Great Western Hospitals NHS Foundation Trust

TRUST BOARD

Thursday 15 January 2026, 9.30am to 1.00pm
By MS Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Chris Burton	Verbal	LC	-	09.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 11 December 2025 (draft)	6 – 13	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	14	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	LC	-	-
6.	**Care Reflection – Duty of Candour Process** Tania Currie, Head of Patient Experience & Engagement & Chris Bull, Deputy Chief Nurse	15 – 16	TC/CB	Receive	09.35
7.	**Chair's Report** Liam Coleman, Chair	17 – 19	LC	Note	10.05
8.	**Chief Executive's Report** Cara Charles-Barks, Chief Executive Lisa Thomas, Managing Director	20 – 28	CCB/ LT	Note	10.20
BREAK (10 minutes) at 11.00 to 11.10am					
9.	**Integrated Performance Report** Integrated Performance Report – Breakthrough Objective and Pillar Metric deep dive	29 – 84	Executive Directors	Receive	11.10
	• Quality & Safety Committee Board Assurance Report (December) – Claudia Paoloni, Non-Executive Director & Committee Chair	85 – 88	CP	Assurance	-

		PAGES	BY	ACTION	TIME
10.	**GWH Maternity Incentive Scheme (CNST) Year 7 Submission – Compliance Report** Kat Simpson, Director of Midwifery & Neonatal Services and Laura Little, Project Co-ordinator for Maternity & Neonatal Services *(received at Quality & Safety Committee 18 December 2025)*	89 – 95	KS/LL	Approve	12.00
11.	**Safe Staffing 6-month review for Nursing, Midwifery & AHP** Luisa Goddard, Chief Nurse *(received at Quality & Safety Committee 20 November 2025)*	96 – 125	LG	Note	12.15
12.	**Cyber Security Framework – Board Assurance Report** Jonathan Hinchliffe, Group Chief Transformation & Innovation Officer (Interim) *(received at Finance, Infrastructure & Digital Committee 24 November 2025)*	126 – 155	JH	Receive	12.30
CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**					
13.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	None	CC	Approve	12.55
14.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-
15.	**Date and time of next meeting** Thursday 12 March 2026 at 9.30am, Wichelstowe & Oakhurst Meeting Room, Pierre Simonet Building (Vygon), Swindon, SN25 4DL	Verbal	LC	Note	-
16.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	13.00

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF TRUST BOARD HELD IN PUBLIC
VIA MICROSOFT TEAMS
11 DECEMBER 2025 AT 9.30AM

Present (voting):

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

In attendance:

Caroline Coles (CC)	Company Secretary
Emma Sedgwick (ES)	Acting Board Secretary
Jade Booy (JB)	Named Professional Safeguarding Children (agenda item 134/25)
Katherine Simpson (KS)	Director of Midwifery & Neonatal Services (agenda item 140/25)

Apologies:

Simon Wade (SW)	Chief Financial Officer

* non-voting member

Number of members of the Public: There were 5 members of the public in attendance (Vivien Gibbs, Governor; Mary Day, Governor; Chris Shepherd, Governor; Gordon Wilson, Governor; Harriet Walters, Clinical Educator/Clinical Scientist (Cardiac) - *observing as part of doctoral training programme*)

Matters Open to the Public and Press

Minute	Description	Action
129/25	**Apologies for Absence and Chair's Welcome** Liam Coleman, Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public, apologising for the difficult decision to move the meeting online at short notice due to health and safety considerations. The decision was made following an assessment of the increased flu activity within the general population and the Trust. It was acknowledged that attendees generally prefer in-person meetings, but the decision was considered appropriate given current circumstances. Apologies were received as above.	
130/25	**Declarations of Interest** There were no declarations of interest.	

Minute	Description	Action

131/25 **Minutes of the previous meeting (public)**
The minutes of the Board meeting held in public on 11 September 2025 were adopted and agreed as a correct record subject to the following amendments:-

- Minute No. 081/25 – Chief Executive's Report – NHS League Tables : Replace "managing reputation" with "managing the public's trust and confidence in GWH services".
- Attendance list – inconsistencies noted within the membership and in attendance to be amended.

Matters Arising
It was agreed to refer the opportunities to explore AI more broadly to the Finance, Infrastructure & Digital Committee (FIDC).
Action : **Chief Transformation & Innovation Officer**

132/25 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list. No updates or amendments were provided.

133/25 **Questions from the public to the Board relating to the work of the Trust**
It was noted that the question received has been responded to within the paper and no further questions were received.

134/25 **Staff Story Presentation – Victim of Modern Slavery and Human Trafficking**
Jade Booy, Named Professional Safeguarding Children joined the meeting to present this item.

Jade Booy presented an overview of her role and team, outlining her background and commitment to ensuring children are seen, heard and protected. She shared a complex safeguarding case involving a young female, "Rosie," suspected to be a victim of modern slavery and trafficking who entered the UK in 2020. Despite discrepancies in age documentation, Rosie was treated as a child, and a coordinated multi-agency response was initiated involving police, social care, the voluntary sector and the Integrated Care Board (ICB).

A Section 47 investigation confirmed significant harm, and after 17 days Rosie was discharged to a specialist placement for victims of modern slavery. Key strengths included rapid escalation, strong advocacy and effective multi-agency working. Learning points related to age assessments, escalation processes and managing language barriers. Positive feedback was received from partners, and Rosie expressed gratitude for the support, describing her discharge as a "second chance." Jade Booy emphasised that safeguarding is a core, embedded function within the Trust, enabling timely intervention and improved outcomes for children.

The Chair thanked Jade for the presentation, recognising the emotional impact of the work and the importance of reflecting on both successes and learning.

Board members commended the safeguarding team and sought assurance on Rosie's current wellbeing, dissemination of learning, staff support and system-wide safeguarding capability. It was confirmed that Rosie was settled in her placement, the ICB intended to share learning nationally, and the safeguarding team was well-supported through regular supervision, clear boundaries and a strong focus on wellbeing.

Further discussion covered voluntary sector capability and assurance processes, alignment of safeguarding practice across the BSW group, and whether hospital admission could have been avoided. It was confirmed that established assurance processes exist within the

Minute	Description	Action

safeguarding partnership and that opportunities to align practice across BSW were being explored.

The Chair concluded by thanking Jade and her team, noting the value of real-life safeguarding cases in bringing policy and training to life and recognising the positive impact of their work.

The Board **noted** the staff story.

135/25 **Chair's Report**

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

- The outcome of the recent Council of Governor elections;
- Confirmation that Chris Callow had been appointed as Lead Governor
- The Group Chair recruitment long-listing meeting held on 21 November. It was noted that Liam Coleman, Chair did not attend as this was appropriately managed by the Senior Independent Director (SID) in line with governance arrangements.

The Chair then sought Board approval for the allocation of the new Non-Executive Directors (NEDs) and Associate NEDs to Board sub-committees. It was confirmed that committee allocations were intended as initial placements based on experience and availability, with a review after six months to allow flexibility and broader exposure over time.

RESOLUTION:

The Board approved the allocation of the new NEDs and ANEDs to the relevant Board sub-committees.

136/25 **Chief Executive's Report**

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

An update was provided by the Chief Executive on key areas of concern and organisational priorities. Cara Charles-Barks, Chief Executive highlighted two main challenges currently dominating focus across the three organisations: urgent and emergency care pressures and financial sustainability.

A significant increase in ambulance conveyances and Emergency Department attendances had been reported at the Trust over the past two months, compounded by rising flu cases. While the 45-minute ambulance handover target had improved offloading times, it had also contributed to overcrowding in Emergency Departments and to increased corridor care. In response, a system-wide monthly programme had been put in place to stabilise emergency care, working closely with system partners. Luisa Goddard, Chief Nurse, reported that sustained operational pressure had impacted on some key quality metrics however robust mitigating actions were in place to maintain safe care.

Financial pressures were noted, with the Board advised that despite an agreed recovery plan, increased costs linked to industrial action and sustained clinical pressure had adversely impacted financial performance. Balancing operational delivery and financial sustainability remained a priority, with the emergency care reset expected to provide some mitigation. Additional national funding had been secured for an elective "sprint" focused on increased outpatient activity to reduce waiting lists, with all three organisations working collaboratively to target areas of greatest system need and reduce inequity.

Faried Chopdat, Non-Executive Director/Deputy Chair, sought assurance that the winter plan remained appropriate in light of sustained pressures and whether further action was needed to maintain capacity and financial resilience. It was confirmed that the winter plan

Minute	Description	Action

was under active review, with further mitigations, including capacity options, being assessed. With regard to the integrated front door programme it had improved Emergency Department performance, particularly for same-day discharge pathways. However, full benefits had yet to be realised as the second phase, providing additional assessment capacity, had not been implemented, due to financial restrictions.

The Board noted that a prioritisation process was underway to manage multiple transformation programmes, together with a clinical review would identify six priority specialties for transformation over the next 6-12 months, using model hospital data, cost-weighted activity and GIRFT benchmarking.

Samaher Sweity, Associate Non-Executive Director, asked whether any initiatives should be paused to protect safety and quality and whether leadership capacity remained sufficient following recent changes. It was confirmed that the Executive Team had prioritised mission-critical areas such as performance and financial recovery, EPR implementation, corporate services redesign and clinical transformation with other initiatives, including the strategy refresh, deferred until after April. The Chief Executive emphasised that this approach was necessary to support organisational resilience and future improvements. It was noted that recent key Group level leadership appointments had strengthened resilience and strategic capability.

Chris Burton, Non-Executive Director, commended the high staff flu vaccination uptake and asked how staff morale was being supported during current pressures. Lisa Thomas, Managing Director outlined a range of measures, including enhanced communications, letters to frontline staff acknowledging challenges, promotion of wellbeing support, increased leadership visibility, and initiatives such as tea trolley rounds and thank-you visits.

Will Smart, Non-Executive Director, asked how plans to reduce non-criteria-to-reside patients and introduce “call before convey” would achieve sustained improvement. Cara Charles-Barks confirmed the 9% target remained part of the agreed system plan, supported by daily oversight, closer partnership working and increased system accountability.

Sandra Gordon, Non-Executive Director, asked which quality indicators were most affected by current pressures. Luisa Goddard, Chief Nurse, advised that some nurse-sensitive measures, including pressure ulcers and falls, had deteriorated but remained under close review and robust mitigating actions were in place to maintain care standards, including senior oversight, daily checks for patients in non-standard bed spaces and ongoing monitoring of incidents.

The Chair noted that headline urgent and emergency care data did not fully reflect the severe pressure within Emergency Departments, particularly from ambulance arrivals and that on-going overcrowding and corridor care were acknowledged as system capacity challenges, not a lack of staff effort.

The Board **noted** the report.

137/25 **Integrated Performance Report**

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

Board Assurance Reports

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meeting on 29 October 2025 and 3 December 2025 and the following was highlighted:

Minute	Description	Action

- There was a significant disparity in mean waiting times – UTC approximately 2.5 hours and ED around 7 hours – which illustrated ongoing pressure within emergency departments.
- Ambulance conveyances had increased by an average of 8 per day.
- Handover times had improved with patients now transferred into ED within 30 minutes.
- Cancer performance had shown a downward trend over recent months, with particular concern regarding the 28-day faster diagnosis standard for skin, colorectal and breast pathways. Additional funding was being used to run 18 weekend clinics for skin cancer to reduce backlog. Referrals had increased by 9%, adding further pressure.
- Target performance for diagnostics had been achieved 5 months early which had provided substantial assurance for the first time and also reflected significant improvement through efficiency and reorganisation.
- RTT performance had continued to improve for the fifth consecutive month; however rising referrals had made the achievement of sub 18-month targets more challenging.
- Excluding the financial override, the Trust was ranked at approximately 125th out of 205 hospitals in the NHS Performance Assessment Framework and had placed this Trust mid-table.

Will Smart, Non-Executive Director, sought clarification on references to workforce and financial constraints impacting cancer pathways. The Chief Operating Officer replied that cancer alliance funding had reduced significantly this year, limiting additional clinic capacity. Rising referrals, particularly for skin cancer, had increased pressure on services, and future planning would need to consider whether additional internal funding was required to meet demand.

Will Smart, Non-Executive Director, asked about the recent increase in referrals to the general patient tracking list. It was reported that no single cause had yet been identified, the trend was recent and varied by specialty, and further analysis was underway to determine whether this reflected seasonal change or rising long-term demand, including demographic factors.

Vivien Gibbs, Governor, asked about improvements in diagnostics and whether this was the use of AI. While AI was being piloted, improvements have largely come from increased staffing, equipment investment and community diagnostic centres.

Samaher Sweity, Associate Non-Executive Director, asked whether the Trust was meeting NHS England expectations on health inequalities. It was noted that the Trust was broadly compliant, though data quality and small sample sizes limited interpretation. Further work was noted to strengthen analysis and target actions where health inequalities were most evident.

The Board **noted** the report.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (QSC) at its meetings on 18 September 2025, 23 October 2025 and 17 November 2025 and the following was highlighted:

- The majority of areas remained rated as ‘Good’ assurance.
- Some areas were rated as ‘Partial’, primarily due to outcomes or results but were supported by robust action plans and strong oversight.

