoring of adherence to the marking policy, and no systematic solution to the underlying Millennium workflow issue. Controls address awareness rather than compliance.
RUH-2973	Insufficient Medical Palliative Care	RUH	**Pass**	Aligned	Maintained from May. Dorothy House 4 sessions per week for 42 weeks, honest gap acknowledgement for annual leave and absence cover, OOH advice line, nurse-led 7-day service, and MD/CNO/CMO engagement

					with Dorothy House are specific and auditable.
RUH-3198	Inconsistent Consent Form 4 Documentation	RUH	**Pass**	Aligned	Unchanged from May. Named leads (Alex Crisp, Sarah Thornell), full audit commitment covering all elective surgeries involving autistic patients or those with a learning disability, Datix reporting for non-compliance, MCA/DoLS in mandatory training, and interim documentation improvements submitted to Change Board are all present and auditable.
RUH-3230	Patient Safety, Risk, Audit and QI Resource	RUH	**Partial**	Aligned	Improved from May. The June entry provides specific workforce gap data by role band and stage: two Band 6 central roles, one Band 7 requiring approval, four divisional roles requiring establishment, one Band 7 in second recruitment round, one Band 6 pre-recruitment. This directly addresses the May finding that vacancy data was absent. Business case partially approved, funding pending. May finding addressed; entry remains Partial as recruitment is not yet complete.
RUH-3235	Outdated Policies and Limited Governance Resource	RUH	**Fail**	Aligned	Two controls: a policy register maintained by Corporate Governance, and a note that prioritisation of high-risk policies is limited. The second is a self-assessed gap rather than a control. For a risk at residual 12, no controls describe the update backlog, priority review schedule, named ownership, or governance oversight of compliance. Control score of 4 is consistent with the limited control base.
RUH-3288	Insufficient Capital Funding	RUH	**Partial**	Aligned	Expanded from May. The Group Strategic Capital Group addresses the group-wide CDEL overcommitment. The internal audit assessment (Strong Assurance, 25/26) is an independently verifiable reference. Four named sub-groups (Medical Equipment Committee, Capital Projects Team, IT team, Sulis Exec Board) add specificity. The entry retains one generic phrase ('pro-active risk management') which does not pass the three-question test.
RUH-1882	Non-Compliance with Fire Compartmentation	RUH	**Pass**	Aligned	Maintained from May. Risk-assessed remedial works, L1 fire detection, staff evacuation training, current FRAs incorporating known breaches, fire warden audits, and annual authorising engineer audit are all in place and unchanged.
RUH-2110	Business Interruption – Backlog Maintenance	RUH	**Pass**	Aligned	Improved from May. Decision-makers are named (Associate Director of Estates, Associate Director of Capital Projects), and the criteria for prioritisation are described (condition/environmental reports and risk assessments by technical leads). This directly addresses the May finding that the methodology was absent. Previously Partial.
RUH-2124	Oncology/Haematology Workforce and Service Delivery	RUH	**Pass**	Aligned	Maintained from May. 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 present.
RUH-2683	Emergency Department – 4-Hour Standard	RUH	**Pass**	Aligned	Maintained from May. GIRFT Tier 1, UEC Breakthrough Objective reporting to Engine Room fortnightly, EEMAC (operational since February 2026), flow and capacity controls, ambulance handover SOP/HALO, 24/7 clinical oversight huddles, OPEL escalation, and workforce controls are all present.
RUH-3242	Delays in Clinical Letters	RUH	**Partial**	Aligned	Unchanged from May, which itself had regressed from the April standard. Specialty triage against clinical risk and weekly trajectory monitoring — present in the April Pass submission — remain absent. Three controls are present: temporary staffing via MEC approval, weekly Elective Delivery Group review, and cancer navigator tracking. AI/digital exploration is described as a future aspiration. May finding not addressed.
RUH-3243	IT Equipment Age Replacement	RUH	**Partial**	Aligned	New to the active register. Replacement prioritised to critical clinical areas and devices not fit for purpose. 750 devices replaced in 2025, with a noted reduction in IT support requests from those areas. The £650k capital bid (5-year plan, not yet approved) is a planned action rather than a confirmed control. The entry accurately represents a position of partial mitigation.
RUH-3280	Absence of Retrospective Building Fire Strategies	RUH	**Partial**	Aligned	New to the active register. Annual fire risk assessments, monthly AE(Fire) audit reviews, compartmentation survey programme, and PPM for active and passive fire systems are appropriate fire safety controls. The specific action plan to produce the missing RBFS documentation — which buildings, in what priority order, to what timeline, and by whom — is not described.

Salisbury NHS Foundation Trust (SFT)

Risk Ref	Risk Title	CO	Verdict	Score Alignment	Assessment
SFT-8102	Central Booking – Workforce and Process Instability	SFT	**Partial**	Aligned	New to the active register. RPA for eRS tasks is a specific technological control. The booking working group (with members close to operational detail) is auditable. Datix and governance escalation provide a formal reporting route. DMT on-site intervention is named. Transformation programme and recruitment are listed without milestones or outcomes. Exit interviews are diagnostic rather than mitigating.
SFT-6229	DSU Estate Infrastructure Failure	SFT	**Fail**	Aligned	Unchanged from May. The entry opens with an acknowledgement that no systematic controls are in place ('None – ad hoc nature of issues', duplicated). The ECC (Elective Care Centre) is a planned capital solution, not a current operational control. There is no preventative maintenance regime, no service

					closure or diversion protocol, and no contingency for service continuity during infrastructure failures. May finding not addressed.
SFT-6412	Harm to Women and Babies – Lack of 2nd Obstetric Theatre	SFT	**Partial**	Aligned	New to the active register. The SOP with a defined decision pathway (check main theatre first; exception for time-critical cases), Datixing all instances of second theatre use, and MDT case review are specific and auditable. The controls are procedural and retrospective; there is no description of the arrangements when both the main theatre and the anaesthetic room are simultaneously unavailable.
SFT-8791	Financial Position 2026/27	SFT	**Pass**	Aligned	Maintained from May. Cash flow forecasting, F&P monitoring, SFIs, signed-off budget, deficit support (£6.4m), ICB transitional funding, weekly agency monitoring, group financial recovery structure, enhanced vacancy control, medical rate card adherence, NHSE enhanced oversight, and divisional financial escalation meetings are all present and unchanged.
SFT-7917	Fire Risk in Main Theatres Corridors	SFT	**Pass**	Aligned	Unchanged from May. Weekly Fire Team walk-rounds, daily fire-walk, weekly Theatre Fire Warden checklist, corridor clearance, fire door and extinguisher clearance, increased Designated Fire Safety Officers, band 6/7 training, and daily housekeeping are all present. The DSU escalation policy update (February 2026) remains embedded.
SFT-7931	Electrical Power Infrastructure in Theatres	SFT	**Partial**	Aligned	Unchanged from May. Two-weekly PPM visual checks (documented frequency increase history), daily walkarounds, work orders for remedial issues, and DSU escalation policy update (February 2026) are present. The capital programme for infrastructure upgrade has been removed from the entry compared to May. Load management protocol remains undescribed. May finding not addressed.
SFT-7946	Transformation Programme Delivery	SFT	**Partial**	Aligned	Expanded from the original submission. The 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. The entry acknowledges that effectiveness of controls is lower than desired. Transformation programme delivery milestones are not described
SFT-8068	Switchboard 2222 Calls – Lone Working Cover	SFT	**Fail**	Possible	A single operational shift adjustment — relief shift extended to cover until 7pm — is the only control for a risk at residual 12. There is no description of arrangements for 2222 call coverage overnight or at weekends under the lone working model, no technical redundancy, and no protocol for when the operator is unavailable. Control score of 4

					may accurately reflect the limited control base, but the entry does not describe the arrangements that justify it.
SFT-7734	Capital Funding	SFT	**Partial**	Aligned	New to the active register. Capital control group prioritisation, Datix monitoring for infrastructure and equipment incidents, rolling 15-month cashflow forecast, risk-assessed 5-year plan, and Estates Safety Fund are present. The 15-month cashflow forecast and 5-year plan provide forward planning structure. The capital control group's composition, decision criteria, and governance escalation are not described.
SFT-5664	Capital Required to Manage Backlog Maintenance	SFT	**Partial**	tbc	Three controls, all focused on funding bids: Trust capital bids, ERIC data tracking, and National Estates Safety Fund bid. ERIC tracking provides transparency but does not mitigate the backlog risk. No controls describe the management of the backlog itself — no prioritisation framework, no reactive maintenance protocol, no risk triage for safety-critical items. Control score is tbc and must be assigned before the July submission.

Section 2 – Response to May 2026 Feedback

The May Controls Quality Analysis identified 19 items of feedback. This section assesses the June response to each item.

Status categories:

- Addressed: the finding has been substantively resolved in the June submission.
- Partially addressed: a meaningful step has been taken but the core gap persists.
- Not addressed: the finding remains open and unchanged.
- Below threshold: the risk scores below 12 under the 5+5+5 model and is not assessed in the active register.
- Confirmed below threshold: the risk appears in the below-threshold register with controls in place.

Summary

Status	Count
Addressed	5
Partially addressed	3
Not addressed	2
Below threshold	3
Confirmed below threshold	1
Total tracked	**19**

Of 19 items of May feedback tracked: 5 have been addressed, 3 are partially addressed, and 2 remain open and unchanged. Four items fall below the 5+5+5 active register threshold and are noted accordingly. The response rate represents an improvement on the May cycle.

Detailed Feedback Tracker

Risk	CO	May Finding	June Response	Status
GWH-1382 Interventional Radiology	GWH	April finding (score inconsistency) was addressed in May. May entry remained Partial.	Five new controls added: SLA with third-party provider, agency staff cover, NHSE hub-and-spoke support, NBT agreement for emergency urology IR, exec agreement with GRH. Entry upgraded to Pass.	**Addressed**
GWH-1576 Capacity/Capability – Financial Plan	GWH	Deteriorated in May to a single generic phrase. All April controls removed.	Five substantive controls restored: Hunter Healthcare engagement, ERM reviews, defined savings targets, financial reporting, corporate project oversight. Entry recovered to Partial.	**Addressed**
GWH-1539 Elective Activity and RTT	GWH	Partial. Controls described monitoring but not corrective action when trajectory was off-track.	Plans on a Page when gaps identified, and DD-led RTT recovery meeting with action updates and escalation, added. Entry upgraded to Pass.	**Addressed**
RUH-3230 Patient Safety / QI Resource	RUH	Partial. Vacancy numbers, functions most at risk, and recruitment timeline not provided.	Specific workforce gap data provided by band and stage for each vacancy. Business case status and funding position clarified. May finding directly addressed.	**Addressed**
RUH-2110 Backlog Maintenance	RUH	Partial. Prioritisation methodology not described – who decides, using what criteria.	AD of Estates and AD of Capital Projects named as decision-makers; criteria described (condition/environmental reports and risk assessments by technical leads). Entry upgraded to Pass.	**Addressed**
GWH-1577 Suboptimal Clinical Environment	GWH	Fail. Single generic phrase. Specific controls, improvement programme, triggers, and accountability requested.	Entry expanded to six controls including named capital bids (maternity triage), IPC audit, health and safety monitoring, divisional governance review, and Way Forward Programme. Entry recovered to Partial. Improvement programme specifics remain absent.	**Partially addressed**
GWH-299 Estates Lifecycle Works	GWH	Partial. P2G tool described without response process – who receives escalation, what is the timeline, what governance body oversees backlog.	EFM Board oversight and named escalation ownership added. Response protocol when P2G flags delayed works still not described in detail.	**Partially addressed**
GWH-1314 Paediatric Radiology – Suspected Abuse	GWH	Not addressed in May. NUH arrangement absent; primary reporting pathway unclear; recruitment without timeline.	RUH referral pathway added as an interim control. Tertiary centre reporting remains unspecified (no named arrangement). Recruitment still without timeline.	**Partially addressed**

RUH-3242 Delays in Clinical Letters	RUH	Deteriorated in May from Pass (April). Specialty triage against clinical risk and weekly trajectory monitoring removed.	Same entry as May. April controls not restored. May finding not addressed.	**Not addressed**
SFT-7931 Electrical Power in Theatres	SFT	Partial. Load management protocol undescribed. Capital programme still in development.	Entry unchanged. Capital programme not referenced. Load management not described. May finding not addressed.	**Not addressed**
RUH-2806 Digital Clinical Safety	RUH	Deteriorated in May from Pass (April). Clinical safety cases and monthly review removed.	Risk scores residual 11 under the 5+5+5 model (L=4, I=4, C=3) and is below the active register threshold. Not assessed in this document.	**Below threshold**
RUH-2432 Mental Health Provision – ED	RUH	Deteriorated in May. Daily staffing review and agency RMN cover removed.	Risk scores residual 11 under the 5+5+5 model (L=5, I=3, C=3) and is below the active register threshold. Not assessed in this document.	**Below threshold**
RUH-1999 Respiratory Lung Cancer Capacity	RUH	Partial. VCARP extension unconfirmed; control score of 2 queried.	Risk scores residual 9 under the 5+5+5 model (L=3, I=4, C=2) and is below the active register threshold. VCARP extension outcome should be confirmed with the risk owner.	**Below threshold**
SFT-8344 MaST Reporting Assurance	SFT	Status unclear in May. SOP described as being socialised.	Risk appears in the June SFT register at residual 10, below the active register threshold. Controls now describe the SOP between Education and Safeguarding teams, manual compliance checking, and interim safeguarding reporting.	**Confirmed below threshold**

BSW Hospitals Group – Group Risk Register: June 2026

Active risks scoring 12 and above | Residual Score = Likelihood (L) + Impact (I) + Control Score (C)
Control Score: 1 = Fully Effective 2 = Largely Effective 3 = Partially Effective 4 = Limited Effectiveness 5 = Absent

Risk Ref	Risk Title	CO	Risk Description	Risk Owner	L	I	C	Residual Score	Controls in Place	Last Reviewed
Great Western Hospitals NHS Foundation Trust (GWH)										
GWH-286	Utilities Site Infrastructure	GWH	There is a risk that the current and future utilities (e.g. electrical, heating, water) may not be enough for the planned developments, leading to expensive mitigations / strengthening works.	Rupert Turk - Site Director of Estates and Facilities	5	3	4	**12**	1. Strategic Utilities Capacity Plan: Maintain a Trust-wide utilities infrastructure strategy (10–15 year horizon) 2. Capital Planning Gate Control: A mandatory utilities capacity sign-off at early capital stages 3. Embedded Estates Representation at Capital Group: Formalise Estates role as a "gatekeeper" for infrastructure capacity risk 4. Phased / Modular Infrastructure Options - Alternative engineering strategies to reduce the overall risk 5. Utilities Capacity Dashboard - Maintain a live capacity tracker for: Electrical (kVA headroom) Heating (MW output vs peak demand) Water storage / pressure 6. WFP may open funding avenues as the project continues to develop 7. Works with significant load are escalated via EFM Board, WFP Board and	10/06/2026
GWH-299	Life cycle works and access	GWH	The risk is that minimal access is given to PFI provider to undertake lifecycle works, resulting in a backlog of condition issues, if unresolved by end of the contract in 2029 we will have a significant funding issue.	Johanna Bogle - Site Finance Director	4	4	4	**12**	1. Estates/Lifecycle Planning Manager: Estates Planning Manager is responsible for the day to day management of lifecycle planning 2. P2G Fault Reporting App: Using P2G app to log and monitor all maintenance jobs identified . 3. Trust/THC/Serco Collaboration: Working closely with THC/IPSL and Serco, the Estates planning manager is the escalation for works delayed, cancelled or postponed due to clinical priorities 4. Director of Estates and Facilities provides oversight and escalates backlog issues/position as appropriate. EFM Board has oversight of backlog positions.	10/06/2026
GWH-1085	There is a risk that the high hospital occupancy leads to poor patient flow through the hospital affecting the delivery of safe care	GWH	There is a risk that high hospital occupancy leads to poor patient flow through the hospital which impacts on the safe delivery of care. High occupancy resulting in delays to offloading ambulances (risk 731) , overcrowding in ED / ED majors (690) and the use of temporary esclation spaces to deliver care. This results in increased patient safety incidents / increased mortality and reduction in patient experience. The General and Acute bed occupancy operates above 98% on a regular basis.	Benny Goodman - Chief Operating Officer	5	4	3	**12**	1. Breakthrough objective focused on length of stay 2. Development of improved monitoring and oversight on the level of use of Corridor Care 3. Emergency zone operational group (set up to support communication between all partners) 4. Escalation Policy in place to support identification and management of gaps relating to sitewide care. 5. Handover Improvement Group set up (with TORs reports to UEC sub committee) meets weekly 6. Immediate esclation of safety concerns 7. Increased safety and welfare checks 8. Information to patients when placed in bed spaces 9. Introduction of additional cohort areas 10. NCTR improvement plan with system partners 11. New IFD area – not in place until September 2024 12. Review of push / pull model 13. Seasonal plan actions 14. Support for teams who are supporting cohort areas, extra bed spaces on wards 15. UEC and Flow Programme focusing on flow improvement 16. Use of nerve centre	10/06/2026
GWH-1230	Risk to the Trusts ability to fulfil all aspects of the legal services due to low levels of staffing and increasing demand.	GWH	There is a risk of significant reputational damage, poor staff morale, financial liability, and inability to fulfil statutory disclosure timeframes due to increasing demand for legal services and lower than benchmarked staffing levels in the legal services team in the GWH. Legal functions include: • Assessment of inquest requirements and support of staff prior to, during and after inquest. • Ability to factually assess clinical negligence claims, which includes statements from staff. • Delay in providing information requested as part of a disclosure (statutory requirement 28 days). • Limited ability to support the Court of Protection process including the accurate review of statements and support of staff. There has now	Kathryn Bateman - Chief Medical Officer	4	4	4	**12**	1. External advice sought after approval from deputy exec or exec oversight 2. Provide a summary of areas of concern at each legal services meeting. To include immediate actions required and level of concern anticipated. 3. Requested band 0.4 WTE band 7 for a period of 10 weeks to forward plan as much as possible 4. Support from the wider Insights and Learning team (administration and facilitator role) 5. To gain mutual aid from SFT or RUH at points of extrem demand. E.g. periods of annual leave.	10/06/2026
GWH-1267	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.	GWH	There is a risk that patients will not receive quality care and timely interventions across the acute stroke pathway. This involves timely diagnosis, access to the stroke unit, senior decision maker reviews as well therapy input and rehabilitation. This is reflected in the SSNAP performance criteria that involves domains involving diagnostics, ED, acute stroke team and therapies. Each domain is measured and contributes to the overall SSNAP score. The delays in each of these domains impacts on patient safety and cause potential harm.	Benny Goodman - Chief Operating Officer	4	4	4	**12**	1. Amendment of Stroke Unit SOP to ensure two Falcon beds are ringfenced 2. Bournemouth predictor tool 3. Completion of visual field assessment being completed between all MDT members 4. Continue efforts to safeguard dedicated stroke beds, ensuring timely admissions and reducing delays on specialist care. promotion of ring fenced beds in Acute Stroke Unit. Launch of new stroke SOP. 5. DDD and DD to attend meeting bi-monthly to ensure appropriate oversight of SSNAP 6. Maintain regular improvement huddles with the Emergency Department to strengthen collaboration and improve timely stroke referrals 7. Oversight of cross divisional SSNAP performance recovery plan 8. Performance and op manager overseeing data input 9. Weekly oversight of 4 hour performance (time from arrival in ED to accessing stroke unit)	10/06/2026
GWH-1314	There is a risk of delayed diagnosis in Suspected Physical Abuse (SPA) cases due to lack of Paediatric Radiologists	GWH	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 contracted 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. SLA is progressing 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 currently offering a limited and suboptimal service for any Child Protection Medicals	Kathryn Bateman - Chief Medical Officer	4	4	4	**12**	1. Recruitment of Consultant Paediatric Radiologist 2. Tertiary centre reporting 3. TMC are able to provide backup cover (this has not been tested as not required at present) 4. Referrals for child protection medicals could be sent to RUH	10/06/2026
GWH-1382	There is a risk to service provision & patient safety due to Interventional Radiologist shortage.	GWH	There is a risk to patient safety and experience due to a shortage of Interventional Radiologists at GWH. Currently, only one Interventional Radiologist is employed, with no cover during absences, leading to service gaps. This results in potential delays to urgent interventions, increased patient morbidity and mortality, reliance on operative treatment, transfers to other Trusts, and possible patient deterioration. The Trust previously had three interventional radiologists however due to retirements, this has reduced this to only one since January 2025. In addition, GWH has no IR cover for OOH i.e. overnight all week and at weekends/BH. This has always	Kathryn Bateman - Chief Medical Officer	4	4	4	**12**	1. Cases are triaged and decisions are made regaring waiting v transfer 2. Patients able to be transferred for IR procedures 3. Referral of urgent cases to tertiary centre 4. There is one Interventional Radiologist who is on the bank 0.4 WTE a week when available 5. SLA with third party provider provision for IR radiologists 6. Agency staff to provider additional cover 7. Support from NHSE confirmed for hub and spoke model. 8. Agreement from NBT to support emergency urology IR cases 9. Exec agreement at GRH to support emergency IR cover pending future model agreement	10/06/2026
GWH-1401	Building Safety Act	GWH	There is a risk that the recently introduced Building Safety Act 2022 introduces complexities, uncertainties & liabilities on building upgrade works that could result in difficulties negotiating commercials between PFI partners as well as finding competent suppliers, which may lead to capital, maintenance & life cycle works being delayed, more costly or non-compliant.	Rupert Turk - Site Director of Estates and Facilities	5	3	4	**12**	1. Estates & Facilities Board 2. EFM monthly Risk Review meeting 3. Legal Advice procured from Bevan Brittan to better understand Trust's position and our approach to defining the Higher-Risk Building (HRB) boundary 4. Testing advised position with the Building Safety Regulator (BSR) to provide clarity and, subject to agreement, enable significant areas of the site to be reclassified as no longer high risk. 5. Building Control to act as the determining body and arbiters to testing approach. 6. Submissions to the Building Safety Regulator via SERCO and THC covering the IFD, UTC, BTC and GWH. Each submission will include the same legal basis, with the aim of achieving a consistent and agreed position on the HRB boundary. 7. Serco have recently changed their position and will now act as Principal Designer/Contractor for THC. 8. Appointments and Competence Checks are being finalised with Serco's central commercial team. 9. Legal advice being procured from Bevan Brittan to understand if the hospital site could notionally be split up into smaller	10/06/2026
GWH-1493	Insufficient Clinical (Medical) leadership capacity and training.	GWH	If we do not increase our medical leadership capacity into the Divisions, through training and recruitment, there is a risk that we, as a Trust, will not be able to deliver the breadth, depth or speed of the changes required by the clinical workforce to deliver on our key priorities (including EUC, Elective, and Partnership working) or Group priorities (incl EPR, Clinical strategy) which will require both process/change management and cultural change.	Kathryn Bateman - Chief Medical Officer	4	4	4	**12**	1. New CMO appointment. 2. Support from current AMD and Exec leadership team. 3. New training for Clinical leaders commenced May 2026	10/06/2026
GWH-1539	Risk to Elective activity and RTT trajectory due to insufficient elective admissions resource	GWH	Due to insufficient resource within the elective admission team, there is a risk to T&O activity plans and RTT trajectories due to under utilised or unfilled theatre lists, pre assessment slots and consent appointments. The T&O PTL has sufficient patients awaiting surgery for all T&O sub specialities, however due to gaps within the booking team as well as sickness and under resourced aspects, these patients remain un-booked or validated, meaning patients are waiting longer for surgery and T&O utilisation remains at risk due to clinical teams not being able to plan theatre resource i.e Kit and Anaesthetic team accordingly. 72 patients are waiting longer than should be despite sufficient theatre list capacity.	Kathryn Bateman - Chief Medical Officer	5	3	4	**12**	1. Weekly utilisation meeting: Admissions ops manager and General manager meet weekly with T&O ops team to review utilisation and gaps 2. Weekly Access meeting with division to review trajectory and long waiting patient plans for 52-65 week cohort. Cohorts are reviewed and capacity plans are implemented. 3. The Elective Admissions (EA) Manager and T&O Operations team hold weekly meetings to review and approve any additional consent capacity required. 4. DD led RTT recovery meeting held between service and Divisional Tris for oversight on the RTT trajectory and activity plan. This involves working through action updates and escalating any areas for support. 5. Plans on a Page to address gaps identified, or off-track trajectory. These are presented at identified weekly meetings with recommendations from the service tri. Recommendations are reviewed and approved by the Divisional tri	10/06/2026
GWH-1576	There is a risk GWH does not have the capacity or capability to achieve the scale of the financial improvements to achieve the plan.	GWH	There is a risk GWH does not have the capacity or capability to achieve the scale of the financial improvements to achieve the plan.	Benny Goodman - Chief Operating Officer	5	4	4	**13**	1. Financial governance oversight in place with clearly defined savings targets, timelines and accountable owners. 2. Financial performance information and reporting mechanisms are used to track progress, forecast variances and support decision making. 3. External expertise is engaged where internal capacity is insufficient e.g. Hunter Healthcare 4. Corporate Project oversight identifies overlap/resource constraints and aids prioritisation of effort and resources. 5. Performance management frameworks executed through monthly ERMs - linked to breakthrough objectives	10/06/2026
GWH-1577	There is a risk that suboptimal clinical environment is impacting patient experience and effectiveness of clinical care.	GWH	There is a risk that suboptimal clinical environment is impacting patient experience and effectiveness of clinical care.	Benny Goodman - Chief Operating Officer	4	4	4	**12**	1. Infection prevention and control measures including audit to minimise risk. 2. Duty of candor to patients and feedback mechanisms. 3. Compliance with health and safety risk assessments. Routine risk assessments and monitoring 4. Regular reviews of environmental risks through divisional governance committees. 5. Capital bids submitted for areas identified as a risk e.g. maternity triage. 6. Capital masterplan for Way Forward Programme in place - limited planning at GWH.	10/06/2026
GWH-570	There is a risk to patient safety at times of pressure due to the increasing demand of patients who attend the Surgical Assessment Unit	GWH	There is a risk to patient safety at times of pressure due to the increasing demand of patients who attend the Surgical Assessment Unit. The risk is which could take place is a a delay in triage and first assessment by a doctor, and the delivery of care in an inappropriate space which could compromise patients experience.	Benny Goodman - Chief Operating Officer	5	4	3	**12**	1. Daily Divisional Huddle, monitors demand and challenges faced by SAU which takes place 3 times a day in the week. 2. Daily Divisional safety & Quality Meeting. Meeting takes place at 9am each day to discuss any immediate safety concerns , review of acuity across the division and staffing allocation. 3. Matron of Day role - has oversight of staffing position and is an escalation point for safety concerns	10/06/2026
GWH-1608	PFI Expiry Planning - lack of capital/funding for betterment works alongside THC-funded lifecycle	GWH	There is a risk that insufficient capital funding is available to support betterment or enhancement works alongside THC-funded lifecycle activities during the final years of the PFI, limiting the Trust's ability to address legacy issues, improve asset condition beyond contractual minimums, and optimise the estate ahead of handback and future service delivery.	Johanna Bogle - Site Finance Director	4	4	4	**12**	1. Development and maintenance of a Trust-approved PFI Expiry Capital & Betterment Plan, aligned to lifecycle delivery and informed by condition survey outputs, with prioritisation through the EFM Board and active engagement with System, IPA and DHSC to identify and secure available central or alternative funding sources 2. A Trust approved, resourced PFI Expiry Programme Plan is in place which identifies expiry critical activities, sets out required clinical and corporate capacity, prioritises expiry delivery over business as usual where necessary. 3. An application is being made to Charitable funds to secure funding for betterment	10/06/2026