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- The outcome of deep dives into medical safety reports, pressure ulcers and Sepsis Pressure ulcers.
- Areas of concern related to Stroke, deteriorating patients and integrated front door reports.
- Despite pressures, systems and oversight remained strong

Chris Burton, Non-Executive Director, queried the limited assurance rating for stroke services. Luisa Goddard, Chief Nurse, explained this reflected access and therapy capacity issues, particularly 7-day therapy, and confirmed that business planning and a divisional action plan were in place to improve front-door identification, patient flow and assurance. Andrew Hollowood, Chief Clinical Transformation Officer, added that while stroke was not yet prioritised for group-wide review, wider pathway redesign, including hyper-acute and specialist transfers, was likely to be considered in future.

Samaher Sweity, Associate Non-Executive Director asked whether the limited assurance rating for sepsis reflected a recurring theme or a snapshot of a single period, and whether this area was scheduled for a deep dive review. Luisa Goddard, Chief Nurse, advised that sepsis performance against the one-hour antibiotic standard was reported as satisfactory, with further improvements underway for other bundle elements, supported by a new clinical lead and targeted training. Claudia Paoloni, Non-Executive Director and Chair of Quality & Safety Committee, highlighted that sepsis performance was closely monitored through detailed triangulation by the Committee, building on strong improvements in infection control. While some sepsis metrics may appear challenging, overall infection outcomes have improved, providing assurance that performance is well understood, actively challenged

Samaher Sweity, Associate Non-Executive Director also queried whether poor communication, particularly around waiting times and lack of updates for patients, could be addressed through digital tools such as text messaging or other technological solutions. Luisa Goddard, Chief Nurse, advised that patient experience concerns, particularly waiting times, were being addressed through focused improvement work, including better communication, use of technology and a “waiting well” approach.

Liam Coleman, Chair concluded that quality and safety would remain the Trust’s overriding focus amid severe operational pressures, including high front-door demand and seasonal flu, and noted that senior executives were providing daily oversight and actively reallocating resources to manage risk, acknowledging that this may impact some performance metrics but was necessary to maintain patient safety.

The Board **noted** the report.

Our People

People & Culture Committee Chair Overview

The Board received an overview of the detailed discussions held at the People & Culture Committee (PCC) at its meeting on 28 October 2025 and the following was highlighted:

- The Committee assessed assurance on each division’s ability to meet workforce recovery targets.
- Good assurance on the recovery target was noted for Surgery and Planned Care (clear, targeted plan) and Family and Specialist Services.
- Risks remained in relation to Corporate Services (digital and estates) and Medicine (substantial challenges).
- Reports received on undergraduate and postgraduate education, with strong feedback from partner universities for undergraduate education, and noting progress around postgraduate education with further work required.

Minute	Description	Action

- Work underway to consolidate three temporary staffing solutions into a single system which was expected to deliver efficiencies and cost savings.
- The Committee reviewed rollout plans for simplified Behaviours Framework and that positive progress could be reported.

Will Smart, Non-Executive Director, asked how the Board would deliver the NHS England workforce reduction target while managing quality and safety risks. It was advised that workforce decisions were subject to continuous risk assessment supported by Equality and Quality Impact reviews, with strong controls in place over temporary staffing and ongoing efforts to convert locum roles to substantive posts. The Board was advised that a structured discussion on the achievability of the target and next steps would take place at the January 2026 Finance, Infrastructure & Digital Committee, alongside consideration of short- and longer-term workforce and efficiency plans. It was also noted that clearer triangulation of workforce changes and quality outcomes would be reported through the Quality & Safety Committee.

Samaher Sweity, Associate Non-Executive Director, raised a question on potential inequality in probation-related dismissals. Julian Duxfield, Non-Executive Director and Chair of People & Culture Committee, advised that while initial data suggested possible disparities, case-level review provided assurance, with low volumes and ongoing monitoring through the annual cycle.

The Board **noted** the report.

138/25 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received a verbal overview of the detailed discussions held at the Audit, Risk & Assurance Committee (ARAC) at its meeting on 6 November 2025 and the following was highlighted:

- The Committee noted that outstanding EPR actions previously flagged for escalation were largely resolved, although formal closure had not yet been agreed. This remained an open item but did not require Board escalation at this stage, and any material issues were to be managed through EPR governance.
- Risk management within the Medicine Division was discussed, with staffing, quality and financial pressures acknowledged. The Committee noted that financial risks were not consistently captured in divisional risk registers and emphasised the need for improved documentation and escalation at divisional level.
- The AI benchmarking report was identified as a helpful reference.
- The Board Assurance Framework was reported to be operating effectively, with changes anticipated as the organisation transitioned to a group model.

The Board **noted** the report.

139/25 **Charitable Funds Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) at its meeting on 12 November 2025 and the following was highlighted:

- A major chemotherapy appeal had been developed to support fundraising efforts, acknowledging that central income generation over the past 12 months had been disappointing, primarily due to long-term staff absences. However, improvements were expected in the coming months.
- The Committee also discussed the need to rationalise the current 77 separate funds held across the Trust to reduce duplication, improve coordination, and ensure equitable allocation of resources. A significant rationalisation exercise was planned for implementation in April, with ongoing engagement between the charity team and divisions.

Minute	Description	Action

The Board **noted** the report.

140/25 **Perinatal Services Six Month Summary (Q1 & Q2 2025/26)**
Kat Simpson, Director of Midwifery & Neonatal Services joined the meeting to present this item.

The Board received and considered the above Perinatal Services Six Month Summary provided by Kat Simpson who joined the meeting at this point to present the key highlights aligned with the NHSE 3-year delivery plan and progress against previous CQC actions.

Chris Burton, Non-Executive Director, sought assurance on maternity service quality, staff experience and external scrutiny in light of recent media commentary. Kat Simpson confirmed robust cleanliness audits and external safety oversight were undertaken, noting that outpatient estate challenges remained but were a priority for improvement. She reported strong patient engagement through co-production with local families and multiple staff support and escalation routes, with continued oversight via the Quality & Safety Committee.

Samaher Sweity, Associate Non-Executive Director, asked how equity and cultural competence were being measured. Kat Simpson advised that outcome and safety data were being used to assess equity, with targeted quality improvement work underway on postpartum haemorrhage and OASI, alongside efforts to engage under-represented communities in feedback processes.

The Board **noted** the report.

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

141/25 **Ratification of Decisions made via Board Circular**
None.

142/25 **Urgent Public Business (if any)**
None.

143/25 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 15 January 2025 at 9.30am at the Great Western Hospital, Swindon.

144/25 **Exclusion of the Public and Press**
The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.

The meeting finished at 12.34hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – January 2026				
ARAC – Audit, Risk and Assurance Committee, CFC – Charitable Funds Committee, FIDC – Finance, Infrastructure & Digital Committee, PPPC – Performance, Population and Place Committee, PCC – People & Culture Committee, QSC – Quality & Safety Committee, RemCom – Remuneration Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
11 December 2025	131/25	**Matters Arising** Opportunities to explore AI more broadly to be referred to FIDC.	Chief Transformation & Innovation Officer	

Future Actions				
None				

Report Title	**Care Reflection**				
Meeting	**Board of Directors**				
Date	**15/01/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Luisa Goddard, Chief Nurse				
Report Author	Tania Currie, Head of Patient Experience and Engagement				
Appendices					

Purpose

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

Assurance Level

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

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

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

The Care Reflection highlights areas where practice has been of a high standard in relation to the duty of candour process. Areas for improvement in communication, staff awareness and training are identified.

Report

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

This care reflection centres on Sandra, whose mother Elaine was involved in a patient safety incident following an overdose of blood thinning medication. Elaine describes the event and the distress caused by the delay in being made aware of the incident, despite being her mother's carer and advocate. An investigation report was later shared with Sandra, who appreciated its honesty and thoroughness, recognising genuine learning had taken place.

Sandra highlights some failings in the duty of candour process, particularly in the early stages of communication where there was a delay in informing her. She recommends that

staff receive better support to communicate openly and empathetically with patients and families when incidents initially occur.

A member of the Insights and Learning Team provides further detail into how the duty of candour process is managed within the trust, and how learning from such incidents is shared to improve future care.

Sadly, Elaine died during the process of the investigation. Sandra has been keen to share her experience widely to help raise staff awareness and make improvement in honest communication about errors in future.

The film can be viewed here: https://youtu.be/9YqPuHGchRI

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

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

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

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

Explanation of above analysis:

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

To receive the presentation to note the experience of the duty of candour process along with the developments and improvements identified.

Accountable Lead Signature	Luisa Goddard
Date	**05/01/2026**

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**15/01/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

Purpose

Approve ✓	Receive ☐	Note ✓	Assurance ☐
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Assurance Level

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

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

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

Due process followed.

Report

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

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

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

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

Risk + Oversight	Risk Score

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to note the updates.

Accountable Lead Signature	Liam Coleman, Chair
Date	**06/01/2026**

Chair's Board Report

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

1. Council of Governors

1.1 Vivien Coppen was confirmed as Deputy Lead Governor.

1.2 There were no governor activities to report due to the Christmas and New Year period, except for the Lead and Deputy Lead Governors meeting with the Chair and Company Secretary on 15 December 2025.

2. Non-Executive Directors

2.1 *Safety Visits*

There was 1 Board safety visit during the period covered by this report as follows:-

Date	Area	Board Member
16 December 2025	Jupiter Ward	Ana Gardete, Deputy Chief Nurse Helen Spice, NED Chris Burton, NED

3. Trust Chair Key Meetings during December 2025

Meeting
BSW Hospitals Group Joint Committee
BSW Hospitals Group Remuneration Committee in Common
BSW Hospitals Group Collective Narrative Discussion
BSW Hospitals Group Council of Governors Development Session
BSW Hospital Group Chairs Meeting
GWH Board of Directors Meeting
GWH Board of Directors Development Session – Freedom to Speak Up
GWH Governors/Company Secretary
Nomination & Remuneration Committee
RUH Board of Directors Meeting
RUH Extraordinary Board of Directors Meeting in Private
RUH NEDs Meeting
RUH Lead Governors Meeting
RUH Council of Governors
RUH Staff Governor & NED Monthly Feedback Meeting
Introductory meeting with RUH and GWH newly elected governors
1:1 with ICB Chair
1:1 with South West Regional Director
1:1s with Vice Chairs
1:1s with Managing Directors
1:1s with Chief Executive

Report Title	**CEO report**				
Meeting	**Trust Board**				
Date	**15/01/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Cara Charles-Barks, Chief Executive				
Appendices					

Purpose

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

Assurance Level

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

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

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

Report

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

The Chief Executive's report covers:

- Risks
- National update
- Group development
- Great Western Hospitals NHS Foundation Trust operational update
- Quality
- Workforce, wellbeing and recognition

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

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

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

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

Explanation of above analysis:

The report covers our Never OK campaign which we relaunched last year to highlight the issue of abuse - physical, verbal, sexual and discriminatory - committed against staff by patients or visitors.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	**08/01/2026**

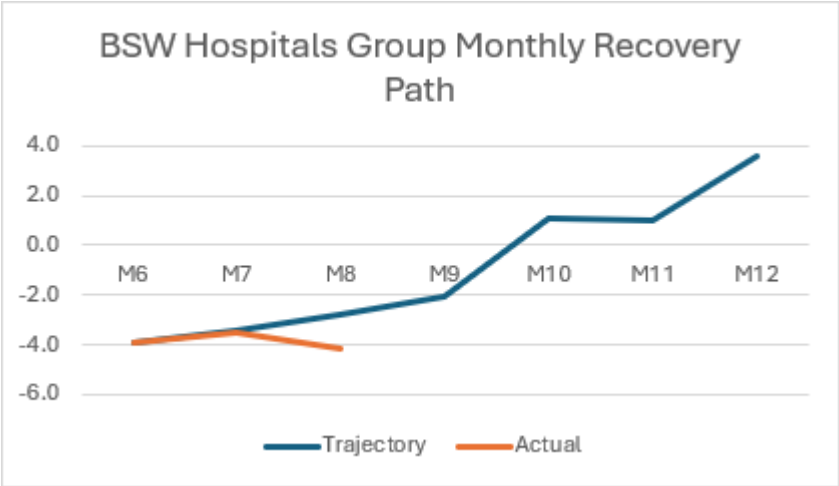
1. Risks

1.1 Financial position and recovery

The financial position across the BSW Hospitals Group has been extremely challenged.

The Hospitals Group has made tangible progress in stabilising its financial position following a period of significant challenge in the early part of 2025/26. While the first quarter saw the components of the Group with significant adverse variances to plan, interventions implemented post Month 4 have begun to deliver tangible improvements. However, at Month 8 this progress has slowed and the recovery plan trajectory has not been met, leading to a number of corrective actions being implemented. This ensured the confidence of regulators was maintained and secured the release of Deficit Support Funding, totalling £15.6m, for the year to date.

At an organisational level the largest in month variance from the recovery plan was at Great Western Hospitals (£0.7m), with the Royal United Hospitals (£0.6m) and Salisbury Hospital (£0.3m) also off plan. In total for the year to date the Group is off plan by £43.3m, which is £1.6m adverse to the recovery plan position. The key drivers remain Urgent Care pressures, Non-Criteria to Reside numbers, Drug costs and inflationary impacts. As can be seen from the graph below, in future months there is a step up in the recovery trajectories at all Care Organisations so it is essential progress gets back on target, despite the pressures faced.



1.2 Urgent & Emergency Care (UEC) update

UEC remains challenged across all three acutes in terms of demand and system flow. Internal actions are underway and will continue over the next few months.

There continues to be significant improvements in the average time for ambulance handovers at all three acute Trusts following the implementation of Wait 45, and each of our hospitals is focusing on increasing P0 discharges and ensuring decisions regarding care are taken in a timely way to improve flow through our Emergency Departments.