GWH-1613	PFI Expiry Planning - Insufficient capacity across clinical & corporate teams and combined with lack of funding	GWH	There is a risk that insufficient resource and capacity across clinical and corporate teams (including EFM, IT, Procurement and Finance), combined with limited available funding, undermines the Trust's ability to plan for and deliver PFI expiry activities, resulting in programme delays, increased reliance on external support, and heightened cost and transition risk.	Johanna Bogle - Site Finance Director	4	4	4	**12**	1. Development and delivery of a resourced PFI Expiry Programme Plan, approved through Trust governance, which identifies critical clinical and corporate resource requirements, prioritises expiry-critical activities over business-as-usual where required, 2. Formal Governance & Executive Oversight: Regular reporting of capacity, funding pressures and delivery risks through PFI Expiry governance (Programme Board), with escalation to EFM Board and FIDC. 3. Use of External Specialist Support: Targeted engagement of external advisors (e.g. legal, commercial, technical, IPA/NISTA-type support) to supplement internal capacity where gaps exist. 4. Integration with Capital and Financial Planning: Alignment of PFI expiry requirements (e.g. surveys, lifecycle, mobilisation, advisory support) with Trust financial planning assumptions and capital programme processes	10/06/2026
Royal United Hospitals Bath NHS Foundation Trust (RUH)										
RUH-3165	Delivery of Annual Financial Plan	RUH	There is a Risk that the Trust (inclusive of Sulis) will not deliver it's Annual Financial Plan, The Risk is Caused By bigger underlying financial deficit compared to deficit support funding, shortfall in delivery of Savings plans, unidentified savings, other emerging cost pressures. Which will impact on: - Cash shortages to fund contract payment terms - Increased regulatory intervention (including scoring 3 or 4 against National Oversight Framework) - Loss of autonomy (including system triple lock on investment and additional senior management intervention and scrutiny)	Palmer, John	5	4	4	**13**	1.Trust Savings programme - overseen by Financial Improvement Programme Board, reporting Management Executive Committee. Currently 37% GREEN (26 May 26) 2.Group and Trust support via Turnaround team. Although Trust internal focus and capability has been enhanced; overall capacity has been reduced in 26/27 3.BSW Hospitals group collaboration, including direct efficiency plans such as Procurement, shared resources such as SOC and shared planning and service support such as Planned Care and Urgent Care 4.BSW Integrated Care System collaboration such as Urgent Care 5.Enhanced Pay Controls eg. VCARP 6.Enhanced Non Pay Controls eg. No PO No Pay policy and limits on Discretionary Spend 7.Enhanced Investment Controls via System Triple Lock	12/03/2026
RUH-3273	Future RUH site development lack of electrical infrastructure	RUH	There is a risk that the RUH has insufficient electrical capacity to support any future significant development on the RUH site. This is caused by the lack of available electricity coming onto the Combe Park site The capacity of the electrical infrastructure on the site is nearing full load. Once there is additional available electrical capacity a new primary sub station will be required because the current primary sub station cannot give sufficient capacity for future projects Once the new primary substation is provided the existing electrical power will need to be reconfigured Therefore, before any significant developments are undertaken on site both will need to be upgraded. In the interim, any service and estate developments require assessment against available existing capacity to determine ability to support and monitor increased demand on the existing capacity. This will impact on	Caulfield, Mr Jamie	5	4	4	**13**	1. The PV panels on site help to reduce costs but do not address capacity issues. 2. 2MVA Combined Heat and Power facility (CHP) available for energy cost reduction - does not give additional capacity 3. All new projects run through Electrical SEO 4. Electrical demand monitored	18/06/2026
RUH-3289	Working Capital cash shortfall	RUH	There is a Risk that there will be insufficient cash to finance day to day liabilities caused by I&E deficit - shortfall in commissioner funding, new cost pressures arising and shortfall of cost improvement plan delivery this will impact on ability to pay suppliers in a timely fashion, deferred capital expenditure and process demands on finance, procurement teams and budget holders	Palmer, John	4	5	4	**13**	1. Internal - Budget delivery 2. Internal - Under development 3. External - apply for Revenue support PDC	29/04/2026
RUH-3314	Discontinuation of RUH Hospital at Home Service	RUH	There is a risk that the Hospital at Home Service will be significantly reduced as a result of: - HCRG withdrawing funding for 42 HH@H beds - RUH provides insufficient funding to maintain a service above 20 beds This will impact on: - Increased in patient bed pressure and escalation - Increased ED pressure and flow failure - Financial risk from unmanaged escalation spends . Cost per bed will increase due to logistics - Quality and patient safety deterioration - Elective activity disruption and cancellations - Workforce impact (acute wards and ED) Uncertainty of future of service has led to medical and nursing staff seeking alternative employment Health and wellbeing of staff already under pressure during times of high patient flow. Recruitment and retention risk. System level catastrophic and	Macgregor, Mr Calum	4	5	4	**13**	1. Business case is written for submission to RUH MEC in May 2026 2. Staff advised of cessation of contract and pending business case	18/06/2026
RUH-1977	Millennium Electronic Order Comms Marking samples as Collected	RUH	There is a risk that if the clinician does not mark the sample as collected, then as a result the date/time of when the request was made is not updated to the date/time when the sample was taken. This results in the result being reported under an incorrect date and time. This can be several days or even weeks or months older than the actual sample date. As a consequence of this, results may be interpreted incorrectly. Datix records show issues with near misses such as a neutropaenic patient being sent home with sepsis due to the CRP being logged as 3 days earlier so the clinician thought the CRP was falling when in fact is was rising. The second consequence is that the pathology lab cannot process some of these samples due to some assays requiring samples to arrive within the lab in a certain time frame. Even if taken correctly, if not marked as collected the time will state an older date/time. This leads to the re-bleeding of patients; some datixes are showing this is occurring several times in order to generate a single result. There is a risk of increasing costs to the trust and to the patient who often needs to come into the trust to have such tests performed, taking time off work or arranging transport to get here. A third consequence is that any request which has not been marked as collected can be used again. The risk is that any outstanding order is printed off and taken. This results in duplicate requests, and as the lab have used this requests bar code once before pathology IT systems can not read the duplicate request. The lab do not know what is being requested and therefore cannot proceed. Currently the lab add a comment asking the clinician to phone in order to inform the lab of the correct request. As a result of this there is significant workload to lab and clinical staff. There is a real reputational risk to the lab. The laboratory needs to maintain accreditation with UKAS ISO 15189, which states that the time and date needs to be included in the request and report. We are at risk of not achieving this standard within the current system. As an organisation this is detrimental to our reputation; We are being informed that clinicians are no longer using millennium to look up results but have defaulted back to ICE as they do not trust the system. As a result of incorrect labelling, staff are frustrated and demoralised with the system, which is causing increased workload on both clinical and laboratory staff. Patients are being inconvenienced which is a further reputational risk. Although these are all low level	Staveacre, Mrs Liz	4	4	4	**12**	1. Trust policy is to mark as collected when samples are taken. 2. Clinicians have an induction which includes some Millennium training at the start of their job. 3. Phlebotomists are taught to mark as collected. 4. Lab has been adding a comment if barcode already used (this can not continue due to workload.	26/05/2026
RUH-2973	Insufficient medical palliative care provision	RUH	There is risk that patients will not having timely access to specialist medical palliative care support and advice as a result of the current lack of substantive specialist medical palliative care provision within the RUH This will impact on: 1. Inadequate provision of counselling of patients within the cancer services when active treatment is not felt to be beneficial 2. Increased attendance to the emergency department due to lack of advanced care planning 3. Clear leadership in the delivery of care for complex palliative care patients 4. Inappropriate treatment within inpatient settings 5. Poor patient and family experience 6. Moral injury to staff	Kerslake, Dr Ian	4	4	4	**12**	1. Dorothy House Hospice is currently commissioned to provide 4 sessions of medical cover a week for a total of 42 weeks (no cover for annual leave or absence). This includes 3 sessions for patient review and management activities within the hospital and 1 session for an outpatient clinic within the oncology service. The CNS team triage and prioritise patients for medical consultation. 2. Medical advice can be sought via Dorothy House medical team (in hours) and general advice from the Dorothy House advice line (OOH). 3. There is a highly skilled and experienced nurse-led service in place that offers a 7-day service. 4. Managing Director, Chief Nursing Officer and Chief Medical Officer meeting with Dorothy House to explore options to review service provision.	12/03/2026
RUH-3198	Inconsistent Consent Form 4 Documentation	RUH	There is a risk that elective surgeries involving vulnerable people (notably including autistic patients or those with a learning disability) proceed without properly documented Consent Form 4. The risk will be caused as a result of staff not consistently applying Mental Capacity Act requirements, or failing to record best interest decisions clearly, due to the reliance on a form which does not have sufficient prompts to follow the MCA code of conduct. Which will impact on patient safety, legal compliance, and the Trust's ability to evidence lawful decision-making, potentially leading to regulatory breaches or reputational harm.	Baker, Ms Jo	4	4	4	**12**	1. Joint briefing delivered by the Professional Lead for MCA/DoLS (Alex Crisp) and Lead Nurse for Learning Disability & Autism (Sarah Thornell) to safer surgery. 2. Agreement that all elective surgeries involving autistic patients or those with a learning disability will be audited. 3. Datix reporting triggered where documentation is found lacking for autistic patients or those with a learning disability. 4. MCA/DoLS Lead includes MCA code of conduct compliance in Level 3 safeguarding training sessions. 5. Interim documentation improvements (e.g. updated best interest templates) submitted to Change Board	02/04/2026

RUH-3230	Insufficient Patient Safety, Risk, Audit and Quality Improvement Resource	RUH	There is a significant risk that Safety and Quality which includes patient safety, risk, audit, and quality improvement functions are under resourced and unable to deliver statutory, regulatory, and improvement requirements. This is as a result of: - Operational pressures limit clinical engagement in improvement workstreams as protected time is not consistently available - competing priorities and reduced participation from key clinical stakeholders. This impacts on the organisation's ability to: - Progress of Trust wide quality improvement priorities - Embedding PSIRF, and strengthen core governance processes. Impact: Collectively, these gaps increase the likelihood of missed learning, repeated harm, delays in investigations, and reduced ability to identify and address systemic risks. Additional Information to support risk: Regulatory and Performance: Failure to demonstrate PSIRF compliance, meet Duty of Candour requirements, and deliver mandatory national audit programmes poses a significant risk of regulatory scrutiny, adverse CQC ratings (particularly under Well Led and Safe), and loss of confidence from patients, families, staff, and system partners. Limited triangulation of safety, audit, operational and outcomes data weakens assurance and hinders early detection of emerging risks. Inadequate progress on improvement priorities (e.g., falls, nutrition & hydration, deteriorating patient) and advanced accreditation programmes, stalling progress toward quality improvement maturity and service excellence. These gaps collectively threaten the Trust's ability to meet strategic objectives and contractual obligations. Limited meaningful compassionate engagement and involvement with patients, families, and staff, combined with poor feedback loops, creates a culture gap, eroding trust and confidence in governance and safety systems. Resilience: Sustained workload pressures, limited capacity, and single points of failure within patient safety, audit and QI teams affect morale, wellbeing, resilience, and productivity. Reliance on a small number of individuals without robust succession planning or cross cover increases operational vulnerability. Clinical teams report	Lugg, Mr Jason	4	4	4	**12**	1. Partial implementation of approved governance structure with defined workforce gaps: • Central team: 2 Band 6 roles requiring optimisation of scope/capacity; 1 additional Band 7 role requiring establishment and funding approval • Divisional teams: 4 roles (Band 4–7) requiring establishment and funding; 1 Band 7 role in second round of recruitment following unsuccessful initial recruitment, 1 Band 6 a pre recruitment phase. • Business case partially approved, funding confirmation pending 2. Targeted interim capacity management and prioritisation across patient safety, audit and QI: • Capacity focused on PSIRF compliance, Duty of Candour, harm/impact investigations, and national audit submissions • Improvement workstreams prioritised and performance monitored through governance forums, with lower-priority activity progressing in line with capacity 3. Role optimisation and redistribution of responsibilities to support delivery: • Defined accountability for investigation quality, audit coordination and QI programme delivery • Cross-cover arrangements in place to reduce single points of failure • Targeted deployment of limited specialist resource (patient safety, audit, QI) to highest-risk and/or lowest-engagement areas • Defined workstream membership and clinical leadership, with oversight to identify and address variation in engagement and risk 4. Strengthened investigation and organisational learning processes: • Implementation of standardised PSIRF-aligned templates, structured training, and system-based learning approaches • Compliance and quality monitored through routine audit, supporting consistency	16/03/2026
RUH-3235	Outdated Policies and Limited Governance Resource	RUH	There is a risk of non-compliance with statutory and regulatory requirements, including Care Quality Commission (CQC) Fundamental Standards, NHS England governance frameworks, and other applicable legislation. This is a result of the Trust having a significant number of corporate policies and guidelines that are out of date and limited resource within the Corporate Governance team to administer the policy process, due to an inherited and inefficient process. Potential Impact: • Failure to comply with CQC regulations and NHS governance standards. • Increased likelihood of adverse findings during inspections or audits. • Reputational damage and potential enforcement action. • Operational inefficiencies and lack of clarity for staff, leading to inconsistent practice. Statutory/Regulatory References: • CQC Fundamental Standards (Regulation 17: Good Governance – requires systems and processes to assess, monitor, and improve quality and safety). • Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. • NHS England Policy Framework and Code of Governance for NHS Provider Trusts. • Patient safety and quality risk due to the potential that clinical staff are unable to locate contemporary	Palmer, John	5	3	4	**12**	Current Controls: • Policy register maintained by Corporate Governance team. • Limited prioritisation of high-risk policies for review.	18/06/2026
RUH-3288	Insufficient Capital Funding	RUH	There is a Risk that there is insufficient CDEL capital funding for business critical infrastructure and strategic objectives to be maintained in line with acceptable risk appetite which will impact regulatory, performance, quality & safety, digital and cyber and financial objectives	Palmer, John	4	4	4	**12**	1. Bid for national capital funds 2. Revenue funding to maintain equipment and backlog maintenance 3. Pro-active risk management 4. Proactive prioritisation of Capital budget owned by the Capital Prioritisation Management Group, supported by 4 key sub groups (Medical Equipment Ctte, Capital Projects Team, IT team, Sulis Exec Board) 5. 4 year rolling capital prioritisation process 6. Trust-wide Board of Directors approves the capital plan, however the cost overrun of EPR has led to Group wide CDEL budget being over-committed therefore a new Group Strategic Capital Group to be created to ensure group-wide risk is prioritised. 7. The Capital Programme Management was subject to internal audit during 25/26 and was assessed as Strong Assurance with limited areas for improvement.	29/04/2026
RUH-1882	Non-compliance with fire compartmentation	RUH	There is a risk that the Trust will be in breach of our statutory duty to provide safe fire compartmentation. This is as a result of: - numerous fire doors across our site identified as requiring repair, upgrading or replacement, - fire doors may not effectively contain fire or smoke due to their current condition. This could lead to: - Reduced effectiveness of progressive horizontal evacuation and increase in danger to life. - Prosecution and could potentially endanger our staff, patients and members of the public due to a reduced effectiveness in maintaining fire compartmentation. - A recent inspection by the Fire Authority of the accommodation blocks highlighted this as an extreme risk that would result in a prohibition notice if not resolved	Flint, Mr Neil	4	5	3	**12**	1. Remedial works completed to some 60-minute compartmentation for inpatient areas, prioritised on a risk-assessed basis, but is dependent on capital being available. 2. Compliant, L1 fire detection system in place for early warning. 3. Through fire safety training, staff are trained in the safe evacuation of their areas. 4. Fire Risk Assessments are in place, and current for each area. These risk assessments take into consideration any known breaches in fire compartmentation for inclusion in the capital funding programme. 5. Fire wardens are required to carry out frequent audits of their areas and share their findings through the fire safety team. 6. Annual audit by the authorising engineer is undertaken, which demonstrates improvements and shortfalls in fire safety. 7. Installation of door closers in accommodation blocks and replacement of some doors (within available capital). 8. Programme of upgrade accommodation fire safety has been developed. 9. Thorough fire safety training, staff are trained in the safe evacuation of their areas.	02/04/2026
RUH-2110	Business interruption as a result of backlog maintenance, or critical infrastructure risks	RUH	There is an escalating risk that the Trust is unable to maintain the estate to the required standard as set by Health & Safety Executive (HSE), SFG20 and HTM. This will be caused by: - An ageing estate requiring increasing investment to maintain - Limited available funds which do not meet the required demand The residual impact of this risk is that clinical services experience interruption (at an increasing rate), key infrastructure - equipment, plant and building fabric deteriorates at an increasing rate that compromises safe operation and frequency of breakdowns. All of which has a direct impact on the ability to provide safe care and environment for patients and staff. This would like to the risk of harm and / or an inability for the Trust to deliver its key constitutional requirements - RTT, ED and Cancer standards. This will also impact on: - Growing backlog maintenance and critical infrastructure, currently valued at £74m - Failure of daily use equipment such as heating system, water supply - Service disruption or loss of Trust wide services - Infection control through failed water supply or lack of water hygiene - Inadequate ventilation - Deficient fire safety measures - Outdated or damaged internal decorations - Faulty nurse call systems - Compromised roof coverings - IPC adherence and standards - safety of	Flint, Mr Neil	5	4	3	**12**	1. Board Assurance Framework established. Reported by Chief Operating Officer. 2. Prioritisation of capital spend to prioritise the most high risk infrastructure risks. 3. There is capital allocated annually to target the highest priorities of RUH high and significant risks within the backlog maintenance plan. 4. Backlog priority decision taken by Associate Director of Estates and Associate Director of Capital Projects. Decisions are based on condition / environmental based reports and risk assessments provided by technical leads for each discipline. 5. Planned preventative and reactive maintenance schemes implemented by the onsite maintenance team to prolong the life of Estate assets and to react quickly to breakdowns to minimise operational impact. 6. Specific high risks are separated from this umbrella risk and have their own risk assessment, control measures, action plans, etc.	26/03/2026
RUH-2124	Oncology/Haematology Workforce and Service Delivery	RUH	There is a risk that Haematology & Oncology service cannot deliver care safely due to capacity and workforce vacancies - current consultant substantive gap stands between 4.18 and 5.21 WTE. The following impacts have been identified: This is a long-standing risk which has resulted in workarounds such as the substantive establishment working beyond their Job Plans to try and meet the clinical needs of the service leading to further recruitment and retention challenges including junior doctors choosing to work elsewhere due to the challenges and lack of senior support. Service heavily reliant on consultant agency cover with gaps remaining and further increased by staff sickness due to health and well-being/morale. Agency cover often is on a remote working basis, further increasing risk and diminishing safety as observed in Patient Safety Incident Investigations (PSII). In a challenging Haematology & Oncology workforce market, retention of staff is essential to service viability. Capacity is exceeded, Consultant clinics are overbooked daily in an attempt by the wider team to minimise waits and the potential for disease progression. In addition, the service cannot increase the duration of appointments for complex patients. This is having an untoward effect on staff wellbeing and patient experience and overall, the safety of the service. These workarounds whilst attempting to support our sickest patients carry risk and have been shown to cause LTFU and increase treatment times. The nursing staffing position has improved;	Kerslake, Dr Ian	5	4	3	**12**	1. Haem/Onc business case presented to MEC (February 26), approved with some detail required and onward progression to F&P Committee 2. Agency Locum Consultants cover in place due to being unable to recruit substantively at Consultant level 3. Significant overbooking and waiting list initiatives to meet demand 4. Use of cancer pharmacists for designated outpatient clinic work 5. Increased use of non-registered staff to support registered nurses 6. Overview of rosters to optimise patient safety and staff wellbeing 7. Neuro cancer patients closed at RUH and permanently send to Bristol following previous mutual aid arrangement	12/03/2026

RUH-2683	Emergency department unable to meet the NHS England target of four hour waiting times	RUH	There is a risk that compliance with the NHS constitution for England and Department of Health target of four hour patient waiting times in the emergency department (ED) will not be met as a result of: - Insufficient capacity (overcrowding) in ED - Ambulance service implementing the W45 policy - Staffing levels unable to meet the demand due to significant RN vacancies and medical staffing in ED - High numbers of no criteria to reside patients in the wider hospital bed base reducing patient flow - Seasonal demands on the ED department This will impact on: - Increased overcrowding in the ED - Increased risk of mortality and morbidity associated with ED overcrowding - Increased risk of inappropriate decision to admit (DTA) acknowledged when ED is overcrowded - Insufficient staff to monitor and care for patients in ED - Increased risk of 'did not wait' frequency due to long wait times - Patient deterioration - Patients being cared for in the corridor or non-standard areas - Increase in undifferentiated emergency patients in non-standard areas in an overcrowded department - Compromised privacy and dignity being cared for the corridor - Poor patient experience with a poor environment and associated increase in complaints - Overcrowding in the UTC due to high demand and limited alternative pathways - Environmental hazards from idling ambulances and unsafe patient transfers across roads - Increased patient safety and staff wellbeing incident reporting - Reputation of the organisation - Key quality and performance indicators associated with overcrowding (inaccurate data capture and performance reporting)	Lloyd-Rees, Ms Johanna	5	4	3	**12**	1. Placed in Tier 1 for performance, working with the GIRFT team to improve Urgent Emergency Care (UEC) performance and safety. 2. UEC performance improvement is a Breakthrough Objective for 2025/26 reporting to the Trust Engine Room every two weeks. 3. Extended Emergency Medicine Ambulatory Care (EEMAC) commenced in February 26 to improve safety, care & experience and reduce delays/breaches. 4. Flow & Capacity: Rapid Assessment and Ambulatory areas in place; limited direct admissions to manage demand. 5. RUH Timely ambulance handover SOP to fill all appropriate capacity. 6. Ambulance Handover: HALO support, handover nurse, Pitstop triage and offload SOP for corridor care. 7. Clinical Oversight: 24/7 regular huddles and specialty reviews. 8. Governance: Monthly governance and quality meetings reviewing incidents and learning. 9. Staffing & Safety: Block booking additional bank shifts to fill gaps, HCSW support, and safety equipment (e.g. air mattresses). 10. Key quality indicator spot checks on a daily basis conducted by the nurse in charge of ED 11. Regular board rounds to identify appropriate discharges or escalation to support community discharge 12. Operations Pressure Escalation Levels (OPEL) measuring stress demand and pressure the hospital is under - triggers varying levels of response internally and externally to support flow and demand. 13. Staff support though regular listening events and wellbeing offers e.g. TRIM, occupational health and local senior nurse support 14. Bi-weekly review of staffing, recruitment and retention trajectory through NAMIP 15. Monthly key quality indicator audits to monitor accurate data recording and compliance with targets 16. Friends and family action ongoing	26/03/2026
RUH-3242	Delays in typing and sending clinical letters	RUH	There is a risk that delays in typing and sending out of patient's letters (clinic letters, treatment plans, discharge summaries) will occur as a result of: - the absence of key administrative staff through sickness and vacancy. - administrative capacity not meeting current demand - reliance on manual processes compounded by the absence of a consistent IT system - lack of cross-cover arrangements. This will impact on: - a substantial backlog in the typing and sending of clinical letters - timely communication with patients, GPs and other healthcare providers potentially affecting patient care, experience and service efficiency as well as delays in treatment times and patient flow up. - disease deterioration, missed diagnosis, delayed treatment and medication errors - adverse impact on patient experience and confidence in care delivery, increased complaints and reputational risk	Reed, Emma-Kate	5	4	3	**12**	1. Temporary staffing resource in place following approval at Management Executive Committee to focus on improving performance. 2. Discussed and reviewed weekly by Senior Operations Team at the Elective Delivery Group. 3. Cancer patients are tracked by a navigator following a confirmed cancer diagnosis 4. Exploration with Digital Team of sustainable AI solutions to optimise digitalisation.	25/03/2026
RUH-3243	IT equipment age replacement (laptop/desktops)	RUH	There is a risk that laptops and desktop PCs over 5 years old will not be replaced. This risk will be caused as a result of lack of capital funding availability due to the Shared EPR. Since paperless working was introduced, our reliance on working IT equipment has significantly increased. This will impact end users, primarily clinical teams and new starters. Existing laptops and desktops will become unusably slow and risk not being supported on the latest operating systems. This will significantly increase our vulnerability to cyber attacks.	Thorn, Mr Spencer	5	4	3	**12**	1. Devices due for age replacement have been limited to critical clinical areas and any that are not fit for purpose. 2. 750 devices have been replaced in 2025, which has dramatically reduced the requests for IT support from these areas. 3. £650k has been requested in the 5 year capital plan which would partially mitigate the risk - this has not yet been approved.	26/05/2026
RUH-3280	Absence of Retrospective Building Fire Strategies (RBFS) for Existing Healthcare and Other Buildings	RUH	There is a risk that current fire precautions, compartmentation arrangements, evacuation methodologies, and fire safety systems do not meet required standards. This is caused by: - Several existing Trust buildings—including clinical, patient facing areas and other buildings do not have formal Retrospective Building Fire Strategies or are without up to date fire strategies aligned to HTM 05 02 and national building and fire safety legislation. - Historic estate development, legacy buildings, and incremental refurbishment over time without the production of comprehensive fire strategies capturing as built design information. This Impacts on: • uncertainty regarding the effectiveness of existing fire protection measures and may lead to undetected compliance gaps or unsafe assumptions within operational practice. • The Trust may operate buildings with fire precautions that are not fully suitable, sufficient, or coherent, resulting in increased life safety risk and potential regulatory action. • Life safety risk: Inadequate or unclear fire safety design principles may compromise staff and patient safety during fire incidents, including progressive horizontal evacuation. • Legal and regulatory exposure: Non compliance with the Building Regulations, Regulatory Reform (Fire Safety) Order 2005 and Fire Safety Act 2021, increasing the likelihood of enforcement action by the Fire & Rescue Service. • Operational disruption: Delays or errors in fire response procedures due to unclear evacuation strategies and compartmentation boundaries. • Financial impact: Potential for unplanned remedial works, enforcement driven upgrades, or increased insurance scrutiny. • Governance and assurance gaps: Reduction in the Trust's	Lynch, Ms Antonia	4	5	3	**12**	1 Annual Fire Risk Assessments. 2 Monthly AE(Fire) audit reviews. 3 Ongoing compartmentation survey programme. 4 Passive and Active Fire Safety Systems - Fire alarms, detection systems, and emergency lighting maintained via PPM schedules.	18/06/2026
Salisbury NHS Foundation Trust (SFT)										
SFT-5664	Capital required to manage the Trust Backlog Maintenance	SFT	The Trust commissioned a survey in February 2018 to establish the backlog liability of the Trusts Estate. The level of backlog is reported nationally through all Trusts annual Estates Reporting Information and Collection (ERIC). SFT have been indentified as an outlier in this area in recent years reporting a backlog of circa £4M. The survey completed in 2018, higlighted a total backlog of £42M, this risk identifies the challange of managing the risk with the limited capital funding that will be availble in the next 5 - 10 years.	O'Keeffe, John	3	4	tbc	**tbc**	-Bids for Trust Capital. - The capital investment made by the Trust is included within the ERIC data set - accordingly, can be tracked overtime and is publicly available -Bidding for National Estates Safety Fund	30/09/2026
SFT-7917	Fire risk in Main Theatres corridors	SFT	As a result of the storage of equipment in corridors. Hazards to staff/patients and visitors should they need to evacuate. Restricted egress in an emergency, fire doors being restricted from closing due to racking, fire extinguishers being obscured, emergency exit signage being obscured. Potential hazards to the Fire & Rescue Service should they be required to fight a fire within the area due to equipment and cylinder storage. Risk that staff will have difficulty transferring patients into theatres.	Dawson, Gary	5	3	4	**12**	Areas cleared as best as possible so that a theatre trolley can be evacuated out of all the theatres using all designated routes. All fire doors and extinguishers cleared of obstructions. Fire Team to conduct a weekly walk round as a minimum. Increase in the number of trained Designated Fire Safety Offers across the theatres footpint Further embedding of the Fire Safety and Anson Policy Training for all band 6's and 7's ongoing Daily fire-walk in Theatres to assess risks. Theatre Fire Wardens monthly checklist to be completed on a weekly basis and sent through to the Fire team. Theatre staff maintain general housekeeping of the area daily to ensure the actions are continually achieved. Any issues to be escalated to the Theatre Management team / Fire Safety Officers as applicable	30/06/2026
SFT-7931	Lack of appropriate electrical power infrastructure in theatres (Main, DSU and Obstetrics)	SFT	Electrical- Extension leads being used, clinical and patient risk. Risk of fire and electrical shock. The inadequate availability of sockets for medical equipment poses a concern, further compounded by the absence of dedicated IPS/UPS sockets. These shortcomings may compromise the reliability and safety of critical healthcare infrastructure, warranting attention to mitigate potential hazards and ensure functionality of medical equipment.	Thorne, Jon	4	4	4	**12**	Updated 18.06.24 - Weekly PPM visual check of power points and extension leads to check no broken points. Updated 12.12.24 - Now currently doing Two weekly PPM visual checks are carried out and Work orders raised if there are remedial works required. Daily walkarounds to review fire hazards and electrical equipment - feedback to go through Theatre Coordinator. DSU has been removed from the escalation policy and not be used for outlying upstairs due to the fire risk (put in place Feb 26).	30/06/2026
SFT-7946	Transformation programmes and projects are not delivered to time	SFT	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work, delaying the start of new work and spend more corporate resource time than budgeted. This may result in the Trust being unable to deliver it's full savings programme for the year. This risk has been further impacted by the decision announced on 22/05/2025, to put all non clinical vacancies across the organisation through the workforce control process (WCP). This has led to the Transformation team holding vacancies and reducing capacity.	Talbott, Alex	4	4	4	**12**	Note re score: Consideration of controls in place, draws us to conclude the effectiveness of current controls is lower than desired. All controls listed are running and have minutes and agendas to evidence their work in decision making. Transformation programme Boards, including Digital Steering Group (DSG) Resource scheduling bi-weekly meeting Urgent and Emergency Care and Planned Care Boards Small projects Board Corporate Projects Prioritisation Group feeding into the Engine Room Project documentation to support delivery Each programme works to define the benefits it should realise and those benefits are then tracked. Transformation team has a driver in their performance review meeting, focused on project delivery and use of budgeted resources. This is reviewed on a monthly basis and worked on weekly. As part of the 26/27 business plan a review is underway to decide on allocation of resources for the next financial year in order to deliver across the Transformation programme. We have created the SFT turnaround team to support the delivery of our high risk and dependency laden business plan. This team drives a bi-weekly rhythm of CIP and transformation delivery meetings	30/09/2026
SFT-8068	Increase in 2222 calls to Switchboard when lone working, Single operator cover	SFT	Switchboard have seen an increase in emergency 2222 calls made outside of office hours. The team now process more emergency calls out of hours compared to office hours with 3-5 operators. Between the hours of 6pm -8am Mon - Fri and frequent weekends the switchboard only have one operator working to cover incoming call. Operator needs to also cover window duties covering out of hours accommodation, Disabled car parking validation, central collection point for hospital keys, Bleep battery replacement. Operators need to walk away from the working environment to use the toilet leaving the board unattended. When member of the team is away from the switchboard console it increases a delay in processing 2222 emergency call. This could increase the time a response team would receive an emergency alert to respond to a medical emergency. Patient care and onward treatment could be affected. Switchboard currently process circa 75k-90k calls per month in total. Update 03/12/2025 Staff sickness levels have increased since risk log created. Switchboard no longer have a relief cover due to covering 2 members of the team long term sick. Single point of failure. If one more of the team are off on sick leave	Pearce, Richard	4	4	4	**12**	The team have currently changed the relief shift to cover the switchboard until 7pm this has helped with the busier periods of time and to allow the operator time away from the working environment to take a lunch break.	31/07/2026