The number of patients waiting to leave acute trust beds remains a challenge – with continuing high numbers of No Criteria to Reside (NCTR) across all three. In December

2025, a system wide Mega MADE event was undertaken to support increased community daily discharges and P0 discharges, with on-site support from all partners to ensure timely discharge on the more complex pathways. This has contributed to an increase in the number of future planned discharges and there is a dashboard being created to monitor the effects of the MADE impact.

As expected, winter flu has brought operational challenges. However, due to planning of cohort wards and testing, the impact has been less than in previous years despite the earlier presentation of flu across the system than predicted.

Demand into EDs continues to be a challenge and there is ongoing work with community providers to develop understanding of this change and what we can collectively action to mitigate the risks that are associated with this increase.

1.3 Elective performance

Whilst a number of risks exist in elective performance, it is worth celebrating the enormous hard work and perseverance by teams across BSW to reduce the number of patients waiting over 65 weeks. A year ago more than 3.5% of our patients were waiting over a year for treatment – this now stands at 1.2%. At the end of December 2025, we had 18 patients waiting over 65 weeks (14 GWH, 4 SFT, 0 RUH).

Some of the key risks currently being managed in elective care are:

- Rising demand in referrals leading to challenges sustaining our access standards. This is being mitigated by the development of a clear demand management programme with the ICB.
- Loss of capacity due to winter pressures and industrial action. Clear winter plans have been developed across the group aiming to maximise elective activity during this period however this remains a significant risk.
- Planning for 2026/27 not providing sufficient capacity to meet our access goals. Given the challenged financial environment and high growth, the group needs to ensure adequate capacity and productivity is delivered in the year ahead to continue our positive progress in meeting our national targets around elective access. Each Trust is actively developing these plans to ensure we maximise the care we deliver within limited funds.

2. National Update

2.1 Resident Doctors Industrial Action

Resident Doctors took industrial action from 7.00 am on Wednesday 17 December to 6.59 am on Monday 22 December 2025. Thanks to the staff across our hospitals who worked hard to keep services running and minimise the impact of industrial action on our patients as much as possible.

2.2 NHS Oversight Framework – NHS Trust Performance League Tables

In November 2024, the Secretary of State announced that NHS England would assess NHS Trusts against a range of performance criteria and publish the results.

NHS England published the 2025/26 quarter two segmentation results and performance dashboard, an outline of performance within BSW Hospitals Group is outlined below:

Great Western Hospitals NHS Foundation Trust was ranked 82 out of 134 Trusts in the country, the previous quarter's ranking was 76.

Royal United Hospitals Bath NHS Foundation Trust was ranked 105 out of 134 Trusts in the country, the previous quarter's ranking was 112.

Salisbury NHS Foundation Trust was ranked 70 out of 134 Trusts in the country, the previous quarter's ranking was 57.

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

Further information on the league tables can be found via https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/

3. Group Development

3.1 Joint Committee

Our latest BSW Hospitals Group Joint Committee meeting was held on 17 December 2025 with the focus being on discussion of Group Priorities and Prioritisation Approach, Financial Sustainability and Recovery, Care Organisation Risks, the EPR Programme, as well as our Clinical Transformation and Corporate Services Programmes. A report from the December Group Joint Committee has been included with January Trust Board papers.

3.2 Leadership Team

December saw changes to both the composition of the Group Executive and to the responsibilities associated with respective Executive Director portfolios considered at the Remunerations Committees in Common. The creation of a Chief Risk Officer role was approved, as were changes to the portfolio of responsibilities relating to the existing Chief Strategy Officer; Chief Transformation and Innovation Officer; and Strategic Clinical Transformation Director roles. The proposed changes are intended to ensure that respective Executive Director portfolios will effectively support the delivery of the Group's strategic aims, operational objectives, and regulatory requirements, and that the 'balance' of responsibilities across all Executive Director roles is appropriate.

The recruitment of the Group Chair continues with interviews scheduled during January.

3.3 Group Governance and Assurance Arrangements and Transition Roadmap

To support safe and effective mobilisation of our new Operating Model by April 2026, the Governance Working Group has continued developing the Group's detailed operating blueprint and governance and assurance framework. The Governance Working Group will work closely with the newly established Non-Executive Director Reference Group which met on 5 January 2026.

3.4 Group Priorities and Prioritisation Approach

In November five areas of prioritised focus for the Group were agreed as follows:

1. Recovery (Performance & Finance)
2. EPR re-planning and implementation
3. Clinical transformation and clinical services framework design
4. Completion of the Corporate Services Review for services identified as mission critical
5. 2026/27 planning including Group Mobilisation

Interaction between these component parts (particularly recovery and EPR implementation) remains significant. To enable alignment and understanding of constraints a Group 'Engine Room' is to be established to sit alongside the CEO-led Performance, Risk and Recovery Committee. The purpose of this forum is to facilitate agile and dynamic management of resources available in the delivery of the Group's programmes of work.

3.5 EPR Deployment Options Appraisal

A team of Executives from across the Group is nearing completion of an EPR Deployment programme options appraisal. Joint Committee review and decision is scheduled in January 2026.

3.6 Clinical Transformation Programme

In November and December our BSW Hospitals Transforming Models of Care Programme mobilised, led by the Chief Transformation and Innovation Officer and a Clinical Transformation Steering Group. Three workstreams are planned:

- Designing single managed services
- Designing a model care organisation
- Supporting the medium-term financial planning

Through the Clinical Transformation Programme, clinical services will be supported to work together and explore potential service models. Clinical Transformation Groups (CTGs) will support clinical service transformation, with an ambition to mobilise six CTGs in 2026.

3.7 Corporate Services Programme

Our Corporate Services Programme is making progress and the design stage for each of the services is underway with governance arrangements well established.

3.8 Group Board-to-Board Development Days

The 2026/27 Group Board and a series of Board development days are being scheduled with the next Board-to-Board development day planned to take place in February 2026.

3.9 Councils of Governors Workshop

In early December 2025, the three Councils of Governors met to discuss the emerging Group Operating Model, our developing Group narrative and vision, and our Clinical Transformation Programme; the next session will be held in early February 2026.

Great Western Hospitals NHS Foundation Trust update

4. Operational update

4.1 Latest operational position

Following an extremely busy start to the new year, we declared an internal critical incident on 4 January.

This declaration reflected severe pressure on patient flow and bed capacity, with high numbers of patients attending the Urgent and Emergency Departments, along with many patients with significant acuity. This level of demand unfortunately meant that patients have had to be cared for in escalation areas.

We launched our 'January Blues' initiative at the start of this month, asking clinical teams to remember five key actions to help us improve the flow of patients through the hospital:

- Board rounds: Staff are asked to hold consistent, multi-disciplinary led board rounds with a set planning framework on every ward
- Length of stay: Staff should conduct reviews for patients who have been in hospital for longer than seven days, 14 days and 21 days and escalate every day if there any barriers stopping a patient from returning to the place they call home
- Use of the Discharge Unit: Staff should aim for ten patients to be transferred from a ward to the Discharge Unit before 10am every day, having been identified at board rounds the day before
- Earlier in the day: Medication to take aways and Electronic Discharge Summaries should be completed the day before and social care partners will be asked to support with earlier care home bed allocation
- Safest possible care: Senior leaders will be present on every ward and department to support patient safety, help discharge planning and escalate any concerns from staff.

We have seen high levels of demand over a period of several weeks, with a previous critical incident declared in December.

During this period, we have asked the public to consider whether there are alternative places they could seek advice or treatment rather than coming to hospital, such as 111 and pharmacies, but expect attendances to remain high over the forthcoming weeks.

4.2 Mask-wearing

Following a rise in the number of patients in hospital with flu, and respiratory illnesses prevalent in the community, we re-introduced mask wearing towards the end of last year. Saturn ward became a flu ward, so that all patients with flu can be cared for in one space, to avoid the spread of infection.

Masks are now mandatory in all front door areas, including the Emergency Department, Urgent Treatment Centre, assessment areas, Neonatal Unit, Delivery Suite, Early

Pregnancy Unit, The Meadows and Day Therapy Unit, all paediatric services, including on the Children's Unit.

Patients and visitors must also wear a mask in front door areas and will be provided with a mask when they arrive. We will continue to keep this decision under review, monitoring flu cases in the hospital and in the community.

4.3 Industrial action

Resident Doctor members of the British Medical Association held a five-day strike between 17 and 22 December, which caused some disruption to our services which has unfortunately impacted upon patients.

Resident Doctors are currently being balloted whether to extend their strike ballot until August 2026. The ballot will run until 2 February, with the result expected to be announced shortly afterwards.

The industrial action is part of BMA's ongoing dispute with Government over pay and conditions, not our Trust as their employer.

5. Quality

5.1 Reuseable tourniquets

We have been piloting the use of reuseable tourniquets, to reduce single-use waste and support our sustainability and cost-saving goals.

Following an initial successful launch in phlebotomy, the reuseable tourniquets are now being rolled-out right across the organisation. The product, tournistretch, has been reviewed and approved for use by clinical teams, infection prevention and control and the sustainability team.

Reuseable tourniquets enable an improved patient experience, as the findings from feedback and research papers on their use suggest that patients find them more comfortable and less likely to pinch the skin.

Moving to reuseable tourniquets is also reducing our carbon footprint, by reducing single-use plastic waste, with an estimated saving of 96 tonnes of carbon emissions.

The project is also supporting our financial recovery work, by saving an expected £34,000 a year once rolled-out to all wards and departments, and with the phlebotomy department making £6,300 worth of savings alone already.

5.2 New endoscopy unit

The new endoscopy unit in Swindon opened its doors to the public towards the end of last year.

The unit, based in the Community Diagnostic Centre, will be managed by hospital clinical teams working in the community, and will enable people to access diagnoses and care quicker, and in a setting that is closer to their home or place of work.

This represents a significant expansion of local capacity to deliver timely, high-quality endoscopic care, with around 6,000 patients a year expected to be treated in the new unit.

6. Workforce, wellbeing and recognition

6.1 Flu vaccination campaign

We continue to encourage our staff to take up the offer of a flu jab, to help protect themselves, their family and loved ones, and colleagues from catching the virus.

With high numbers of cases of flu in the community, it is really important that everyone – our staff and the wider community – protect themselves.

Our current flu vaccination rate is 62 per cent of our substantive staff, which is the top rate in the South West and the eighth highest in the country. This is a real credit to our vaccination team who have worked tirelessly to run drop-in clinics and visit teams around the Trust.

6.2 Never OK

We relaunched our Never OK campaign last year to highlight the issue of abuse - physical, verbal, sexual and discriminatory - committed against staff by patients or visitors.

Last month we launched a new seven-step plan, which has been developed alongside Wiltshire Police for use when recording incidents of abuse

Its purpose is to collate key information to support effective reporting of harm towards staff, enable improved levels of support, limit the immediate and long-term effects of abuse and prevent further incidents of abuse to safeguard staff.

The plan can be used at any time, by any member of staff. It is encouraged that any colleagues support a victim of abuse in the immediate aftermath of the incident to so that the correct information can be logged quickly for any future investigations that may be required.

The seven-step plan also advises when line management should become involved in the process, to ensure the victim receives the support and care they need.

The seven steps are:

1. Memory capture
2. Detail the harm sustained
3. Immediate needs of the victim
4. Further support required
5. Ownership
6. Outcomes
7. Learning and sharing

We recently partnered with Swindon Town Football Club on the campaign, with players showing their support for staff who have faced abuse from patients.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**15/01/2026**	Part 1 - Public	☐	Part 2 - Private	☐
Accountable Lead	Benny Goodman, Chief Operating Officer Luisa Goddard, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Rob Presland – Deputy Chief Operating Officer Ana Gardete – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer Johanna Bogle – Deputy Chief Financial Officer				
Appendices	Use of Resources: • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

Purpose

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

Assurance Level

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

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

Report

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

Our Performance

Key highlights from our operational performance for November (October for Cancer) are as follows:

Strategic Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

November's performance shows the total number of patients waiting over 52 weeks at 602, an increase of 43 from the previous month. This is the first time in the financial year that the 52+ week wait list has been worse than plan. 1.4% of patients on the PTL are currently waiting over 52 weeks which is better than expected for this time of the year, but this is predominantly because the PTL size itself has grown (1,716 more patients compared to a year ago, and 5,787 more than planned).

Overall RTT performance within 18 weeks was 59.8% and 0.6% ahead of plan for November.

Demand and capacity analysis is being undertaken at a specialty level to derive counter-measures for demand side improvement in the clock start position. Opportunities remain in areas such as Advice and Guidance and Referral Assessment Services to mitigate growth, with NHS England announcing changes to the deployment of the E-referral service over the next 6-9 months. This presents an opportunity to provide greater consistency and timeliness of response for avoiding unnecessary additions to the non-admitted RTT waiting list.

Patients waiting over 65 weeks at the end of November was 22 and there were 5 x 78-week breaches reported (3 Plastics, 1 ENT and 1 General Surgery). Plastics remains a key risk due to the impact on RTT and cancer pathways, with two week wait demand being prioritised over long waiting patients. All patients have next steps in place but clock stops (with first definitive treatment) remain challenging to achieve in December, especially for Plastics.

Directives from NHS England outline expectations that all 65 week breaches should be eliminated by 21st December 2025 and the Trust is currently forecasting 11 patient breaches.