SFT-8102	Central booking workforce and process instability resulting in risk of patient harm and reduced utilisation across all areas	SFT	As a result of significant workforce shortages, ongoing vacancies, high turnover and inconsistent Booking processes, there is a risk that referrals and appointments are not processed accurately or in a timely manner. Current capacity constraints, including approx. 8.17wte vacancies, combined with a prolonged recruitment process, reduce the ability and flexibility of staff to adequately cover the gaps, prioritise booking activity and process urgent referrals effectively. In addition, there is inconsistency in booking processes, limited adherence to standard operating procedures and insufficient controls to prevent incorrect booking and this inhibits the ability to adequately train new starters or adequately cover vacancies. These factors have resulted in significant operational backlogs, including delays in transferring referrals from eRS into Lorenzo, unprocessed clinic outcomes forms and delays in adding patients to follow up access plans. There is also limited oversight and assurance regarding booking accuracy, clinic utilisation and compliance with booking rules with insufficient reporting to identify and address errors or delays systematically. This may result in delays to patient care, missed or incorrect appointments, patients being lost to follow up and increased burden on clinical teams. It also contributes to poor clinic and theatre utilisation with very high volume of slots being left empty each week. Ultimately, this creates a risk of patient harm, particularly for patients on active treatment pathways, alongside a potential loss of confidence from clinical teams, an impact on Trust performance, operational	Hislop, Nikki	5	4	4	**13**	Recruitment into vacant posts and ongoing recruitment activity Updated processes, including using RPA (Robotic Processing Automation) for some eRS tasks Specialty admin teams providing additional support to process booking and outcome forms Closer working between Central Booking and the wider Specialty Teams - Ops and Clinical Continuing Transformation programme within Central Booking focussing on processes and ways of working Booking Working Group with members of the booking team to highlight areas of change from those that are close to the details Escalation of issues through Datix, governance and operational meetings DMT support and on-site operational intervention Exit interviews are being done to collect data.	30/07/2026
SFT-6229	Risk of DSU - Estate Infrastructure failure	SFT	[07/07/2023 12:00:42 Laurence Arnold] The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous roof leaks and delayed/cancelled procedures. Incidents relating to the building's condition are increasing and impacting on patient safety, care and experience.	O'Keeffe, John	5	4	4	**13**	None ad hoc nature of issues results in limitations around mitigations. Staff manage individual cases and issues None ad hoc nature of issues results in limitations around mitigations. Funding is agreed to create an ECC (Elective Care Centre to include Diagnostics)	30/06/2026
SFT-6412	Harm to women and babies through lack of dedicated 2nd obstetric theatre	SFT	We do not have a second obstetric theatre, and we have therefore repurposed a second anaesthetic room, and as it is not purpose built there is a reluctance to use it which can lead to delays in decision making, and when we do use it there are problems with space and equipment which make it less safe. There is a risk of moderate to catastrophic harm to women and babies due to using the anaesthetic room as a second obstetric theatre. This use is due in part to no second theatre in the maternity unit footprint and partly due to lack of guarantee from main theatres that we can use a theatre there in an emegency. There is a risk that this use of a small, not-for-purpose room will lead to catastrophic harm or death of a woman or baby, and this is in the context of a rising caesarean section rate.	Kingston, Miss Abigail	4	5	4	**13**	There is an SOP that governs decision making. Broadly, in the first instance a member of the obstetric or senior midwifery teams will check availability with main theatre coordinator to assess whether a theatre is available prior to using anaesthetic room, the exception to this would be if there is no time for this conversation to occur. We are datixing all use of second theatre and reviewing as an MDT each case.	01/07/2026
SFT-7734	Capital funding	SFT	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services. This risk has been compounded by the capital demand of the EPR programme.	Wyatt, Jennie	5	4	3	**12**	- capital control group prioritises capital programme - monitor Datix incident reporting related to infrastructure and equipment - rolling 15 month cashflow forecast - maintain a risk assessed 5 year plan - Additional funding received through the estates safety fund.	30/09/2026
SFT-8791	Financial position 2026/27	SFT	The financial plan for 2026/27 is for an break-even plan with assumed 7.2% savings plus productivity improvement requirements. There is a material risk that the plan will not be achieved due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Additionally there is a risk of ongoing underlying deficit if savings are only found non-recurrently. Cash balances have depleted with NHSE instructing that cash must be managed within the system. In the event of under-delivery of savings plans the constraint of capital expenditure will need to be considered. Based on historic delivery and current risk assessed CIP plans there is a identified risk of c£18 million.	Wyatt, Jennie	4	5	4	**13**	- Cash flow forecasting - monitoring reports to F&P - SFI's ensuring strong financial governance - budget signed off for April 2026/27 based on internal assumptions - Deficit support funding agreed £6.4 million - Transitional funding from ICB - Weekly agency usage monitoring - Engagement in group financial recovery structure running from group board down to front-line - Enhanced vacancy control and temporary staffing process - Medical rate card adhered to and escalation for exceptions - Continuation of controls with enhanced oversight by NHSE - Divisional financial escalation meetings in place	31/07/2026

Risk Management Policy

A unified approach to risk intelligence across the Group

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Contents

1. Foreword

This Risk Management Policy sets out how BSW Hospitals Group will identify, assess, manage and report on risk across its three Care Organisations: Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust.

The formation of the Group provides an opportunity to move beyond compliance-based risk recording towards genuine risk intelligence: understanding not just what our risks are, but how well we are managing them, where to focus limited resources, and when to escalate with confidence.

Effective risk management is not an end in itself. It is the means by which the Group Board can be assured that patients receive safe, high-quality care; that public resources are used wisely; that staff are supported and protected; and that the Group can pursue its strategic ambitions with appropriate confidence.

*This policy is founded on the HM Treasury **Orange Book: Management of Risk – Principles and Concepts (2023)** and draws on the **NHS Providers guidance on the essentials of risk management**. It is designed to be read alongside the Group's Assurance Manual, the Group Operating Blueprint and the Board Assurance Framework.*

2. Why Risk Management Matters

2.1 The case for risk intelligence

The BSW Hospitals Group serves a large population across Bath, Swindon and Wiltshire through three acute hospital trusts that are now operating as a single Group. This brings significant opportunities to improve services, share good practice, and deploy resources more effectively. It also introduces new complexities: a larger governance architecture, the need to have both strategic oversight and knowledge of the quality of front line care and the requirement for consistent risk visibility across a diverse operational footprint.

Risk management in this context is not primarily about avoiding harm, though that is critical. It is about enabling better decision-making under uncertainty. When the Group Board and its executives understand where controls are truly effective and where they are not, they can allocate finite resources of time, expertise and money to where they will have the greatest impact.

> *"Improved risk control means Government can manage higher levels of risk to achieve better outcomes for citizens and taxpayers for a given level of resource – or reduce costs for given outcomes." — HM Treasury Orange Book (2023)*

2.2 Benefits of effective risk management

Effective risk management across the Group delivers tangible benefits at every level of the organisation. For the Group Board, it provides confidence that main threats to achieving its strategic objectives are visible, understood and managed. For executive directors, it enables prioritisation of effort and resources based on genuine risk intelligence rather than assumption. For Care Organisations, it supports consistent standards of oversight while respecting local accountability. For patients and staff, it means a safer, better-managed environment in which quality of care is continuously protected and improved.

More specifically, a mature risk management system supports the Group in maintaining patient safety and clinical quality; protecting its financial sustainability and reputation; complying with regulatory requirements including those of the Care Quality Commission, NHS England and the NHS Foundation Trust Code of Governance; fulfilling the requirements of the Annual Governance Statement; enabling informed decision-making at pace when circumstances change; and building the confidence of stakeholders including the Integrated Care Board, regulators and the public.

2.3 Our foundations

This is grounded in two key external references. The **Orange Book** (HM Treasury, 2023) provides the overarching framework for risk management across the public sector, establishing principles of risk identification, assessment, control and reporting that are applicable to all government-funded organisations including NHS Foundation Trusts. It emphasises the central importance of control effectiveness, the need for dynamic risk assessment, and the role of risk management in supporting the achievement of organisational objectives.

The **NHS Providers guidance on the essentials of risk management (**[**The essentials of risk management**]**)** translates these principles into the specific context of NHS provider organisations. It sets out the components of an effective risk management framework including risk vision and strategy, risk culture, risk appetite, policy and governance, risk assessment and control, incident management, and monitoring and assurance. It particularly emphasises the importance of the Board Assurance Framework as a tool connecting strategic objectives to principal risks, controls and assurance.

This policy is consistent with both of these frameworks and applies their principles to the specific circumstances of a multi-site NHS hospital group.

Patient safety risks are managed through this framework alongside the Patient Safety Incident Response Framework (PSIRF), which governs the Group's approach to learning from patient safety incidents. Learning from incidents feeds into risk identification and re-assessment under this policy. Currently each Care Organisation maintains a separate PSIRF policy and Patient Safety Incident response Plan.

3. Key Concepts and Definitions

This section defines the core concepts that underpin the Group's approach to risk management. A shared language is essential for consistent application across all three Care Organisations.

3.1 What is risk?

A risk is an uncertain event or set of circumstances that, should it occur, would have an impact on the achievement of the Group's objectives. Risks may be threats (negative impacts) or opportunities (positive impacts). This policy primarily addresses threats, though the scoring methodology and governance arrangements apply equally to opportunity risk where appropriate.

3.2 Risk appetite

Risk appetite is the level and type of risk the Group is willing to accept in pursuit of its strategic objectives. It provides the boundaries within which the organisation operates and guides decision-making at all levels. A clearly articulated risk appetite enables the Board to set expectations about acceptable levels of exposure, supports executives in making consistent decisions, and provides a framework for escalation when risks exceed tolerable levels.

The Group Board will develop and approve a risk appetite statement that sets qualitative and, where possible, quantitative appetite levels across the principal risk categories. This will be reviewed annually and adjusted to reflect changes in the Group's strategic context. Until the risk appetite statement is formally agreed, the Group will operate on the principle that risks scoring 12 or above (a score of 15 is the maximum) on the residual risk scale require active Board-level oversight and that no risk should be tolerated without explicit acknowledgement at the appropriate governance level.

3.3 Risk tolerance

Risk tolerance refers to the specific level of risk that the Group is prepared to accept for a particular risk at a particular point in time. While risk appetite is a strategic-level statement, tolerance is applied operationally to individual risks. A risk may sit within the Group's overall appetite but be subject to a specific tolerance threshold that, if breached, triggers escalation or additional controls.

3.4 Controls

A control is a specific mechanism, activity or intervention that prevents a risk from occurring, detects when it is occurring, or reduces its impact if it does occur. Controls are the operational actions through which risks are managed day to day.

A key principle of this policy is that controls are verbs, not nouns. They are things that happen, not things that exist. A policy document is not a control; the specific actions taken under that policy are the controls. A committee is not a control; the reviews, challenges and decisions taken by that committee are the controls.

3.5 Assurance

Assurance is the evidence and confidence that controls are operating effectively and that risks are being managed within agreed tolerances. The Group's assurance model is based on the internationally recognised Three Lines Model, described in Section 6 of this strategy.

3.6 Board Assurance Framework (BAF)

The BAF is a structured document that maps the Group's strategic objectives to the principal risks that could prevent their achievement, the controls in place to manage those risks, the sources of assurance that controls are working, any gaps in control or assurance, and the actions being taken to address those gaps. The BAF is the primary risk document reviewed by the Group Board and provides the critical link between strategic intent and risk management practice.

3.7 Risk Registers

The Group operates a structured hierarchy of risk registers to ensure that risks are visible at the right level and managed by the right people. There are three distinct types:

The Care Organisation Risk Register (or Group Corporate Service Risk Register) contains all the risks that have been identified within that organisation or service. On a day-to-day basis these risks are owned and managed by divisions, care groups and individual teams. Each Care Organisation maintains its own risk register, as do Group corporate services.

The Corporate Risk Register contains the higher-scoring risks within a Care Organisation that have been escalated from the full risk register for more senior oversight. While the Care Organisation's leadership team should be cognisant of all risks on the full risk register, it is expected that they will give most focus and attention to those that have been escalated to the Corporate Risk Register.

The Group Risk Register contains those risks that have been escalated from the Care Organisations' Corporate Risk Registers because they affect Group-level functions, affect multiple Care Organisations, or require Group-level coordination and oversight. The Group Executive reviews and maintains this register.

3.8 Principal Risk

A principal risk is a risk that, if it materialised, could seriously affect the ability of the Group to achieve one or more of its strategic objectives. Principal risks sit on the Board Assurance Framework and are owned by the Group Board with Group Executive sponsorship.

4. The 5+5+5 Risk Scoring Methodology

The Group adopts an enhanced risk scoring methodology that introduces a third scored dimension – control effectiveness – alongside the traditional measures of consequence and likelihood. This model is a defining feature of the Group's approach to risk management and is referred to as the 5+5+5 methodology.

4.1 How the methodology works

Each risk is scored on three dimensions, each on a scale of 1 to 5. The three scores are added together to produce a residual risk score ranging from 3 (lowest) to 15 (highest).

Score	Consequence	Likelihood / Frequency	Control Effectiveness	Assurance Level
1	Negligible	Remote / Not expected to occur for years	Fully Effective	Substantial Assurance
2	Minor	Unlikely / Expected to occur at least annually	Largely Effective	Reasonable Assurance
3	Moderate	Possible / Expected to occur at least monthly	Partially Effective	Limited Assurance
4	Major	Likely / Expected to occur at least weekly	Planned but not in place	Very Limited Assurance
5	Catastrophic	Almost certain / Expected to occur at least daily	Absent	No Assurance

Inherent Risk Score = Consequence + Likelihood (range: 2–10). This represents the level of risk before any controls are applied.

Residual Risk Score = Consequence + Likelihood + Control Effectiveness (range: 3–15)

4.2 Why this matters: the power of control scoring

Traditional risk scoring methodologies multiply consequence by likelihood to produce a score. This approach has a fundamental weakness: it cannot distinguish between a well-controlled risk and a poorly controlled risk when both happen to have the same consequence and likelihood scores.

By adding control effectiveness as a third scored dimension, the Group's methodology reveals where controls are genuinely working and where they are not. Two risks may both carry a consequence of 4 and a likelihood of 3, but if one has fully effective controls (scoring 1, total 8) and the other has absent controls (scoring 5, total 12), these represent entirely different management challenges requiring entirely different responses. The former needs monitoring; the latter needs urgent intervention.

This approach aligns with ISO 31010:2019, which requires organisations to assess not merely the existence of controls but their design effectiveness, operating effectiveness, documentation and monitoring arrangements.

> *The critical difference: control effectiveness scoring reveals WHERE to focus effort and resources. There can be the same consequence and likelihood but with vastly different residual risk depending on the quality of controls.*

4.3 Risk classification by score

Risk Level	Score	Review Frequency	Oversight
Significant	12–15	Monthly	Group Board, Risk & Assurance Committee, Group Executive Committee
Serious	10–11	Monthly	Care Organisation Management Group, Group Executive Committee
Moderate	6–9	Every three months	Divisional Leadership Team / Care Group
Low	3–5	Every six months	Local management

This policy confirms that all risks scoring 12 and above are required to be escalated to the Risk and Assurance Committee and Group Board.

5. Controls: The Heart of Risk Management

The quality of control identification and assessment is the single most important factor in effective risk management. Without rigorous attention to controls, risk scoring becomes an exercise in opinion rather than evidence. This section sets out the Group's expectations for how controls are defined, categorised and assessed.

5.1 What is a control?

A control is a specific mechanism, activity or intervention that acts directly on a risk by preventing it from occurring, detecting when it is occurring, or reducing its impact if it does occur.

Every control listed on a risk register must pass a three-question test:

#	Test	Question
1	**Specificity**	Can you describe exactly what happens, when, and by whom?
2	**Direct action**	Does it directly prevent, detect or mitigate this specific risk?
3	**Auditability**	Could someone verify that it is operating as intended?

If the answer to any of these three questions is "no", what has been described is not a control. It may be useful context, infrastructure or aspiration, but it should not appear in the controls section of a risk register.