RTT performance in Quarter 4 will continue to be challenged due to additional growth on the waiting list and further work required to clear down 52 week waits. Significant improvements have been made to the cleanliness of the PTL with over 90% now validated down to within 12 weeks. Capacity related delivery plans will therefore be important to sustain the good progress made and to achieve the year end targets in the final 3-4 months of the year.

- Cancer waiting times

Cancer performance for the 28-day faster diagnosis standard was at 63.9% and therefore 17.4% below the operating plan trajectory for October, and below the national target of 80%.

Cancer Faster Diagnosis is heavily impacted by the capacity issues seen in the Skin, Colorectal and Breast pathways and counter-measures are in place including additional waiting list initiatives to recover performance by December. As Cancer performance is reported one month in arrears, the extent to which performance has recovered will be better

understood in January. Good progress however is being made in tumour sites such as skin where the PTL size has reduced by almost 25% during the last 2 months. However, challenges remain in areas such as Breast.

62-day performance for urgent suspected cancer referral to treatment was at 66.7% and is currently 6.4% below operating plan. Tumour site trajectories are most challenged within Urology, Breast and Plastics. Cancer pathways for Plastic patients remain under review with mutual aid being discussed with Salisbury NHS Foundation Trust. This is becoming more important to resolve because outsourcing arrangements are no longer proving effective at managing the treatment stage of the pathway.

Cancer 31-day performance was at 91.1% and showed a 7.5% improvement from last month.

- Time in Emergency Department

Combined 4-hour performance was 71% in November and 0.1% better than operating plan. Recovery plan counter-measures due in November have delivered with over 92% of Type 3 attendances at the Urgent Treatment being seen within 4 hours, but with improvements also in access times for Type 1 attendances in the main ED. There remains a significant amount of work to do to achieve the 78% standard for March but returning to plan in November is a positive first step.

November's attendances were 8.5% over anticipated volumes and this brings the cumulative year to date position back on plan. Type 1 attendances were 12.5% higher than plan suggesting a higher level of acuity with patients presenting via increased ambulance conveyance as an alternative to walk ins. Despite these challenges the mean stay in ED has reduced month on month which is encouraging.

Ambulance handover performance in November was at an average of 28 minutes and therefore achieving the 33 minute trajectory for the second consecutive month. Improved performance has been sustained since May and as at 10th December the month to date was 37 minutes.

Average ambulance offload times continue to perform in line with operating plan commitments which provides further evidence of sustainable improvements, especially since the Trust has been in a critical incident since 2nd December due to lack of bed capacity and poor flow.

Ambulance conveyance growth is now at 17% year on year, with 94 ambulances recorded on two separate occasions during the December week of critical incident. The Trust is now regularly receiving an additional 15 ambulances per day into the hospital which is not a sustainable level of demand. An ICB and SWAST led audit was completed on 27th November at GWH to inform counter-measures with system partners, with the findings recommending improvements to the utilisation of care coordination and strengthening of SWAST calling before convey protocols with care homes.

Operational Breakthrough Objectives

- Non-Elective Length of Stay

Non-elective length of stay was 6.6 days in November. There has been a 0.2 day reduction since the start of the financial year in April, but the November position was 0.3 days above the same point last year. The UEC programme board continues to focus on countermeasures

to achieve a 0.5 day reduction on the same point last year. The main focus of work before the end of December includes:

- Ongoing focus on counter-measure development on top contributors on older people's wards. This includes review of Board round criteria, referral processes and escalation of capacity delays to partners and changes to front door clerking of frail elderly patients.
- Design and implementation of multi-agency discharge events for the peak weeks of seasonal pressure. This builds upon long length of stay reviews for all patients across ward areas.
- Further embedding of "no referral" pathways for Pathway 1 (home first) patients in Wiltshire
- Review of Trauma pathways and discharge planning processes.
- Chief Medical Registrar pilot of revised weekend planning processes to increase discharges and embed criteria led approaches that do not depend upon consultant decisions.

Bed occupancy was 97.2% in November which remains higher than levels recommended to sustain good flow out ED, and it is therefore important that cross divisional focus remains on making further improvements to length of stay ahead of the busy winter period and anticipated prevalence of winter viruses that risk increasing bed occupancy further.

- Proportion of Outpatient First Appointment Pathways Waiting <18 Weeks

The number of non-admitted (Outpatient) pathways waiting for a first appointment under 18 weeks remained at 66% in November. Current performance reflects the increase in new additions to the non-admitted wait list that have been observed since the summer.

Service developments in areas such as paediatrics have been delayed due to winter pressures but work has commenced on outpatient clinic template redesign including review of job planning policies with the Chief Medical Officer's office, improving data visibility, and establishing clear clinic output expectations at both specialty and service levels.

Clinic template re-design remains a key priority for improving waiting times and productivity.

Alerting Watch Metrics

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

Diagnostics – November un-validated DM01 performance was 92%. MRI, CT and Dexa scans are all achieving the national constitutional standard and the Trust is currently achieving the end of year target six months early. Additional Endoscopy capacity from the Community Diagnostics Centre went live on 18th November and focused recovery efforts on Cystoscopy and Audiology are expected to sustain the good performance and mitigate forthcoming risks from seasonal pressures and demand on non-DM01 diagnostic work.

Temporary Escalation Spaces (TES) and No Criteria to reside patients – The use of TES increased in November with a small reduction in no criteria to reside bed days lost.

Overall no criteria to reside was 21.7% of the bed base and this relates to higher than planned number of days delayed waiting for pathway 2 (inpatient rehabilitation) in Swindon and for Wiltshire Pathway 1 (home without support / restart package of care). Mitigations are in place

including resolving Wiltshire brokerage capacity for Pathway 1 and the extension of successful community therapy in-reach in Wiltshire to include Swindon since September. The latter will help to improve referral completion timescales and reduce discharge ready delays for Pathway 2 patients. A BSW System wide recovery plan is also under review during November to support winter resilience. Capacity remains challenged particularly across Pathway 2.

Our Care

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

Strategic Pillar Targets

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

The number of harms has decreased to 102 in September when compared to 113 in October.

The number of falls has decreased in month to 76 compared to 86 in October. One patient has experienced a fall that resulted in moderate harm. Nine patients have fallen more than once a slight increase from eight in October but remains below the 10% reduction trajectory set.

C. Difficile infections have decreased to one in month, and the Trust is now in line with the threshold trajectory.

The number of cases of Pseudomonas is zero in month a decrease from two in October and the Trust is now in line with trajectory.

Breakthrough Objectives

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

Aim for 2025/26

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

One patient has experienced a fall that has resulted in moderate harm. The number of patients with two or more falls has increased slightly in month to none, compared to eight in October

Alerting Watch Metrics

The numbers of Klebsiella cases have increased in month to four, compared to two in October.

The Emergency Department and Urgent Treatment Centre positive response rate has increased in month to 18.4%.

The number of concerns received in month is 435 a decrease from 457 received in October

Non-alerting Watch Metrics

C*.difficile* numbers have decreased again in month to one, compared to four October.

The number of EColi cases in month has decreased to six in month, compared with eleven in October and are now below the internal target of 7.50.

The number of Day Case positive responses has decreased in month and in now below the internal target of 95%.

The overall Family and Friends positive response rate for November is 84 a decrease and remains below the internal response rate.

The number of complaints received in month has increased to 106. I big increase on the previous months. The number of complaints re-opened has decreased to three in month, compared to five in October.

There has been one Methicillin-Sensitive Staphylococcus Aureus (MSSA) case in November, compared to zero in October.

There has been no Methicillin-resistant Staphylococcus aureus (MRSA) case reported in month. This is the third month of zero cases.

The number of hospital-acquired pressure ulcers was ten in month. The number has been consistent over the last four months.

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

- Safer staffing fill rates remain above the National target of 85% for Registered Nurses.
- Three Patient Safety Incident Investigation have been declared in November.

Our People

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

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

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

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

  Staff Sickness Absence
  Target: 3.5%
  October 2025 figure: **4.4%**, (decline from previous month 4.1%)

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

Breakthrough Objectives

Following a comprehensive review of the 2024 Staff Survey results, a key area of opportunity has been identified to further our strategic aim of improving staff experience and engagement. The Trust's A3 has been updated accordingly, with 'Teamwork' recognised as a critical lever for driving performance against our Pillar Metric: *'Recommending as a place to work'*. As a result, the breakthrough objective for 2024/25 will continue to focus on Staff Survey question 7C: *"I receive the respect I deserve from my colleagues at work."* This will be the second consecutive year targeting this question, to ensure continued and sustained improvement in this area.

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

To support overall improvement in the breakthrough objectives and pillar metric, a number of actions are underway, including:

The **2025 Annual Staff Survey** closed on 28th November, with 3638 colleagues completing the survey, achieving 66% completion rate. Although slightly lower than the 71% 2024 survey completion rate, 66% compares favourably with the IQVIA average for the sector of 48%. Care organisation colleagues at RUH and SFT achieved 54% and 53% respectively which signifies 58% completion as a BSW group. The Trust anticipates receiving initial results by the 15th December followed by the full management reports by the 30th January 2026. The next survey will be the Q4 Pulse Survey which opens in January 2026.

The Trust annual Recognition plan has been approved in principle by the Charitable Funds Board providing sufficient funding for initial planned activities for the new year, with the option for further funding to follow. A monthly **Trust-wide recognition initiative** is planned to launch in January to celebrate achievements, promote refreshed e-cards aligned with our behaviours, and support a reviewed recognition strategy under Charitable Funds. As part of this, the Trust is currently planning for the annual staff awards next July, and Great West Fest next September.

Sickness Absence

The Trust's ambition remains to create a healthy, supportive, and inclusive work environment. Sickness absence has increased from 4.1% in September to 4.4% in October, with the movement attributed to a slight increase in long term sickness cases to 72. This

increase sees all Divisions above the 3.5% target, with only the Corporate Division retaining amber status with 3.61%.

The Sickness Absence Working Group continues to drive improvements through targeted actions, including:

- Collaborative development of the BSW Group Long Term Health Conditions guidance including a 'Reasonable Adjustment Form' to help managers and staff with legal compliance.
- HWB and workstream leads strengthen the Trust-wide HWB communication, to promote a monthly wellbeing focus. December will highlight the value of the 'wellbeing conversations', available training & links to Burnout prevention resources. A successful trial in FASS where medical staff use a QR code to record sickness absence which alerts coordinators for action, is being extended to the DoM, with Divisional Director sponsorship.
- Matrons engaged in the absence working group are trialling the following improvement initiatives across their departments:
    - Burnout prevention plan & resources in SAU during December and January;
    - ED review options to increase attendance at the regular HWB drop-in sessions
    - Rolling out MSK support sessions to support muscle flexibility and reduce MSK related incidents.

Evaluation of the success of these initiatives is reported and monitored through the sickness absence working group.

Vacancy Rate

The overall vacancy rate improved further in November 2025, reducing to 1.8% (92 WTE).

All Nursing remains over-recruited in November by 65 WTE, with Registered Nursing over-recruited by 61 WTE and Unregistered Nursing moving back to an over-recruited position of 4 WTE.

For Medical & Dental staff the current vacancy position is 1 WTE, in line with October. This vacancy level is driven by an over-establishment of Resident Doctors, and a Consultant vacancy level of 16 WTE sits underneath this.

Vacancies for Allied Health Professionals and Healthcare Scientists continued to improve in November, reducing from 44 WTE to 37 WTE (4.6%). Our Admin & Clerical position has reduced marginally to 119 WTE with posts still held in line with current workforce controls.

Temporary Staffing

Bank usage increased further in M8 to 298 WTE (+133 WTE to plan), with spend at £17.1M YTD, £2.1M above plan. Agency usage remained static at 26 WTE (-10 WTE to plan) with spend at £4.0M YTD, £2.7M above plan.

Workforce Recovery

In November there was a further increase to total workforce usage, rising from 5,236 WTE to 5,288 WTE (+52 WTE). This was an adverse variance of 242 WTE to our planned position of 5,046 WTE. Our substantive contract position increased by 28 WTE to 4,963 WTE, however temporary staffing also increased by 24 WTE as opposed to being offset by

additional contracted staff. At M8, temporary staffing is +124 WTE adverse to plan with the majority of this pressure being driven by enhanced care and sickness absence cover.

Reviewing current performance against plan at staff group level:

- Nursing: +167 WTE to plan (of which 95 WTE for Unregistered Nursing)
- Medical: +76 WTE to plan
- AHP/STT: +25 WTE to plan

Use of Resources

For M08 2025/26 the Trust has an adjusted deficit position of £12.1m, which represents a £12.1m adverse variance to plan. In M08, the Trust had a £0.6m forecast deficit as part of the recovery plan but finished with a £1.5m deficit, representing a shortfall of £0.9m. The drivers of the overspend are industrial action costs (£0.6m) and a provision for car parking VAT (£0.3m). It should be noted that non-recurrent benefits totalling £1.7m in M08 have offset a failure in the delivery of recovery plan schemes. If recovery schemes continue to fail and escalation/winter costs continue, then the Trust is likely to finish the year with a £21m deficit position, assuming no deficit support funding is received.

On a year-to-date basis, income is £1.6m behind plan, the key driver being the loss of deficit funding (£6.4m). Lost income associated with industrial action is £0.1m with a further £1.1m of shortfall against efficiency plans, most notably elective transformation schemes in SPC and outpatient/private patient income. ERF income is £0.4m favourable to plan and £0.6m within the affordability cap. The Trust have been asked by the ICB to keep within this for the remainder of the year. There are a further £3.1m of favourable positions from other patient income. Other operating income is £2.5m ahead of plan driven by education funding. It should be noted that if the Trust were receiving deficit funding, the overall variance to plan would reduce to £5.7m, reflecting the tangible YTD gap the Trust needs to bridge.

The pay position is £7.7m adverse to plan, with undelivered cash releasing efficiency savings accounting for £5.1m. This includes a Trustwide target of £2.2m with no associated plans, with service transformation/benchmarking schemes within Divisions accounting for the remainder. The position includes run rate savings of £2.6m driven by prior year gains, the closure of escalation areas and agency framework savings. There is also a £2.0m underspend against Corporate admin lines due to unfilled posts. The remainder of the variance is due to industrial action costs of £0.7m and £6.5m of agency and locum overspends, the majority against medical and dental staff.

Non-pay is £2.8m adverse to plan. Undelivered cash-releasing efficiency savings accounts for £2.6m with a Trustwide target of £1.1m with no associated plans. There are also efficiency plan underperformances against Procurement and Specialty Review schemes. Clinical supply costs across the Trust are overspent by £3.4m, while the position also includes a £0.3m provision for car parking VAT costs and a PFI technical adjustment of £0.1m. Additional run rate savings from prior year benefits total £2.6m with a further £1.0m benefit from education and finance-related costs.

Key to breaking even in 2025/26 is delivery against the efficiency savings target of £32.4m and the recovery actions planned to recover the year to date deficit. At M08 total recurrent efficiency delivery is expected to be £12.1m against a plan to deliver 2/3rds of the target (£21.6m) recurrently. If we cannot improve this delivery, we are carrying an additional £9.5m deficit into our underlying position.

Breakthrough Objectives

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

As at M08 the Trust is £12.1m overspent against budget. A key driver of this is an underperformance of £8.9m against the cash releasing efficiency savings programme, delivering £12.4m year-to-date against a target of £21.3m. Of the £12.4m delivered, 61% was recurrent. It should be noted that the Trust has also delivered £5.3m of cost avoidance/run rate reductions due to prior year benefits taken in year and exiting escalation areas. While not removing budget, they are crucial in helping to reduce the overspent position. Our underlying position remains challenging and the objective for all divisions and specialties is to find recurrent saving schemes.

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

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

Task & finish groups including Finance, Procurement and Specialty leads are continuing for Theatres (SPC) and Cardiology (Medicine). The plan is to roll these out for further specialties with higher trending run rate as the year progresses. Currently T&O, Day Surgery and Pathology are under review.

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

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

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

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

Explanation of above analysis:

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

and planned to reduce discrimination for all staff and specifically those in protected groups.

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

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	Benny Goodman, Chief Operating Officer
Date	**08/01/2026**

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

December 2025

November 2025 & October 2025 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

Section & purpose	Slides
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Executive summary This provides an overview of the targets, performance and countermeasures (remedial actions) for each of our pillar metrics	5-12
Breakthrough objectives This provides a more detailed analysis of performance and risks related to the 4 key metrics for improvement: Patients Developing Pressure Ulcers; Emergency Department - Clinically Ready to Proceed; Implied Productivity and Staff Survey Results	13-17
Our Care This includes key indicators and watch metrics related to our care of patients, as assured by the Quality & Safety Committee	18-20
Our Performance This includes key indicators and watch metrics related to our access performance, as assured by the Performance, Population & Place Committee	21-25
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Our People This includes key indicators and watch metrics for our workforce, as assured by the People & Culture Committee	27-32
Explaining the IPR This section explains how the work of front line teams to drive improvement connects from 'ward to board' through our operational management system, and the business rules we apply to support that.	33-45

Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Target/Thres.	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Percentage of RTT patients treated within 18 weeks		54.2%	54.8%	56.9%	58.0%	57.8%	59.6%	60.8%	61.2%	60.5%	60.7%	60.6%	59.8%
Percentage of RTT patients waiting over one year		3.5%	3.2%	3.1%	2.5%	2.2%	2.0%	1.8%	1.8%	1.6%	1.4%	1.3%	1.4%
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	75% (Nat)	79.5%	80.2%	86.2%	83.5%	80.4%	76.8%	79.2%	74.5%	65.6%	61.4%	63.9%	Reported one month
Percentage of patients treated for cancer within 62 days of referral	85% (Nat)	73.4%	75.3%	72.7%	82.1%	70.8%	69.7%	78.2%	69.3%	65.6%	65.8%	66.7%	Reported one month
Percentage of Emergency Attendances within Four Hours	95% (Nat)	72.1%	73.4%	72.3%	69.9%	69.5%	70.1%	69.1%	69.1%	67.8%	68.1%	69.9%	71.0%
Percentage of Emergency Attendances over Twelve Hours	2% (Nat)	7.9%	10.1%	8.9%	8.3%	9.0%	8.5%	5.6%	5.6%	5.8%	7.4%	7.4%	7.5%
Planned surplus/deficit		-610	-482	74	690	-2149	-3476	-1173	-801	-1411	-1105	-480	-1484
Rate of productivity		-15.0%	-14.0%	-13.0%	-14.0%	-11.0%	-13.0%	-13.0%	-8.1%	-10.0%	-14.0%	-12.0%	Waiting for data
Readmission rate		14.5%	15.0%	14.6%	15.4%	15.3%	16.0%	15.3%	17.0%	17.4%	15.5%	15.1%	16.3%
Summary Hospital Level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
Average number of days between planned and actual discharge date		2.4	2.3	2.7	2.7	2.6	2.4	2.2	2.3	2.7	2.7	2.9	2.9
Percentage of inpatients referred to stop smoking services		12.5%	11.3%	10.0%	11.1%	11.5%	11.9%	12.0%	12.1%	11.3%	11.4%	11.3%	11.2%
Percentage of people waiting over six weeks for a diagnostic procedure or test	99% (Nat)	85%	86%	88%	91%	85%	85%	84%	86%	89%	90%	93%	Reported one month
Rates of MRSA		0.0	0.0	0.0	5.5	0.0	0.0	0.0	5.8	0.0	0.0	0.0	Two month behind
Rates of C-Difficile		38.8	22.2	24.6	27.7	28.1	48.9	33.7	23.0	11.9	11.9	23.0	Two month behind
Rates of E-Coli		33.3	16.6	43.0	33.3	56.1	43.4	39.3	51.8	50.7	41.7	63.4	Two month behind
Percentage of NHS Trust staff to leave in the last 12 months	14.8% (Int)	9.9%	9.0%	10.4%	10.9%	10.3%	11.7%	11.6%	11.9%	13.1%	12.8%	11.4%	One month behind
Sickness absence rate	3.5% (Int)	4.9%	5.1%	4.9%	4.5%	4.1%	4.1%	4.2%	4.4%	4.3%	4.1%	4.3%	One month behind
Rate of annual growth in under 18s elective activity		31.5%	31.9%	30.9%	27.7%	16.4%	11.8%	9.6%	4.9%	4.2%	4.5%	4.1%	0.0%

Key Indicators

Great Western Hospitals NHS Foundation Trust

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

Metrics	Published Date	Score / Rating
CQC inpatient survey satisfaction rate	21st August 2024	8.0
CQC National maternity survey score	28 November 2024	8.6
CQC safe inspection score	09 July 2025	Requires improvement

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

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

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

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

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

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

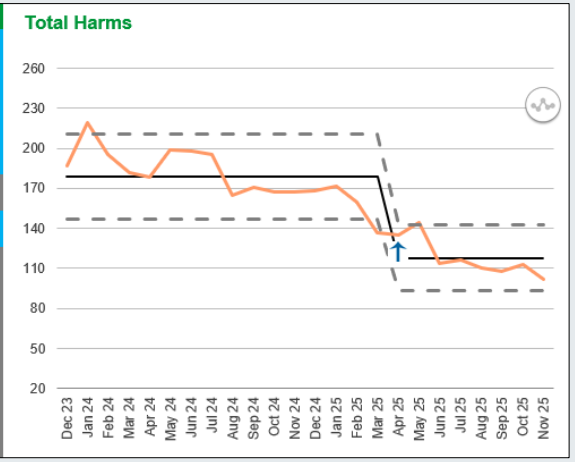
This metric reflects the Trust's commitment to learning from patient feedback and ensuring timely, high-quality responses to concerns raised.

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

Complaints response rate is tracked each month against timescale.

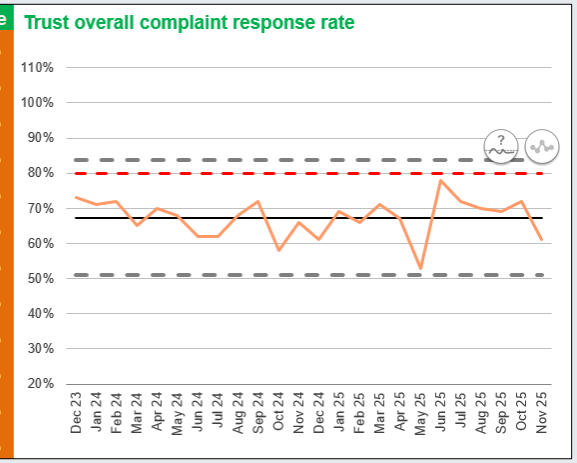
Total Harms
To achieve and sustain zero avoidable harm.

Timescale	Value
Dec 24	168
Jan 25	172
Feb 25	160
Mar 25	137
Apr 25	135
May 25	144
Jun 25	114
Jul 25	116
Aug 25	110
Sep 25	108
Oct 25	113
Nov 25	102



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

Timescale	Value
Dec 24	61%
Jan 25	69%
Feb 25	66%
Mar 25	71%
Apr 25	67%
May 25	53%
Jun 25	78%
Jul 25	72%
Aug 25	70%
Sep 25	69%
Oct 25	72%
Nov 25	61%



Counter Measures

The total number of harms fell to 102 in November compared to 113 in October. This is mainly driven by the reduction in falls, 76 falls in month, compared to 86 in October. There was 1 fall resulting in moderate or above harm.

Klebsiella bacteraemias have increased to 4. The number of E.Coli bacteraemia has decreased to 7 in month, compared to 11 in October. C. diff cases decreased to 1 in month compared to the 4 from last month, this is in line with the Trust's trajectory for the year.
There has been a small decrease in the number of reported Hospital Acquired Pressure Ulcers, with 10 harms reported in November, compared to 11 in October.

The Trust's complaint response rate for the current month is 61%. The reduction reflects efforts to reduce overdue cases in the Division of Medicine, which temporarily impacted closed-case performance but was necessary for sustainability. Closed on time were Surgery & Planned Care 71%, Family & Support Services 77%, Medicine 50%, and Corporate 100%

Trust-wide A3 improvement work continues, with strengthened weekly Divisional meetings to improve oversight and accountability. The Complaints Policy will be updated and reissued to reflect process changes, supporting more efficient and compassionate responses.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance

In October, 78 pathways breached the standard with 62.0 being allocated to GWH resulting in performance of 66.7%. Of these, 29% are attributed to the Urology pathway & 20% to both the Skin & Breast pathways. These pathways are seeing issues with capacity for appointments and diagnostics.

The Plastics service is provided at GWH via an SLA with Oxford. Oxford have been unable to meet this SLA resulting in cancer pathway breaches. In October Plastics was responsible for 12% of breaches, without these performance would have been 70.7%

RTT: Number of patients waiting over 52 weeks (December Submission, November Data)

RTT performance decreased by 0.83%, to 59.77%, when compared to last month's position of 60.59%. This is due to decreasing <18 week waiting list size and the increasing waiting list size in >18-week patient cohort. The total number of patients waiting over 52 weeks in November increased by 43 to 602, compared to the previous month.

There were 22 patients reported at 65 weeks at the end of November, a decrease of 6 from previous month. The majority of breaches were in the plastics pathway. A number of these were due to patient choice and complexity of clinical pathways.

There were 5 x 78-week breaches reported in November 2025 (3 plastic, 1 general surgery, 1 ENT).

A level of risk remains for December across a few specialties including Plastics, Urology and General Surgery. Teams are working on mitigating actions.