5.2 Types of control

Controls fall into three categories based on their function:

Type	Purpose	Characteristics
Preventive	Stops the risk from materialising	Acts before the event; typically systemic, automated or procedural
Detective	Identifies when the risk is materialising or has materialised	Acts during or shortly after the event; relies on monitoring and alerting
Mitigating	Reduces the impact if the risk materialises	Acts after the event; limits damage, enables recovery

A well-controlled risk will typically have a combination of all three types. An over-reliance on any single type represents a vulnerability. For instance, a risk managed solely through detective controls may identify problems but cannot prevent them from occurring in the first place.

5.3 What is not a control

In practice, many items listed as "controls" on risk registers are not controls at all. The following categories should not be recorded as controls, though they may provide important context:

Not a control	Why not
Policy documents	A policy describes what should happen but does not itself act on the risk. The specific actions taken under the policy are the controls.
Organisational structures	Having a committee or a named lead is infrastructure, not a control. The reviews, decisions and actions taken by those individuals and groups are the controls.
Aspirations or plans	Developing a strategy or planning to introduce a new process is not a control until it is operational. Planned controls should be scored as 4 (planned but not in place).
Generic statements	Phrases such as “staff are aware”, “management oversight”, “robust processes” or “appropriate training” are not controls. They describe a general state of affairs rather than a specific, auditable mechanism.

> *Key principle: if you cannot audit it, you cannot assess its effectiveness. If you cannot assess its effectiveness, you cannot rely on it to manage the risk.*

5.4 Assessing control effectiveness

Each control, or the suite of controls for a given risk, is assessed on the five-point scale described in Section 4. This assessment must be evidence-based, drawing on data, audit findings, incident reports, compliance monitoring and operational observation. It is not sufficient to assert that controls are effective without supporting evidence.

Control effectiveness is not a static assessment. It must be reviewed at least as frequently as the risk itself is reviewed and must be adjusted to reflect changes in operational circumstances, staffing, demand, system changes or other factors that may affect how well controls are operating.

Where the control effectiveness score for a significant or serious risk is assessed as 4 or 5 (planned but not in place, or absent) and remains at that level for three or more months, a deep dive will be triggered at Group Executive level to determine what additional support or intervention is required.

6. Risk Governance and Escalation

The Group's risk governance arrangements are designed to ensure that risks are owned at the right level, reviewed at the right frequency, and escalated through clear pathways when they exceed the capacity of the current level to manage them.

6.1 The G Line and T Line

The Group operating model establishes two governance boundary lines that define risk ownership and escalation:

Above the G Line (Governance Line) sit the Group's principal risks and high-scoring operational risks that require Board-level visibility. These are overseen through the Group Risk and Assurance Committee. The Group Board is concerned both with risks to strategic objectives and with significant operational risks that could affect patient safety, service quality or organisational sustainability. This ensures the Board maintains line of sight to the full spectrum of material risk, not only strategic risk.

Between the G Line and the T Line (Threshold Line) sit strategic and operational risks that span the Group and are managed by the Group Executive. These are risks that affect multiple Care Organisations, require Group-level coordination, or have strategic implications but are primarily managed through executive action rather than Board decision-making.

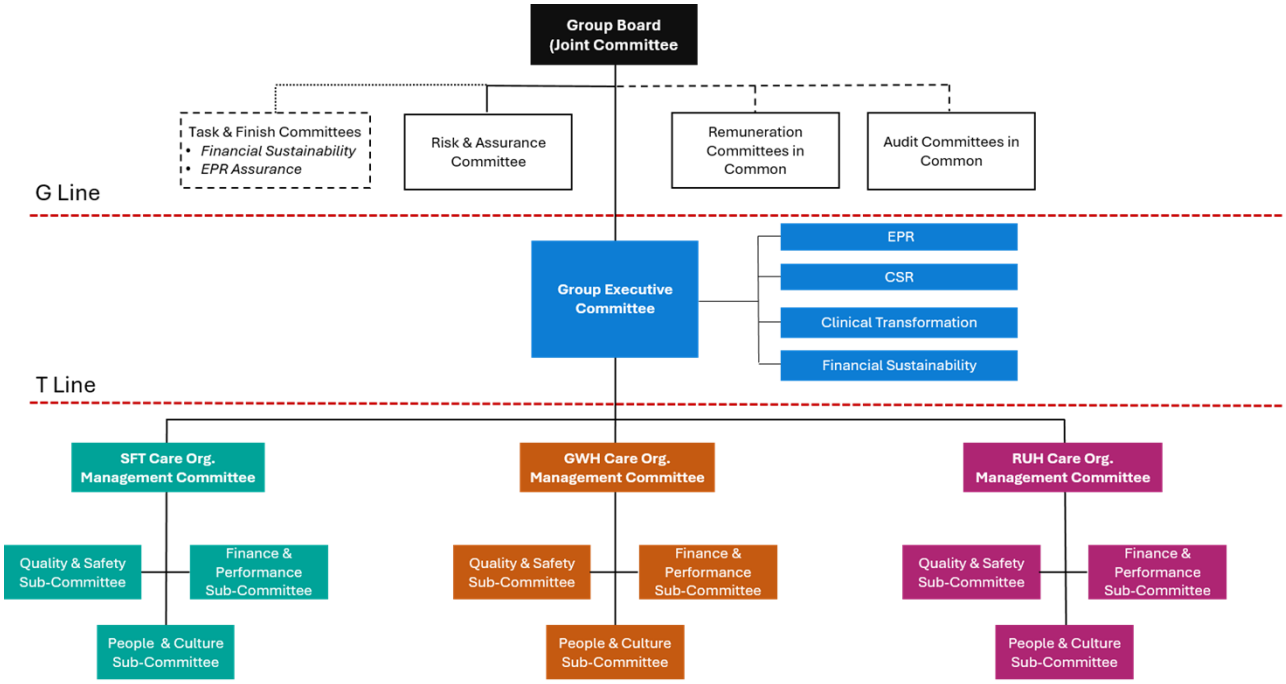
Below the T Line sit operational risks owned and managed by Care Organisation leadership teams, divisional management teams, care groups and local managers. These are risks to day-to-day service delivery that are managed within existing delegated authority.

Escalation flows upward. Risks that cannot be adequately managed at their current governance level, or that signal concerns with wider implications, are escalated upward. This includes operational risks that exceed local management capacity, risks that affect multiple Care Organisations, and any risk – **whether classified as strategic or operational** – that could materially affect patient safety, service quality, financial sustainability, or the Group's ability to meet its regulatory obligations. The Group Board and Risk and Assurance Committee are concerned with the full range of material risk facing the Group, not solely risks to strategic

objectives. **For the avoidance of doubt, all risks scoring 12 and above are required to be escalated to the Risk and Assurance Committee and Group Board.**

6.2 Governance structure

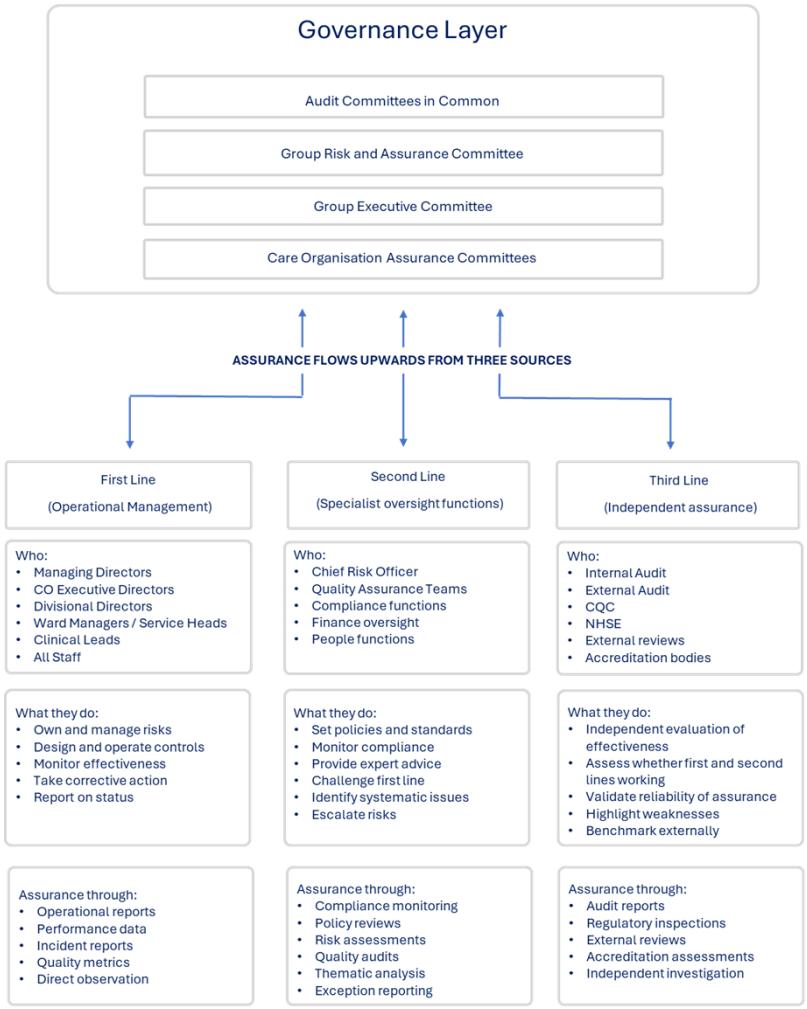
The diagram below shows how the Group's governance committees relate to the G and T Lines and to risk management at each level.



Separation of Board governance from operational management. Reporting above and below the G Line is different to ensure that Board oversight remains focussed on residual uncertainty and system effectiveness while operational management is developed and owned below the T Line.

6.3 The three lines model

The Group's assurance arrangements are built on the internationally recognised Three Lines Model. This model defines three distinct sources of assurance, each providing a different perspective on the effectiveness of risk management and controls.



First Line: Operational Management. Those who own and manage risks and controls day to day, including Managing Directors, Care Organisation directors, divisional directors, ward managers, clinical leads and all staff delivering services. They are responsible for identifying risks, designing and operating controls, monitoring effectiveness and reporting on status.

Second Line: Specialist Oversight Functions. Those who provide oversight, monitoring and challenge to the first line, including the Group Chief Risk Officer and risk management teams, quality assurance and patient safety teams, compliance functions, finance teams and people functions. They set policies and standards, monitor compliance, provide expert advice, challenge assessments, identify systemic issues, and escalate significant risks.

Third Line: Independent Assurance. Those who provide independent and objective assurance, including Internal Audit, External Audit, the Care Quality Commission, NHS England and other external reviewers. They evaluate the effectiveness of governance, risk management and internal control; assess whether the first and second lines are functioning effectively; and validate the reliability of assurance information.

Governance committees sit above the three lines and receive assurance from them. Care Organisation committees receive assurance primarily from the first and second lines. The Group Executive Committee receives assurance from all three lines. The Group Risk and Assurance

Committee and Audit Committees in Common receive assurance primarily from the second and third lines, providing independent scrutiny on behalf of the Board.

7. From Ward to Board: How Risk Connects

A defining feature of this policy is the clear line of sight from risks identified at ward and department level through to Board-level strategic oversight. This connection operates through three distinct but interconnected layers of risk documentation.

7.1 The three layers of risk

Layer	What it contains	Owned by	Purpose
Care Organisation Risk Registers	All risks identified within each Care Organisation or Group corporate service, managed day to day by divisions, care groups and teams	Divisions, care groups and teams, with Care Organisation leadership oversight	Comprehensive record of all identified risks; day-to-day risk management at operational level
Care Organisation Corporate Risk Registers	Higher-scoring risks escalated from the full Care Organisation risk register for senior leadership focus and oversight	Care Organisation Leadership Teams, with Managing Director oversight	Ensure senior leadership focus on the most significant operational risks within each Care Organisation
Group Risk Register	Risks escalated from Care Organisation Corporate Risk Registers that affect Group-level functions, multiple Care Organisations, or require Group coordination	Group Executive	Ensure visibility and coordinated management of cross-cutting operational risks at Group level
Board Assurance Framework (BAF)	Principal risks to the achievement of the Group's strategic objectives	Group Board with Group Executive sponsorship	Provide the Board with assurance that strategic risks are identified and managed

7.2 How risks move between layers

It is essential to understand that these layers are not based on severity. A risk does not move to the BAF simply because it has a high score. The test is what the risk threatens:

Strategic principal risks threaten the Group's strategic objectives – they could prevent the Group from achieving what it has set out to do. These belong on the BAF regardless of their score, because the Board needs assurance that they are managed.

Operational risks threaten day-to-day service delivery. They may score highly, but if they do not fundamentally challenge strategic direction, they belong on the Care Organisation or Group Risk Register rather than the BAF. However, this does not mean they escape Board attention. High-scoring operational risks are visible to the Group Board through the Risk and Assurance Committee, operational performance reporting and Managing Director reports. The Board and

RAC are concerned with the full range of material risk – strategic and operational – that could affect patient safety, service quality, financial sustainability or regulatory standing.

Operational risks may, however, signal the need for a strategic risk. Where a pattern of operational risks across multiple Care Organisations indicates a systemic issue that threatens strategic objectives, the Group Executive should consider whether a new principal risk is required on the BAF.

The Group Executive Committee meeting is the critical assessor and determinant of where risks lie. It reviews escalated risks from Care Organisations, assesses whether they require Group-level coordination, and advises the Board on whether individual risks or patterns of risk have strategic implications.

8. Roles and Responsibilities

Effective risk management requires clear accountability at every level. The following table sets out the principal responsibilities across the Group.

Role	Risk management responsibilities
Group Board	Ultimate accountability for risk management across the Group. Approves principal risks, the BAF, and the Group risk appetite. Ensures the risk management system is effective and provides adequate assurance.
Group Risk and Assurance Committee	Provides detailed scrutiny of principal risks and the BAF on behalf of the Board. Reviews escalated significant operational risks. Assesses assurance levels and control effectiveness. Recommends to the Board on risk appetite and tolerance.
Audit Committees in Common	Independent oversight of the risk management system's effectiveness. Reviews Internal Audit findings. Assesses adequacy of assurance arrangements. Provides challenge to executive risk owners.
Group Chief Executive	Accountable to the Board for the effective operation of risk management. Ensures the Group Executive maintains adequate oversight and challenge of the risk profile. Signs the Annual Governance Statement.
Group Executive Committee	Collective responsibility for identifying, assessing and managing risks across the Group. Determines whether risks are strategic or operational. Scrutinises control adequacy and action plan delivery. Coordinates risk intelligence across Care Organisations.
Group Chief Risk Officer	Provides independent advice to the Chief Executive and Board on risk and assurance matters. Maintains oversight of the Group Risk Register and BAF. Assesses the maturity and effectiveness of risk management across Care Organisations. Coordinates assurance processes and ensures consistency in methodology. Provides independent assessment of control effectiveness. Alerts the Board to emerging risks or weaknesses in the assurance system. Reports functionally to the Board Risk and Assurance Committee to ensure independence from operational management.
Managing Directors	Accountable for risk management within their Care Organisation. Ensure Corporate Risk Registers are maintained and reviewed. Oversee escalation to Group Executive. Report to the Group Board on Care Organisation risk profile.
Executive Directors	Own and champion risks within their functional area. Ensure controls are in place, effective and evidenced. Sponsor action plans and monitor delivery. Lead risk culture within their teams.
Divisional / Care Group Leaders	Maintain local risk registers. Assess and manage moderate and serious risks within delegated authority. Escalate risks that exceed local management capability.
All staff	Identify and report risks arising from their work. Operate controls as designed. Participate in risk assessment and improvement. Report incidents, near misses and concerns.