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

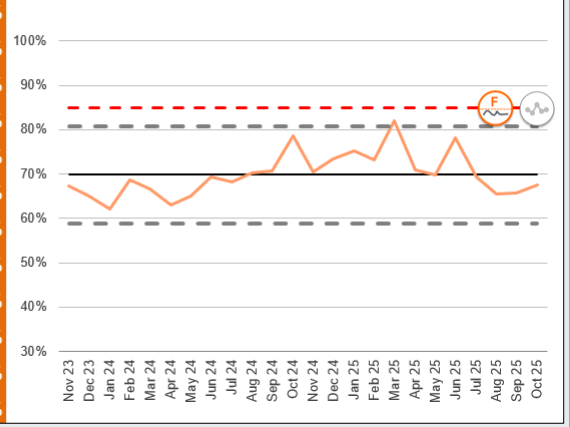
The national ask is that the Trust is reports 0x 65-week breaches by 21st December 2025, this will be a challenge due to the plastic pathway

Benny Goodman | Chief Operating Officer

Cancer 62 Day

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

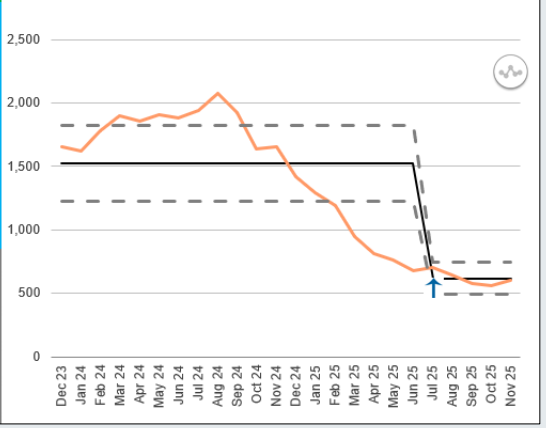
Timescale	Value
Nov 24	70.4%
Dec 24	73.4%
Jan 25	75.3%
Feb 25	73.1%
Mar 25	82.1%
Apr 25	70.9%
May 25	69.7%
Jun 25	78.2%
Jul 25	69.3%
Aug 25	65.6%
Sep 25	65.8%
Oct 25	67.5%



RTT: Number of patients waiting over 52 weeks

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

Timescale	Value
Dec 24	1,423
Jan 25	1,290
Feb 25	1,195
Mar 25	950
Apr 25	816
May 25	764
Jun 25	679
Jul 25	707
Aug 25	646
Sep 25	573
Oct 25	559
Nov 25	602



Counter Measures

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

Risk: Capacity issues for **Dermatology** first and follow up appointments
Mitigation: Additional WLI activity provided by external provider (HBS) and via ENT referral. New pathway to assess risk of malignancy before face-to-face appointment in place

Risk: Capacity in **Plastics** for appointments
Mitigation: Additional clinical capacity provided by ENT and by private provider (CSP)

Risk: Capacity in Breast for first appointment/diagnostic clinicc
Mitigation: addiitonal WLI activiety at weekend to support service demand

Risk: Insufficient capacity to eliminate waits over 65 weeks in 3 key specialties (Plastics, Urology, General surgery)
Mitigation:

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

Executive Summary

Great Western Hospitals NHS Foundation Trust

ED Attendance as a Percentage of Population by Deprivation Quintile

We have developed this as a new measure for the 2025/26 Strategic Planning Framework. We want to understand whether our population's level of deprivation effects the use of emergency services. The metric shows that there is a difference in the percentage of the population who utilise ED/UTC that correlates with deprivation quintile. The populations in the most deprived quintile nationally (group 1) access ED/UTC slightly more frequently than less deprived populations (groups 2-5).

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

In November there was a slight decrease compared to October, this is showing a month on month decrease. System level focus on targets and in reach happening with from PLACE Patient Flow into the Coordination Centre. Countermeasures that have been introduced are:

- Wiltshire In reach results continues to develop with the team in reaching to ED and assessment wards proactively identifying NCTR at Day 0 (which could be seem as a positive or negative as increase in numbers) .
- Early escalation of barriers in CTR now on Nerve Centre for monitoring and utlised
- Targeted approach to Pw0's on site calls and outcomes (internal delays reduction being monitored) - linking with silvers to action
- Introduction of 48 hours.48 hours ,7 days – target dates for partners continues
- 21 day LoS panel to commenced on the 12/11/25 for CTR & NCTR – there is a reduction week on week
- Winter plans internally being implemented
- Mega MADE commencing 15th Dec – system in reach – trying to delay

Discharge Ready to Discharge average days:

Overall: PW0 – 0.6 days, PW1 – 4.4 days, PW2 – 7 days, PW3 –19 days

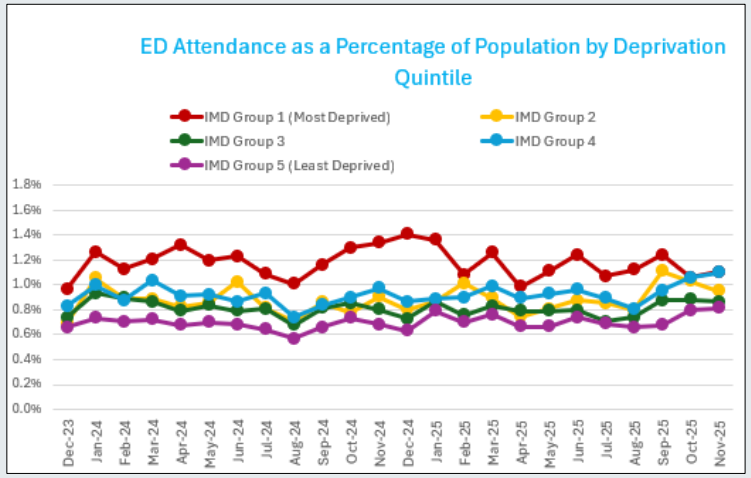
Berks – PW1 – 2 days, PW2 – 1 day, PW3 – 11
Glos – PW1 – 3 days, PW2 – 34 days, PW3 – 2 days
Oxford – PW1 – 4 days, PW2 – 15 days, PW3 – 9
Swindon LA – PW1 – 4.3 days, PW2 – 16 days, PW3 – 34 days
Swindon BSW – PW1 – 3 days, PW2 – 3.4 days, PW3 – 5 days
Wilts LA- PW1 – 5 days, PW2 – 6 days, PW3 – 1 day
Wilts BSW – PW1 – 2.6, PW2 – 4.3 , PW3 – 9
Self funders – PW1 – 5.9 days, PW2 – 6 days, PW3 – 9 days

Areas of focus for improvement – OOA, PW3 for Swindon and self funders

Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

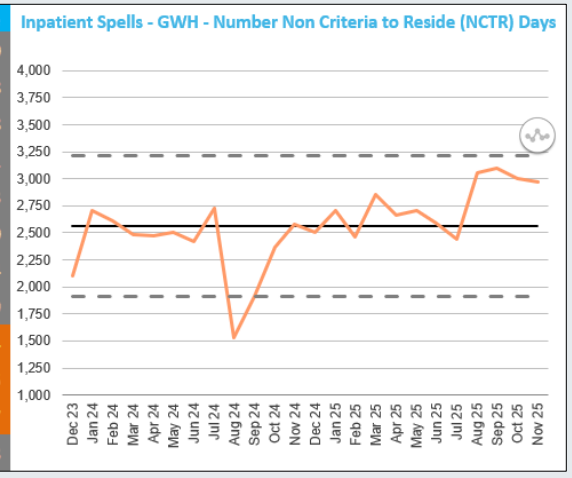
ED Attendance as a Percentage of Population by Deprivation Quintile



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

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

Timescale	Value
Dec 24	2,500
Jan 25	2,708
Feb 25	2,468
Mar 25	2,851
Apr 25	2,663
May 25	2,710
Jun 25	2,594
Jul 25	2,439
Aug 25	3,054
Sep 25	3,095
Oct 25	3,007
Nov 25	2,973



Counter Measures

We are seeking to understand the impact deprivation may have on our population's access to emergency services in order that we can work with people to provide alternative and earlier access to care where appropriate. The difference in access between people from the most deprived quintile and the rest of the population has decreased over the last 4 months with increase in the proportion of the least deprived population accessing ED (biggest increases in IMD group 4 and group 5).

We are working with our high intensity user team to develop a dialogue with our population with a Go & See with the MDT planned. We are also looking to breakdown the data further so that we can understand reasons for different patterns of access to urgent care. We will seek to do this in partnership with people in the most effected populations. We are exploring the opportunities to work with the voluntary sector in this space particularly for mental health presentations where GWH benchmarks high.

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

Opportunities:

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

Reflections:

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

Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime (ED & CEU) in November 2025 was 381 minutes (comparable to November 2024) against the national standard of 240 minutes, and the lowest time since July 2025. Mean LOS has been affected by continued flow across the organisation, leading to ED outward flow and capacity to manage incoming patients.

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

Emergency Care – Urgent Treatment Centre - Mean Stay

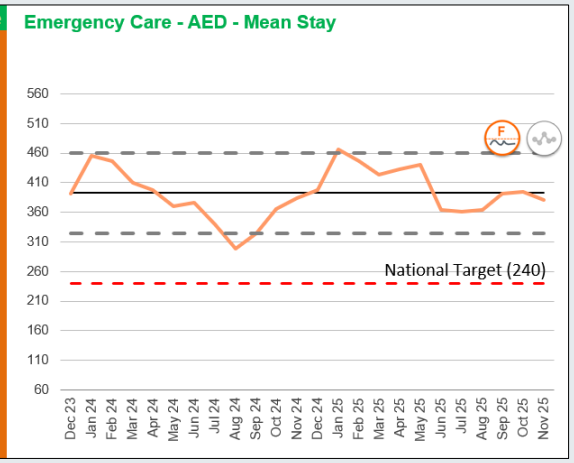
The total attendance mean time wait for a patient in November 2025 was 157 minutes against the national standard of 240 minutes, best performance since February 2025. Staffing and acuity have continued to be challenging leading to periods with longer LOS, sometimes with 4hrs wait to be seen although discharge has then been prompt.

Benny Goodman | Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

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

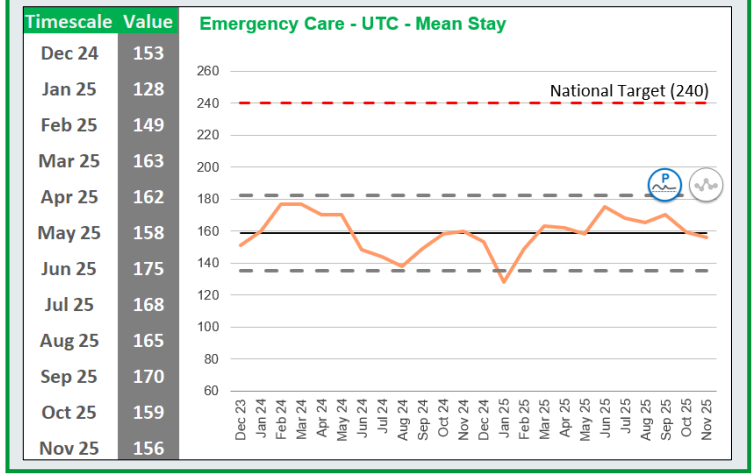
Timescale	Value
Dec 24	397
Jan 25	467
Feb 25	447
Mar 25	423
Apr 25	433
May 25	440
Jun 25	364
Jul 25	361
Aug 25	364
Sep 25	392
Oct 25	394
Nov 25	381



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Dec 24	153
Jan 25	128
Feb 25	149
Mar 25	163
Apr 25	162
May 25	158
Jun 25	175
Jul 25	168
Aug 25	165
Sep 25	170
Oct 25	159
Nov 25	156



Counter Measures

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

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

Executive Summary

NHS Great Western Hospitals NHS Foundation Trust

Sickness Absence (rate)

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

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

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

Our target for sickness absence is 3.5%, and performance in October 2025 was 4.4%, a small increase when compared to the previous month.

Staff Recommendation as a Place to Work

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

In 2023 and 2024 the Trust achieved 60% performance.

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

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

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

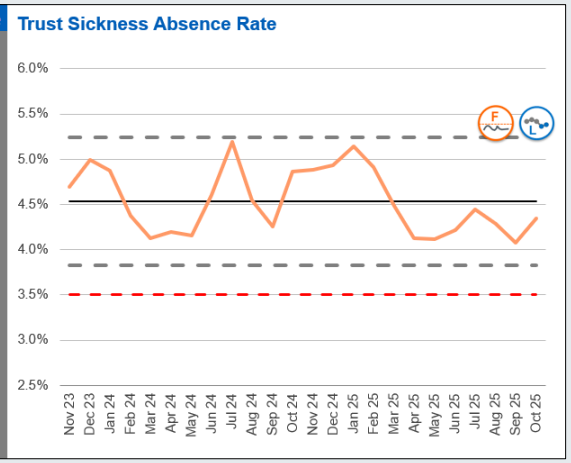
Whilst a small decline was seen in this metric throughout the year, the 2024 Annual Staff Survey results show a sustained result at 59.6%.

Jude Gray
Director of Human Resources (HR)

Trust sickness absence rate

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

Timescale	Value
Nov 24	4.9%
Dec 24	4.9%
Jan 25	5.1%
Feb 25	4.9%
Mar 25	4.5%
Apr 25	4.1%
May 25	4.1%
Jun 25	4.2%
Jul 25	4.4%
Aug 25	4.3%
Sep 25	4.1%
Oct 25	4.3%



Staff % recommend the organisation as a place to work

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

Counter Measures

Sickness absence increased marginally from **4.1% to 4.4%** in October 2025, and long-term sickness cases rose from **61 to 73**. Despite this slight rise, this marks the **third consecutive month** in which the **in-month sickness rate is at its lowest level since 2020**. This suggests that the work underway—focused on sickness as a key driver metric—is beginning to have a **positive impact** on reducing overall sickness rates.

The Absence Management Working Group continues to focus on absence reduction in top contributing areas:

- A total of 61.75 hours of face-to-face People Operations support was delivered to hotspot teams throughout November.
- formal meetings undertaken with 2 resulting in formal sanctions and 3 with monitoring periods
- Absent Audit review undertaken in Ophthalmic Nursing demonstrating an improvement from 95.80% to 97.20%

- The annual flu campaign launched on 1st October, and as 9th November 55% of staff have been vaccinated - this is ranked 2nd in the region. Additional bank staff are been recruited to support reaching the 64% target
- Regular festive tea trolley visits into departments, with mince pies, and Exec team joining these
- Festive tea trolley in a box deliveries to all community sites
- Food hampers to be delivered to staff areas on Christmas Eve
- Monthly HWB Comms headlining/promoting HWB Conversations to take place, and also the training available on ESR, as well as our newly develop resource on preventing burnout
- Additional staff discount on purchases from the Restaurant and Bookends for Dec and Jan
- Training session, open to all staff, on Suicide First Aid Lite

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

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

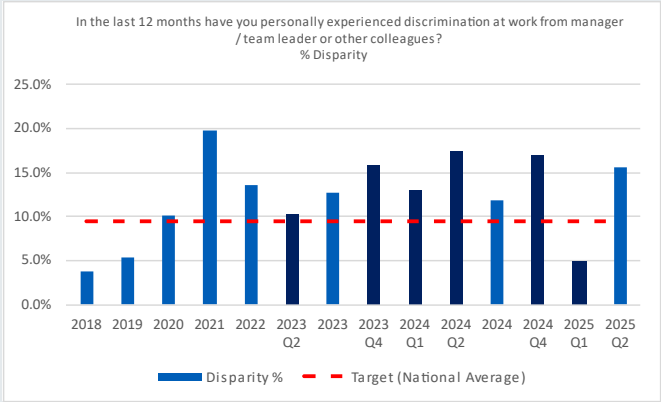
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

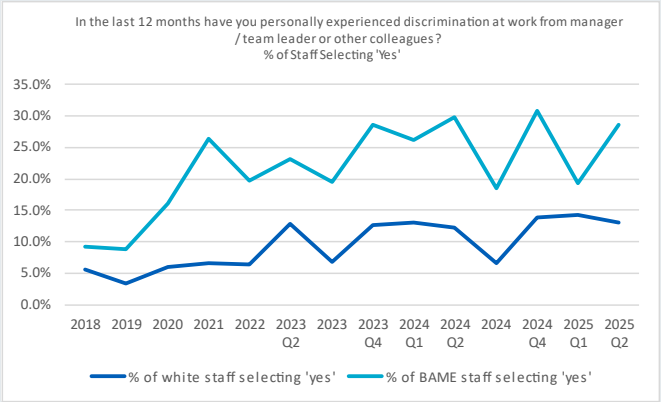
The Trust ambition in 2023 was to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

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

Jude Gray
Director of Human Resources (HR)

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





Counter Measures

- As a result of the Supreme Court ruling (For Women Scotland Ltd v The Scottish Ministers), a working group has formed to discuss changes in policy for both staff and patients to ensure a holistic plan is developed to ensure the Trust is complaint with the Equality Act 2010.
- Sixty Internationally Educated staff completed a survey at the end of the recent period of national unrest which saw increased displays of the British flag. The survey results highlighted their experiences including in the workplace. The results have been shared with the Inclusion & Health Inequalities Subcommittee in November and will be presented at the Behaviours Task & Finish Group in December to inform their actions.
- The Slice of Life event for all staff took place on Monday 17 November, the themes discussed included disparities in staff receiving one-to-ones and personal development plans; and barriers to progression for BME staff who are less likely to have a 'sponsor' and the need to support speaking up for staff from cultures where this is less likely to happen.
- Addressing unwanted behaviours from patients, the public and staff - In response to feedback from multiple sources (WDES, WRES, NETS, and engagement with international staff and Beech Ward), a pilot workshop was held on 1 December. The 'Holistic Approach to Addressing Unwanted Behaviours' workshop contains no theory, it focuses on practice to help staff and learners respond to inappropriate behaviour. Attendees will use the D.A.R.E. bystander model and two Transactional Analysis tools to help them understand their internal responses, build assertiveness, and set boundaries; areas where many staff and learners commonly struggle during conflict.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

For M08 2025/26 the Trust has an adjusted deficit position of £12.1m, which represents a £12.1m adverse variance to plan. In M08, the Trust had a £0.6m forecast deficit as part of the recovery plan but finished with a £1.5m deficit, representing a shortfall of £0.9m. The drivers of the overspend are industrial action costs (£0.6m) and a provision for car parking VAT (£0.3m). It should be noted that non-recurrent benefits totalling £1.7m in M08 have offset a failure in the delivery of recovery plan schemes. If recovery schemes continue to fail and escalation/winter costs continue, then the Trust is likely to finish the year with a £21m deficit position, assuming no deficit support funding is received.

On a year-to-date basis, income is £1.6m behind plan, the key driver being the loss of deficit funding (£6.4m). Lost income associated with industrial action is £0.1m with a further £1.1m of shortfall against efficiency plans, most notably elective transformation schemes in SPC and outpatient/private patient income. ERF income is £0.4m favourable to plan and £0.6m within the affordability cap. The Trust have been asked by the ICB to keep within this for the remainder of the year. There are a further £3.1m of favourable positions from other patient income. Other operating income is £2.5m ahead of plan driven by education funding. It should be noted that if the Trust were receiving deficit funding, the overall variance to plan would reduce to £5.7m, reflecting the tangible YTD gap the Trust needs to bridge.

The pay position is £7.7m adverse to plan, with undelivered cash releasing efficiency savings accounting for £5.1m. This includes a Trustwide target of £2.2m with no associated plans, with service transformation/benchmarking schemes within Divisions accounting for the remainder. The position includes run rate savings of £2.6m driven by prior year gains, the closure of escalation areas and agency framework savings. There is also a £2.0m underspend against Corporate admin lines due to unfilled posts. The remainder of the variance is due to industrial action costs of £0.7m and £6.5m of agency and locum overspends, the majority against medical and dental staff.

Non-pay is £2.8m adverse to plan. Undelivered cash-releasing efficiency savings accounts for £2.6m with a Trustwide target of £1.1m with no associated plans. There are also efficiency plan underperformances against Procurement and Specialty Review schemes. Clinical supply costs across the Trust are overspent by £3.4m, while the position also includes a £0.3m provision for car parking VAT costs and a PFI technical adjustment of £0.1m. Additional run rate savings from prior year benefits total £2.6m with a further £1.0m benefit from education and finance-related costs.

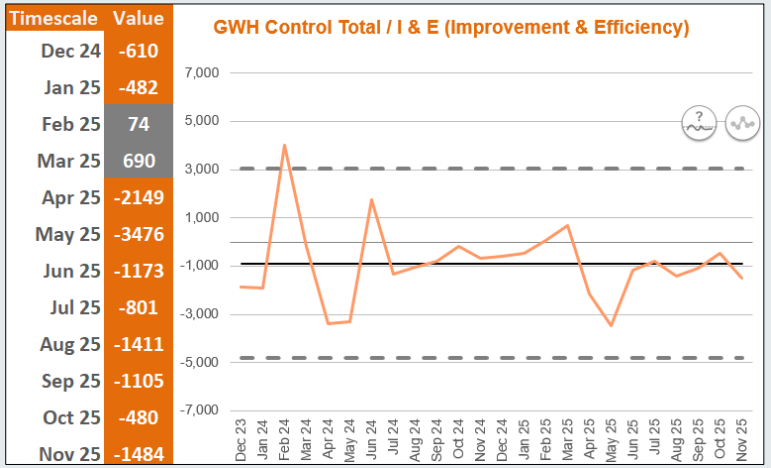
Key to breaking even in 2025/26 is delivery against the efficiency savings target of £32.4m and the recovery actions planned to recover the year to date deficit. At M08 total recurrent efficiency delivery is expected to be £12.1m against a plan to deliver 2/3rds of the target (£21.6m) recurrently. If we cannot improve this delivery, we are carrying an additional £9.5m deficit into our underlying position.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
Dec 24	-610
Jan 25	-482
Feb 25	74
Mar 25	690
Apr 25	-2149
May 25	-3476
Jun 25	-1173
Jul 25	-801
Aug 25	-1411
Sep 25	-1105
Oct 25	-480
Nov 25	-1484



Counter Measures

Cash releasing efficiency savings were £0.2m below target in month. Actual savings delivered were £2.5m against a plan of £2.7m. Pay was £0.6m under plan and non-pay £0.5m over plan. Recurrent delivery was 75% in month and is 61% year-to-date, 3% higher than M07. Note that the Trust has also made cost avoidance/run rate savings of £5.3m at M08 relating to prior year benefits transacted in-year and the closure of escalation areas. Divisions and services are included in financial recovery workstreams such as substantive workforce, temporary staffing and better buying to focus on delivery recurrent cash out savings.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Carbon Footprint / Sustainability

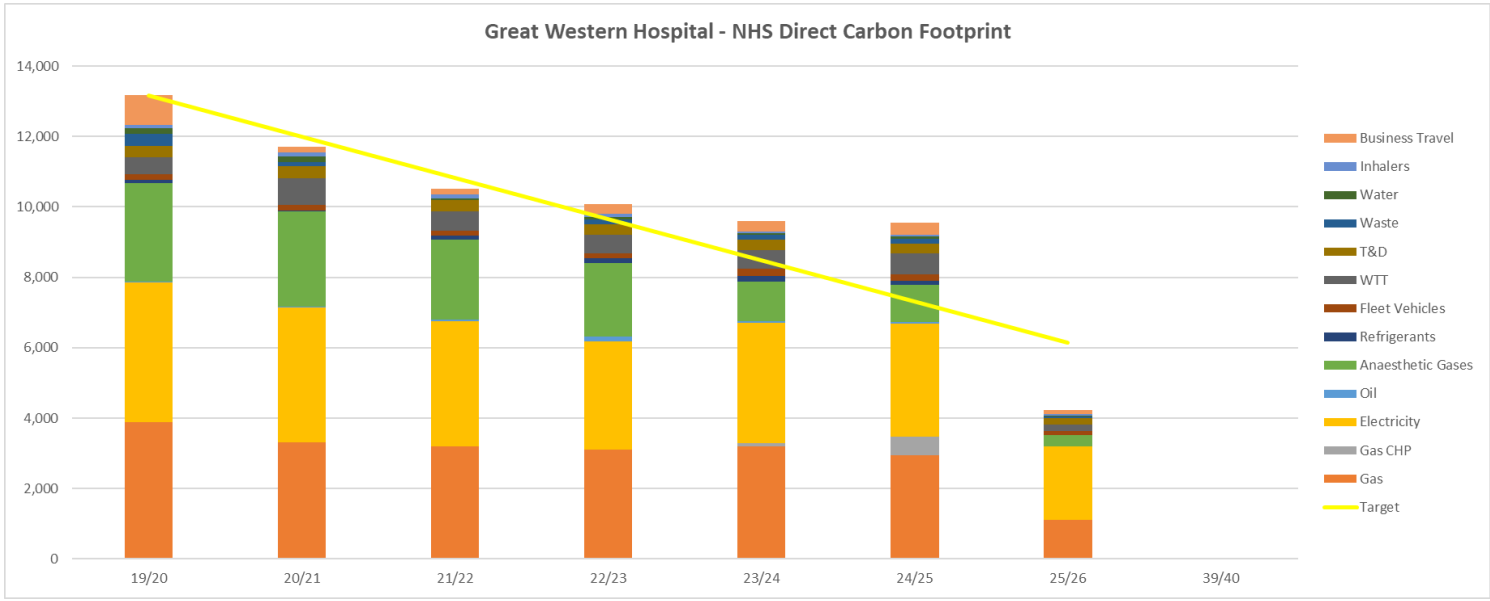
Sustainability is fundamental to maintaining high quality care; to help us meet the needs of today without compromising the needs for future generations.

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

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

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

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



Counter Measures

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

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

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

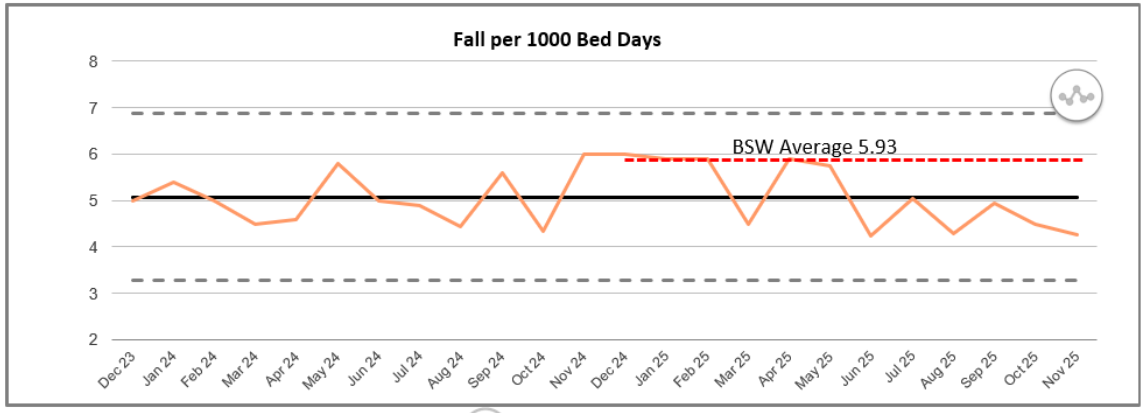
Simon Wade
Chief Financial Officer

2025/26 Breakthrough Objectives

Reducing Falls & Falls With Harm

Great Western Hospitals NHS Foundation Trust

Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
6.00	5.90	5.90	4.50	5.91	5.75	4.23	5.03	4.30	4.95	4.50	4.27



Common cause - no significant change

Understanding the Data

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

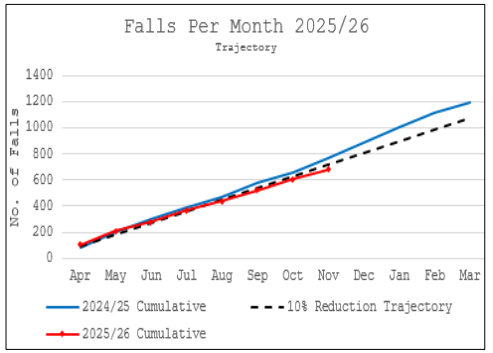
Aim for 2025/26

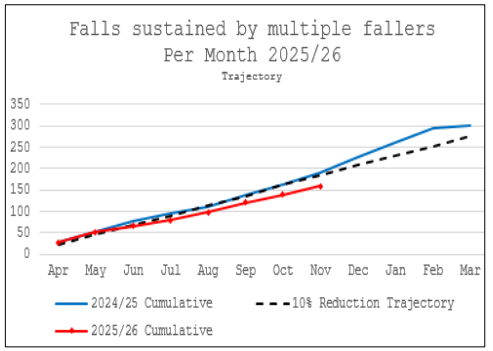
Reduction in the number of Total Falls by 30% over 3 years.
Reduction in the number of patients experiencing moderate harm or above by 10% each year
Reduction in the number of patients that fall more than once by 20%.