9. Risk Ownership and Escalation Summary

The following table summarises the ownership, oversight, monitoring and escalation arrangements for each level of residual risk score.

Risk Level	Score	Ownership	Oversight	Monitoring	Review	Escalation
Significant	12–15	Care Org Leadership / Corporate Leadership Team	Managing Director / Group Executive Director	Board, RAC, Group Executive, CO Management Committee	Monthly	To Group Board as potential Principal Risk
Serious	10–11	Divisional Management Team (or equivalent)	Managing Director / Group Executive Director	CO Assurance Committees*	Monthly	Alignment with risk profile; support needs
Moderate	6–9	Local Management Team	Divisional Leadership / Care Group	Appropriate senior manager	Quarterly	When local mitigation insufficient
Low	3–5	Local Management Team	Divisional Leadership / Care Group	Appropriate senior manager	Six-monthly	

Note: the escalation score thresholds are subject to review by the Group Executive and Board as the new system is embedded and calibrated.

*** under the terms of reference for these committees, they are also required to notify (rather than escalate) the Care Organisation Management Committee of risks scoring 10 and 11.**

10. Glossary of Terms

Term	Definition
Assurance	Evidence and confidence that controls are operating effectively and risks are managed within agreed tolerances.
Board Assurance Framework (BAF)	A structured document linking the Group's strategic objectives to principal risks, controls, sources of assurance, gaps and actions. The primary risk document reviewed by the Group Board.
Care Organisation	One of the three hospital trusts within BSW Hospitals Group (GWH, RUH, SFT), each led by a Managing Director and operating with delegated authority under the Group model.
Care Organisation Risk Register	The comprehensive register of all risks identified within a Care Organisation or Group corporate service, managed day to day by divisions and teams.
Consequence	The impact if a risk were to materialise, scored 1 (negligible) to 5 (catastrophic).
Control	A specific mechanism, activity or intervention that prevents, detects or mitigates a risk. Must be specific, act directly on the risk, and be auditable.
Control effectiveness	An evidence-based assessment of how well a control or suite of controls is operating, scored 1 (fully effective) to 5 (absent).
Corporate Risk Register	A record of the higher-scoring operational risks within a Care Organisation that have been escalated for senior leadership focus. Distinguished from the full Care Organisation risk register and the Group Risk Register.
Escalation	The formal process of raising a risk to a higher governance level when it exceeds local management capacity or has wider implications.
G Line (Governance Line)	The governance boundary above which strategic principal risks are owned by the Group Board and overseen through the Risk and Assurance Committee.
Group Risk Register	The register of risks escalated from Care Organisation Corporate Risk Registers that affect Group-level functions, multiple Care Organisations, or require Group coordination. Maintained by the Group Executive.
Group Chief Risk Officer	The senior officer providing independent advice on risk and assurance, maintaining oversight of the Group Risk Register and BAF, and reporting functionally to the Board Risk and Assurance Committee.
Inherent risk	The level of risk before any controls are applied, assessed by adding consequence and likelihood scores (range 2–10).
Likelihood	The probability of a risk materialising, scored 1 (remote) to 5 (almost certain).
Orange Book	HM Treasury's Management of Risk – Principles and Concepts (2023), the foundational public sector risk management framework.
Principal risk	A risk that could seriously affect the Group's ability to achieve one or more of its strategic objectives. Sits on the BAF.

Residual risk	The level of risk remaining after controls are applied. Under the 5+5+5 methodology: consequence + likelihood + control effectiveness (range 3–15).
Risk	An uncertain event or set of circumstances that, should it occur, would have an impact on the achievement of objectives.
Risk appetite	The level and type of risk the Group is willing to accept in pursuit of its strategic objectives.
Risk intelligence	The organisational capability to understand not just what risks exist but how well they are managed, where to focus resources, and when to escalate.
Risk tolerance	The specific level of risk acceptable for a particular risk at a particular time, within the overall risk appetite.
T Line (Threshold Line)	The governance boundary below which operational risks are owned and managed by Care Organisation leadership, divisional teams and local managers.
Three Lines Model	An internationally recognised assurance framework defining three sources of assurance: operational management (1st), specialist oversight (2nd) and independent assurance (3rd).
5+5+5 methodology	The Group's risk scoring model: Consequence (1–5) + Likelihood (1–5) + Control Effectiveness (1–5) = Residual Risk (3–15).

BSW Group Data Sharing Agreement (Joint Controller Agreement)

BSW Hospitals Group

Royal United Hospitals Bath NHS Foundation Trust
Great Western Hospital Foundation Trust
Salisbury NHS Foundation Trust

Release/ Status	Draft
Version	0.3
Date	**27 May 26**

PROGRAMME DOCUMENT CONTROL

Document Title	BSW Joint Controller Agreement – BSW Hospitals		
Document Owner	Jonathan Hinchliffe Group CDIO/SIRO		
Document Controller	Graeme Temblett-Willis Group DPO	**Contact**	

Version History				
Date	**Status**	**Version**	**Summary of Changes**	**Author / Reviser**
14 April 26	Draft	0.1	Document created	Graeme Temblett-Willis
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Name	**Version**	**Approval Date**
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Distribution	**Purpose**	**Date**	**Version**
IGSG	Review and endorsement	18/06/2026	V0.3
DSMB	Review and Approval	26/06/2026	V0.3

Contents

Parties

This Joint Controller Agreement ("Agreement") is made between:

- Royal United Hospitals Bath NHS Foundation Trust
- Great Western Hospital NHS Foundation Trust
- Salisbury NHS Foundation Trust

(each referred to individually as a "Care Organisation" and collectively as the "Parties").

The Parties are each independent NHS organisations and legal entities within the NHS and each acts as a Data Controller under the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018.

Purpose of the Agreement

The BSW Hospital Group brings together multiple NHS Care Organisations to deliver coordinated clinical, operational and strategic functions. As part of this model, the Care Organisations collectively operate shared services, digital platforms and data capabilities which require the aggregation, analysis and reporting of personal and special category data.

In these circumstances, the Care Organisations jointly determine the purposes and essential means of processing for defined Group level functions. Under the UK General Data Protection Regulation (UK GDPR), this constitutes Joint Controller processing, requiring a formal agreement under Article 26 UK GDPR.

This Agreement establishes the governance and operational arrangements under which the Parties act as Joint Controllers when operating as the BSW Hospital Group.

Joint Controller processing under this Agreement applies where the Parties jointly determine the purposes and means of processing personal data in support of Group level functions, including but not limited to:

- shared digital platforms and data services.
- group wide performance, quality and safety oversight.
- operational planning, reporting and analytics.
- population health management and system transformation.
- delivery of statutory, regulatory and mandatory NHS reporting.

The Agreement ensures compliance with Article 26 UK GDPR, which requires joint controllers to transparently determine their respective responsibilities for data protection compliance.

Background

The Parties are NHS Care Organisations operating as part of the BSW Hospital Group, collaborating to deliver coordinated healthcare services across the BSW system.

In support of the Group Model, the Parties operate shared services, platforms and data capabilities, including shared reporting, analytics and information services.

Each Care Organisation remains an independent legal entity and Data Controller for data originating from its own clinical care activities, and maintains its own data protection registration with the Information Commissioner's Office (ICO).

However, where the Parties jointly determine the purposes and essential means of processing for Group level activities, the Parties act as Joint Controllers for the processing covered by this Agreement. On some occasions, where resource permits, one party may act as a Processor for one or more of the Controllers.

Scope of Processing

This Agreement applies to the processing of personal data and special category data undertaken as part of the BSW Hospital Group operating model.

Group level processing includes:

- ingestion and aggregation of data from Care Organisation source systems.
- standardisation and transformation for Group reporting and oversight.
- storage and management of shared datasets.
- authorised access for clinical, operational and corporate functions.
- production of Group dashboards, analytics and statutory returns.

Processing supports healthcare service management, quality improvement, operational oversight and fulfilment of statutory NHS obligations across the BSW Hospital Group.

Lawful Basis for Processing

Processing is undertaken in accordance with:

- UK GDPR Article 6. Article 6(1)(e). Processing necessary for the performance of a task carried out in the public interest by the BSW Hospital Group and its constituent Care Organisations.

- UK GDPR Article 6. Article 6(1)(f). Processing is necessary for the purposes of a recognised legitimate interest (effective management of a group of undertakings, in the public interest); as amended by the Data (Use and Access) Act 2025
- UK GDPR Article 9.
    - Article 9(2)(h). Processing necessary for the management of health or social care systems.
    - Article 9(2)(i). Processing necessary for reasons of public interest in the area of public health.
- Data Protection Act 2018. Schedule 1 provisions relating to health and social care management.

Joint Controller Responsibilities

The Parties jointly determine the purposes and essential means of Group level processing covered by this Agreement.

Governance and Oversight.

The Parties will establish and maintain BSW Group Data Governance arrangements to oversee Joint Controller processing. These include:

- approving Group level purposes for data use.
- approving data access policies.
- monitoring security and information governance risks.
- approving new data integrations and shared services.
- ensuring adherence to national NHS data standards.
- data privacy will be overseen by the BSW Group Data Protection Officer and their Deputy.
- Completion of DPIAs for high-risk transfers of data under this Agreement, as determined by the BSW Group Data Protection Officer or their Deputy

- Group and Care Organisation will appoint representatives including:
    - Group SIRO/Group Chief Digital Information Officer
    - Caldicott Guardian
    - Group Director of Information Services
    - Group DPO/Deputy DPO
    - Information Governance Lead. (Supporting BSW Group DPO and Deputy).
    - Data & Analytics Lead.
    - Clinical Safety Officer.
- Data Protection Compliance Responsibilities. The Parties agree the following allocation of responsibilities. Each Care Organisation will:
    - remain responsible for the accuracy and integrity of data originating from its systems.
    - ensure lawful collection of personal data.
    - ensure staff access is authorised and appropriate.
    - investigate incidents relating to its staff.
- Joint Responsibilities. The Parties jointly agree to:
    - ensure each Care Organisation operates in accordance with this Data Sharing Agreement.

- maintain appropriate technical and organisational safeguards.
- operate access controls and audit monitoring.
- manage cross-Care Organisation data access governance.
- ensure compliance with the UK GDPR and Data Protection Act 2018.
- Maintain Records of Processing Activities and Information Asset Registers
- Maintain data protection registrations
- Complete annual Data security and Protection Toolkit assessment

Data Subject Rights

The Parties agree to cooperate in responding to requests from data subjects including:

- Subject Access Requests.
- Rectification requests.
- Restriction of processing requests.
- Objections to processing.

Data subjects may exercise their rights against any of the Joint Controller Care Organisations. The Care Organisation receiving the request will act as the primary coordinator and will liaise with other Parties as necessary to ensure a complete and timely response.

Security Measures

The Parties agree to implement appropriate technical and organisational safeguards for Group level data services and shared processing environments including:

- Role-based access control.
- Authentication and identity management.
- Encryption of data at rest and in transit.
- System audit logging.
- Access monitoring.
- Incident response procedures.

Security standards will align with the NHS Data Security and Protection Toolkit, NHS cyber security standards and relevant NHS England guidance

Personal Data Breaches

If a personal data breach occurs within Group level processing activities:

- The incident will be reported immediately to the Shared Data Governance Board.
- The Care Organisation responsible for the affected users or data will lead the investigation.
- All Parties will cooperate in incident response.

Where required, the relevant Care Organisation will notify the Information Commissioner's Office and affected individuals will be informed in accordance with regulatory requirements. The BSW Group Data Protection Officer (or their deputy) will be informed of any incident that requires escalation within 48 hours and this will be managed via the DSPT Incident Reporting portal (Report an Incident)

Data Processors

The Parties may appoint processors to support Group level platforms and services, including analytics, integration and hosting providers.

All processors must operate under GDPR compliant Data Processing Agreements.

Transparency

Each Care Organisation will ensure that its privacy notices inform patients that their data may be processed as part of BSW Hospital Group shared services and data platforms.

Retention and Disposal

Data will be retained in accordance with NHS Records Management Code of Practice. The Parties will jointly ensure that data is not retained longer than necessary and that secure deletion processes are implemented when required.

Liability

Each Care Organisation remains responsible for its compliance with applicable data protection legislation. Where a breach arises from joint processing activities, the Parties will cooperate to determine responsibility and manage any regulatory response.

Review

This Agreement will be reviewed annually, following major system changes affecting the operational activity across the BSW Hospital Group and following significant data protection incidents.

Termination

If a Care Organisation withdraws from Group joint processing arrangements, the Parties will agree appropriate access cessation, data separation or migration arrangements, and ongoing compliance measures in accordance with data protection and NHS records management obligations. This will not impact any data that continues to be needed to support legal compliance.

Signatures

Signed on behalf of each organisation.

BSW Hospitals Group
Name: Jonathan Hinchliffe
Title: Group SIRO/Group Chief Digital and Information Officer
Signature:

Date: 27 May 26

Public Group Board
Annual Cycle of Business 2026/27

TB - Trust Board | Approval

ITEM	PURPOSE	EXECUTIVE LEAD	AUTHOR	Q2 Jul-26	Aug-26	Sep-26	Q3 Oct-26	Nov-26	Dec-26	Q4 Jan-27	Feb-27	Mar-27	Q1 Apr-27	May-27	Jun-27
BOARD ADMINISTRATION **Opening Business**															
Apologies for absence	Noting	Chair	Verbal	✓		✓		✓		✓		✓		✓	
Declarations of interest	Noting	Chair	Verbal	✓		✓		✓		✓		✓		✓	
Patient story	Noting	Chief Nursing Officers	Various	✓ RUH				✓ GWH				✓ SFT			
Staff story	Noting	Director of OD & People	Various			✓ SFT				✓ RUH				✓ GWH*	
Minutes of the last meeting	Noting	Chair	Director of Corporate Governance	✓		✓		✓		✓		✓		✓	
Matters arising and action log	Noting	Chair	Director of Corporate Governance	✓		✓		✓		✓		✓		✓	
Chair's business	Noting	Chair	Verbal	✓		✓		✓		✓		✓		✓	
Chief Executive Officer Update (to include EPR Update)	Noting	Group CEO	Director of Communications	✓		✓		✓		✓		✓		✓	
ESCALATION REPORTS															
Audit Committees In Common Escalation Report	Assurance	Audit Committee Chair	Audit Committee Chair			✓		✓				✓			
Group Risk and Assurance Committee Escalation Report	Assurance	Chair of RAC	Senior Risk Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Escalation reports from SFT/RUH/GWH June 2026 Committees	Assurance	Managing Directors / NEDs	NEDs	✓											
OPERATIONAL PERFORMANCE															
Integrated Group Performance Report	Assurance	Group CEO	Executive Directors	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MD Reports from Care Organisations (SFT/GWH/RUH individual reports)	Assurance	Managing Directors	Managing Directors	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
FINANCE															
Group Finance Report	Assurance	Chief Finance Officer	Finance Directors	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Group Financial Strategy / Medium Term Financial Plan	Approval	Chief Finance Officer	Chief Finance Officer/ Finance Directors									✓			
Approve annual consolidated budget and financial plan (to include operational and capital plan)	Approval	Chief Finance Officer/ Group CEO	Chief Finance Officer / CO COO											✓	
Major Business Case Post-6 Month Review of Benefits/ Delivery (ADHOC)	Assurance	Chief Finance Officer	Executive Directors												
QUALITY & SAFETY															
Quarterly Learning from Deaths Report (NHSNQB National Guidance)	Assurance	Chief Nursing Officers	Chief Medical Officers			Q4		Q1		Q2				Q3	
Director of Infection Prevention and Control (DIPC) Report	Assurance	Chief Nursing Officers	Site Lead Nurse Infection Control			✓									
Clinical Negligance Scheme for Trusts (CNST): Maternity Incentive Scheme Annual Declaration (SFT/GWH/RUH individual reports)	Approval	Chief Nursing Officers	Site Director of Midwifery									✓			
Quarterly Maternity Quality and Safety Report	Assurance	Chief Nursing Officers	Director of Midwifery	Q4				Q1		Q2				Q3	
Freedom to Speak Up Annual Report	Assurance	Chief Nursing Officers	Chief Nursing Officers												
Quality Account (SFT/GWH/RUH individual reports)	Ratification	Chief Nursing Officers	Chief Nursing Officer											✓	
STRATEGY & TRANSFORMATION															
Approve Group strategy and strategic objectives (incl. enabling strategies: workforce, estates, digital, quality)	Approval	Group CEO / Group Strategy Office	Group Strategy Officer	Update		✓		✓				✓			
New Models of Care : Clinical Services Transformation - Bi-monthly	Assurance	Group Chief Clinical Transformation Officer (CCTO)	Group Chief Clinical Transformation Officer (CCTO)	✓		✓		✓		✓		✓		✓	
New Models of Care - EPR Delivery Assurance Report -Bi-monthly	Assurance	Group CEO	Chief Executive Officer	✓		✓		✓		✓		✓		✓	
New Models of Care - CSR - Bi-monthly	Assurancwe	Chief People Officer	Chief People Officer	✓		✓		✓		✓		✓		✓	
Approve major service changes, partnerships or strategic initiatives (ADHOC)	Approval	Group CEO	Executive Lead												
Quarterly update on Executive Objectives to Board	Assurance	Group CEO	Group CEO			✓		✓				✓		✓	

ESTATES & DIGITAL																	
SIRO Annual Data Security & Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR)	Approval	Group Digital and Information Officer	Group Digital and Information Officer			✓											
Green Plan Annual Report / Approval every three years (GWH/RUH/SFT separate report)	Assurance/ Approval	Group CEO / Managing Directors	Site Sustainability Leads										✓				
Health & Safety Annual Report	Assurance	Chief Finance Officer	Health and Safety Manager					✓									
Annual Cyber Report	Assurance	Group Digital and Information Officer	Group Digital and Information Officer			✓											
PEOPLE & CULTURE																	
Workforce Strategy and People Plan	Approval	Chief People Officer	HR Directors					✓							Update		
Nursing and Allied Health Professionals (AHP) Safer Staffing Review (Bi-annual)	Assurance	Chief Nursing Officers	Deputy Directors of Nursing					✓							✓		
Maternity Safer Staffing Review (Bi-annual)	Assurance	Chief Nursing Officers	Head of Midwifery					✓							✓		
Guardian of Safe Working Annual Report (Annual Report)	Assurance	Chief People Officer	Guardian of Safe Working (RS)			✓											
National Staff Survey Results	Assurance	Chief People Officer	Deputy Directof of OD & People	✓													
Medical Revalidation and Appraisal Annual Report (Including Statement of Compliance)	Approval	Chief Medical Officer	Chief Medical Officer	✓													
Equality and Diversity Annual Report (to include WRES & WDES/ Gender Pay Gap)	Approval	Chief People Officer	Site HR Directors										✓				
Corporate Services Review(CSR) Programme - EQIAs*(Develop and report to Group Board a bi-annual view of EQIAs completed associated with the CSR programme*)	Assurance	Chief People Officer	Chief People Officer					✓							✓		
RISK & ASSURANCE																	
Group Risk Management Policy (every 3 years)	Approval	Senior Risk Officer	Senior Risk Officer								✓						
BSW Group-wide Risks scoring ≥12	Assurance	Senior Risk Officer	Senior Risk Officer	✓		✓		✓			✓		✓		✓		
Group Board Assurance Framework (BAF) and Risk Register	Assurance /Approval	Senior Risk Officer	Senior Risk Officer	**Q1**				**Q2**			**Q3**				**Q4**		
Group Risk Appetite and Tolerance Levels	Approval	Senior Risk Officer	Senior Risk Officer										✓				
GOVERNANCE																	
TB - Annual Report and Accounts including AGS (Reports to public board once laid before parliament) (GWH/RUH/SFT separate report)	Approval	Director of Corporate Governance/ Chief Finance Officer	Director of Corporate Governance			✓											
TB Standing Financial Instructions, Standing Orders and Scheme of Reservations and Delegation (GWH/RUH/SFT separate report)	Approval	Chief Finance Officer	Chief Finance Officer												✓		
Annual review of Board effectiveness and Improvement Plan (including Group Committee Terms of Reference) N.B. committees in common approval to each Trust Board)	Approval	Director of Corporate Governance	Director of Corporate Governance										✓				
Annual Review Fit and Proper Persons Test	Approval	Director of Corporate Governance	Head of Corporate Governance												✓		
Annual review of Directors Interests	Approval	Director of Corporate Governance	Head of Corporate Governance												✓		
TB - External Well-led Review (Report Q4; Fieldwork Q3)	Assurance	Group CEO / Senior Risk Officer	Senior Risk Officer/ Director of Corporate Governance								✓				✓		
External Well-led Review Assurance Report (ADHOC)	Assurance	Group CEO / Senior Risk Officer	Senior Risk Officer/ Director of Corporate Governance														
Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance	Approval	Managing Directors	Chief Operating Officers										✓				
Bi-annual assurance visits to Care Organisations - Formal record of outcomes and agreed actions	Assurance	Group CEO/ NEDs	Director of Corporate Governance					✓							✓		
TB NHSE Self-Certification (CoS7)	Approval	Chief Finance Officer	Director of Corporate Governance												✓		
TB - Review of the Constitution (every 3 years)	Approval	Chief Executive	Director of Corporate Governance												✓		
GROUP TRANSITION																	

Approve transition programme milestones and governance readiness	Approval	Group CEO	Executive Directors																
CLOSING BUSINESS																			
Reflections of meeting	Noting	Chair	Verbal	✓		✓		✓			✓		✓			✓			
Any Other Business	Noting	Chair	Verbal	✓		✓		✓			✓		✓			✓			
Public Questions	Noting	Chair	Director of Corporate Governance	✓		✓		✓			✓		✓			✓			
Date of Next Meeting	Noting	Chair	Verbal	✓		✓		✓			✓		✓			✓			

*Resident Doctors

Statutory Roles for NHS Boards

Subject to review

Adapted from Liverpool University Hosptials Group

Portfolio	Role	Legislation / Requirement	BSW Group level	RUH Lead	SFT Lead	GWH Lead
Overall Responsibility for the Trust	Chair	NHS Act 2006	Group Chair			
	Accounting Officer	NHS Act 2006	Group CEO			
	Senior Independent Director	NHS E Code of Governance	tbc			
Emergency Preparedness	Accountable Officer for Emergency Preparedness	Emergency Preparedness Resilience and Response (EPRR), NHS England 2009	Group CEO	Chief Operating Officer	Chief Operating Officer	Chief Operating Officer
Medicines Management	Accountable Officer for the Destruction of Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)	Chief Medical Officers (x3)			
	Accountable Officer for Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373) think 1 and 2 fall under the CDAO responsibilities				
	Medicines Safety Officer	Patient Safety Alert NHS/PSA/D/2014/005				
	Non-Medical Prescribing Lead	NMC Code of Conduct/Standards				
	Chief Pharmacist. Director of Pharmacy	CQC (part of well led and responsible for systems and processes for medicines management				
	Chief Pharmacist	The Pharmacy (Preparation and Dispensing Errors – Hospital and Other Pharmacy Services) Order 2022 (allows the Trust to benefit from the dispensing error defences)				
	Hospital Pharmacy and Medicines Optimisation Executive Lead	NHSI, Carter Project				
	Hospital Pharmacy and Medicines Optimisation Lead	NHSI, Carter Project				
Finance	Accounting Officer	NHS Act 2006	Group CEO			
	Counter Fraud Board Lead (Executive)	Directions to NHS Bodies on Counter Fraud 2004	Group CFO	CO Finance Lead	CO Finance Lead	CO Finance Lead
	Local Counter Fraud Specialist	Directions to NHS Bodies on Counter Fraud 2004				
	Security Management Director	Secretary of State Directions March 2005				
	Local Security Management Specialist	Secretary of State Directions March 2005				
	Senior Compliance Officer	Bribery Act 2010				
Information Management/Governance	Caldicott Guardian	HSC1999/012	Group Chief Digital & Information Officer	CO Digital & Information Lead	CO Digital & Information Lead	CO Digital & Information Lead
	Senior Information Risk Officer (SIRO)	Information Governance Toolkit				
	Information Governance Lead	NHS Standard Contract				
	Chief Clinical Information Officer	NHS Information Strategy				
	Data Protection Officer	Data Protection Act and General Data Protection Regulations				
	Executive Board member for data and cyber security	Data Protection Act and General Data Protection Regulations				
	Trust Board Lead (Executive)	As below	Group Chief Finance Officer	Associate Director	Associate Director	Associate Director
	Health and Safety Assistance	Reg 7: Health and Safety Assistance. The Management of Health and Safety at Work Regulations 1999				
	Responsible Person (Fire)	Part 2 Fire Safety Duties. The Regulatory Reform (Fire Safety) Order 2005				
	Safety Assistance (Fire)	Reg 18: Safety Assistance. The Regulatory Reform (Fire Safety) Order 2005				
	Board Level Director (Fire)	Firecode – fire safety in the NHS Health Technical Memorandum 05-01: Managing healthcare fire safety				
	Fire Safety Manager	Firecode – fire safety in the NHS Health Technical Memorandum 05-01: Managing healthcare fire safety				

Health & Safety	Expert Advice	Reg 14: Expert Advice. The Ionising Radiation (Medical Exposure) Regulations 2017	Group Chief Finance Officer (supported by Group Director of Estates and Facilities)	Associate Director of Estates & Facilities	Associate Director of Estates & Facilities	Associate Director of Estates & Facilities
	Radiation protection Adviser	Reg 14: Radiation Protection Adviser. The Ionising Radiations Regulations 2017				
	Dangerous Goods Adviser	1.8.3: safety adviser. ADR 2023 - Agreement concerning the International Carriage of Dangerous Goods by Road				
	Designated Duty Holder (Medical Pipelines, ventilation, water, Electrical)	Health Technical Memorandum 00: Policies and principles of healthcare engineering				
	Designated Person (Medical Pipelines, ventilation, water, Electrical	Health Technical Memorandum 00: Policies and principles of healthcare engineering				
	Senior Operational Manager (Medical Pipelines, ventilation, water, Electrical)	Health Technical Memorandum 00: Policies and principles of healthcare engineering				
Infection Control	Director of Infection Prevention & Control (DIPC)	Health & Social Care Act 2008 Code of Practice on Control of Infection	Chief Nursing Officers (x3)			
	Decontamination Lead	Health & Social Care Act 2008 Code of Practice on Control of Infection				
Safeguarding	Safeguarding Executive Lead	Safeguarding Accountability Assurance Framework	Chief Nursing Officers (x3)			
		NHS Standard Contract				
	Lead Professional for Safeguarding	Safeguarding Accountability Assurance Framework				
	Designated Doctor for Child Protection	Safeguarding Accountability Assurance Framework				
	Designated Doctor for Safeguarding Adults	Safeguarding Accountability Assurance Framework				
	Named Nurse for Safeguarding Adults	Safeguarding Accountability Assurance Framework				
	Designated Midwife for Safeguarding	Safeguarding Accountability Assurance Framework				
	Deprivation of Liberty & Safeguarding (DoLS) Lead	Mental Capacity Act 2005				
	Mental Health Act Administrator	Mental Capacity Act 2005				
	Prevent Lead	Counter-Terrorism and Security Act 2015	Managing Directors (x3)	Chief Operating Officer	Chief Operating Officer	Chief Operating Officer
		NHS Standard Contract				
Freedom of Information Act	Freedom of Information Act Lead	Freedom of Information Act	Group Chief Digital & Information Officer			
	Qualified Person for FOIA	Freedom of Information Act				
Freedom to Speak Up	Freedom to Speak Up Guardian	NHSE Requirement & requirement of NHS Standard Contract	Group Chief People Officer	CO People Lead	CO People Lead	CO People Lead
	NED Champion for Freedom to Speak Up	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles.				
Quality/Patient Safety	Quality Executive Lead	Francis Inquiry	Chief Nursing Officers (x3)			
	Executive Lead for End of Life Care	More Care, Less Care Report 2013				
	Responsible Person for Compliance with Complaints Regulations	NHS Complaints Regulations				
	Complaints Manager	NHS Complaints Regulations				
	Guardian of Safe Working Hours	NHS Employers	Chief Medical Officers (x3)			
	Medicines Devices Safety Officer	Patient Safety Alert NHS/PSA/D/2014/006	Chief Medical Officers (x3)			
	Central Alerting System (CAS) Liaison Officer	NHS England – Introduction to the National Patient Safety Alerting System	Chief Nursing Officers (x3)			
	Responsible Officer for Revalidation	General Medical Council				
	Quality Review Service Lead	NHS England	Chief Nursing Officers (x3)			
	Patient Safety Specialist	NHS Patient Safety Strategy	Chief Nursing Officers (x3)			
	NED Champion for Doctors Disciplinary	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles.	tbc			
		Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors Dentists in the NHS	tbc			

		Directions on Disciplinary Procedures 2005	tbc			
Human Tissue Authority	Designated Individual	Human Tissue Act	Chief Medical Officers (x3)			
Human Fertility & Embryology	Responsible Person	Human Fertility & Embryology Act	Chief Medical Officers (x3)			
Care Quality Commission	CQC Nominated Individual	Health & Social Care Act 2014	Chief Nursing Officers (x3)			
Sustainability	Trust Board Lead (Executive)	NHS Carbon Reduction Strategy 2009	Group Chief Finance Officer (supported by Group Director of PFI and Group Services)	Associate Director of Estates & Facilities	Associate Director of Estates & Facilities	Associate Director of Estates & Facilities
	Designated Person (Sustainability)	NHS Carbon Reduction Strategy 2009				
	Senior Operational Manager (Sustainability)	NHS Carbon Reduction Strategy 2009				
Equality & Diversity	Board Executive Lead	Equality Act 2010	Group Chief People Officer			
Wellbeing	NED Champion for Wellbeing	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles.	tbc			
		We are the NHS People Plan for 2020-21-action for us all.				
Maternity	NED Champion for Maternity	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles.	tbc			
		Ockenden Review 2020.				
Security Management	NED Champion for Security Management	NHS England – Enhancing Board Oversight, A New Approach to NED Champion Roles.	tbc (Chair of Audit Committee)			
		Directions to NHS Bodies on Security Management Measures 2004.				