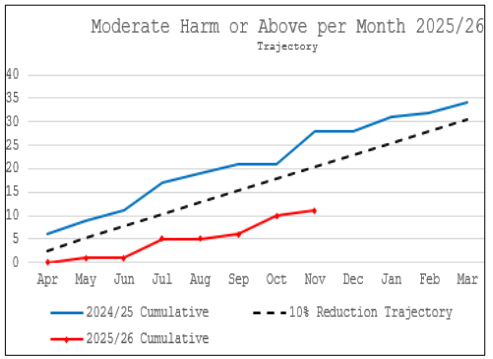
We are driving this measure because...

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

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







Performance

In November, 76 falls were reported, a decrease from 86 in October. The level of harm also decreased with one patient experiencing moderate harm. The Trust remains below trajectory for moderate harm reduction.
Falls involving patients who had fallen more than once has remained similar to the previous month and below trajectory.

Improvement Actions considered:

The falls incident form has been streamlined by removing duplicate questions, reducing administrative burden. This change is expected to encourage timely reporting and enable faster reviews, supporting improved learning.

Teal and Jupiter are trialling a Multidisciplinary Team post fall debrief process. A prompt card has been developed to ensure all risk factors are considered and addressed with each fall.

Several projects are underway to review and address deconditioning:

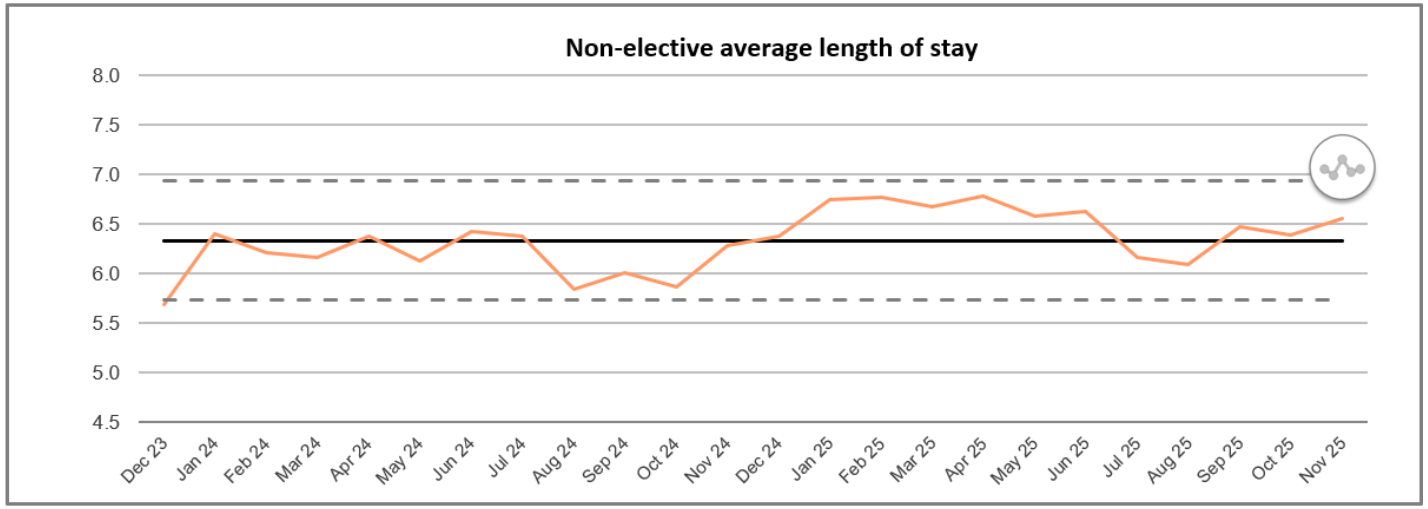
- Encouraging reporting of deconditioning incidents has been identified to support learning
- A pilot project on deconditioning, to commence in January on three wards
- A Bedside Mobility Assessment Tool project on one ward supporting the development that each patient has an activity goal, where appropriate.

2025/26 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Non-elective average length of stay

Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
6.4	6.7	6.8	6.7	6.8	6.6	6.6	6.2	6.1	6.5	6.4	6.6



Common cause - no significant change

Understanding the Data

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

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

We are driving this measure because…

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

Performance

Non-elective length of stay was 6.6 days in November. There has been a 0.2 day reduction since the start of the financial year in April, but the November position remained 0.3 days above the same point last year. 3 workstreams remain in place:

1. Pre-Admission: Increasing the volume of same day emergency care (patients that are seen, treated and discharged within 24 hours). This will include improving our SDEC capability with improvement to volumes and discharge of patients on the same day in our assessment areas with primary focus within Medicine. We are also reviewing the Frailty Pathway to improve our service provision for Frailty SDEC and have undertaken a review of our Integrated Front Door streaming pathways to support reduction in attendance to admission conversion.

2. Admission: Reducing the time between admission to becoming discharge ready. Key initiatives include Ward level quality improvement and standardisation of flow processes and Medical specialty bed base changes to improve patient access to the right medical specialty first time.

3. Transfer of Care: Reducing time between discharge ready and discharge. Key initiatives include a review of Transfer of Care hub processes and improvement in partner capacity to meet demand, especially across Pathway 1 (home first) and Pathway 2 (rehabilitation in a bedded setting/D2A). We will also improve the utilisation of the Discharge Lounge and increase capacity to improve flow from ED to assessment areas and specialty wards to increase discharges before midday.

GWH also continues to receive support from the NHS England Getting it Right First Time team to support implementation of recovery actions before March 2026.

Risks

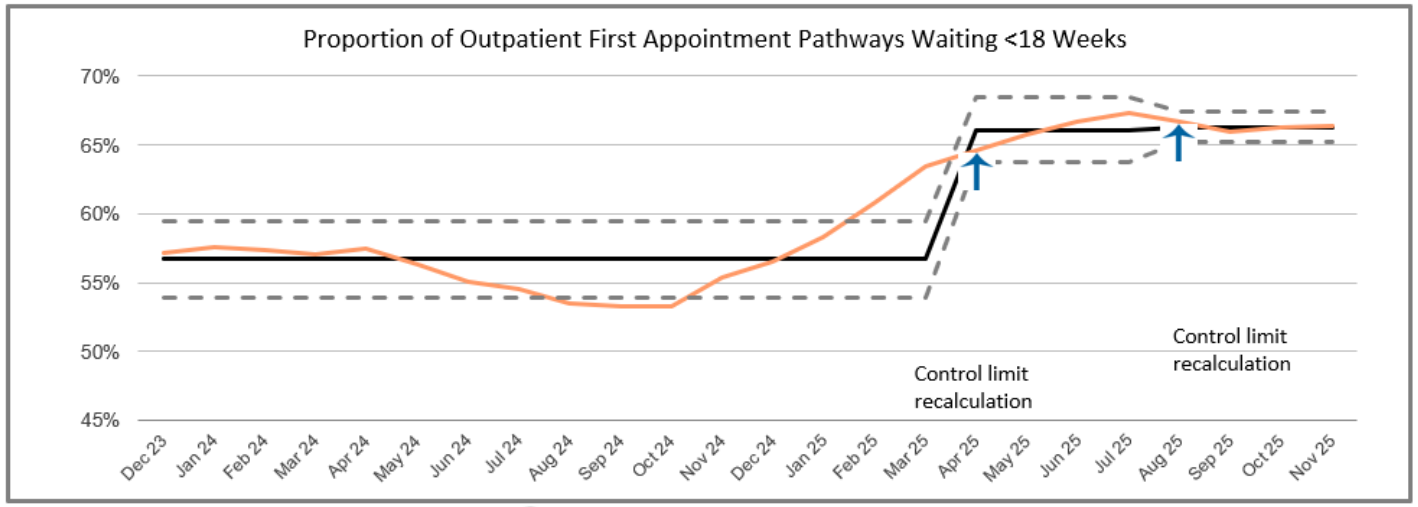
There is a risk that high hospital occupancy leads to poor patient flow through the hospital which impacts on the safe delivery of care. High occupancy resulting in delays to offloading ambulances (risk 731) , overcrowding in ED / ED majors (690) and the use of temporary escalation spaces to deliver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

2025/26 Breakthrough Objectives

Proportion of Outpatient First Appointment Pathways Waiting <18 Weeks

Great Western Hospitals NHS Foundation Trust

Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
57%	58%	61%	63%	65%	66%	67%	67%	67%	66%	66%	66%



Common cause - no significant change

Performance

Performance remains static at 66%. The new patient waitlist increased from 4,927 to 5,040 in November, and 9,917 patients have now waited longer than 18 weeks for their first outpatient appointment. Four specialties account for 41% of these breaches: Oral Surgery (12%), Gastroenterology (10%), Gynaecology (10%), and ENT (9%). The focus continues to be on working collaboratively with these teams to drive improvements in efficiency and productivity.

Straight to test: Work is underway to provide the specialty and outpatients teams with guidance on how to utilise the new automatic pathways that are progressed from tests. This is in response to services continuing to duplicate pathways.

Service Development: redesigning services across the Paediatrics and ENT specialties has been delayed due to winter pressures and competing priorities. This is likely to remain the case throughout December.

Clinic Templates: The working group has identified root-cause issues affecting clinic activity volumes following a go-and-see to compare clinic templates with SFT and RUH. Agreed countermeasures include developing a job plan policy with the Chief Medical Officer's office, improving data visibility, and establishing clear clinic output expectations at both specialty and service levels.

Understanding the Data

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

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

We are driving this measure because…

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

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

Risks

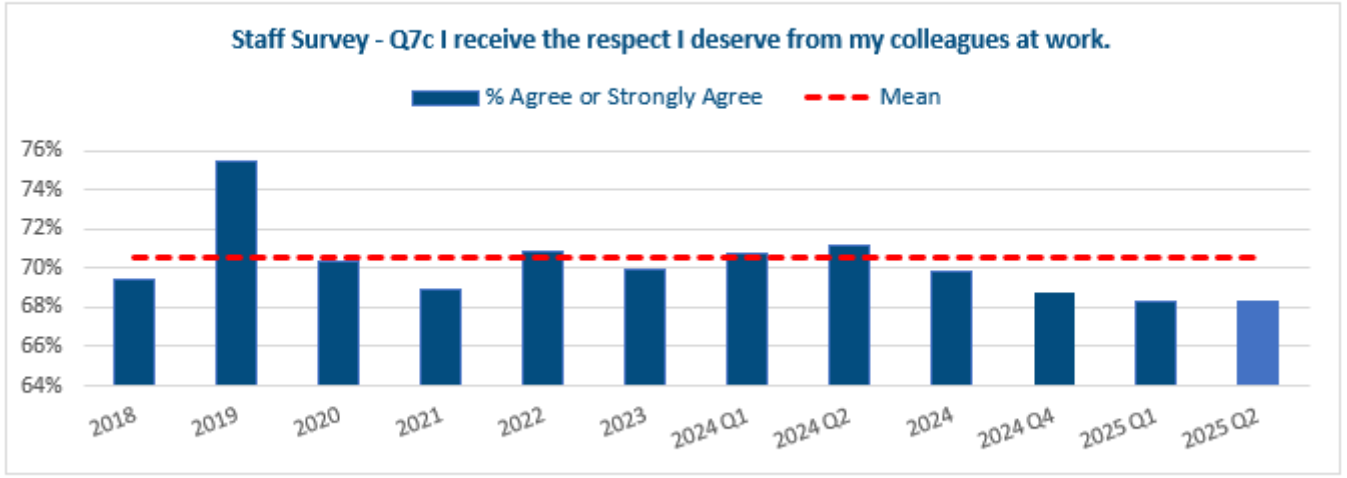
- Administrative capacity to build and support new pathways may result in delays to implementation or pausing of this sub workstream.
- Capacity Constraints: If there is insufficient capacity to handle the increased demand for early appointments, it could delay the overall process and hinder the achievement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

2025/26 Breakthrough Objectives

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

Great Western Hospitals NHS Foundation Trust

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



Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

2025 Staff Survey

The annual staff survey ran from 22nd September to 28th November. The Trust achieved a 66% response rate, which is slightly lower than last year's 71%. However, this is the highest response rate for the provider and the highest among BSW trusts. The NHS has reported an overall reduction in response rates nationally this year.

Our Behaviours

.Ongoing fortnightly Task & Finish meetings and monthly STAR Engagement Champion sessions are driving progress on the behaviour framework. Phase 1 is largely complete, covering Trust communications, updated presentations (including induction, leadership, and management programmes), organisational signage, and redesigned documentation such as appraisals. Remaining touchpoints, including behaviour eCards and a self-assessment tool, are on track for completion by the end of December

Trust Recognition

The recognition strategy was XXXXX

The events planned for 2026 are

XXX

XXX

Risks

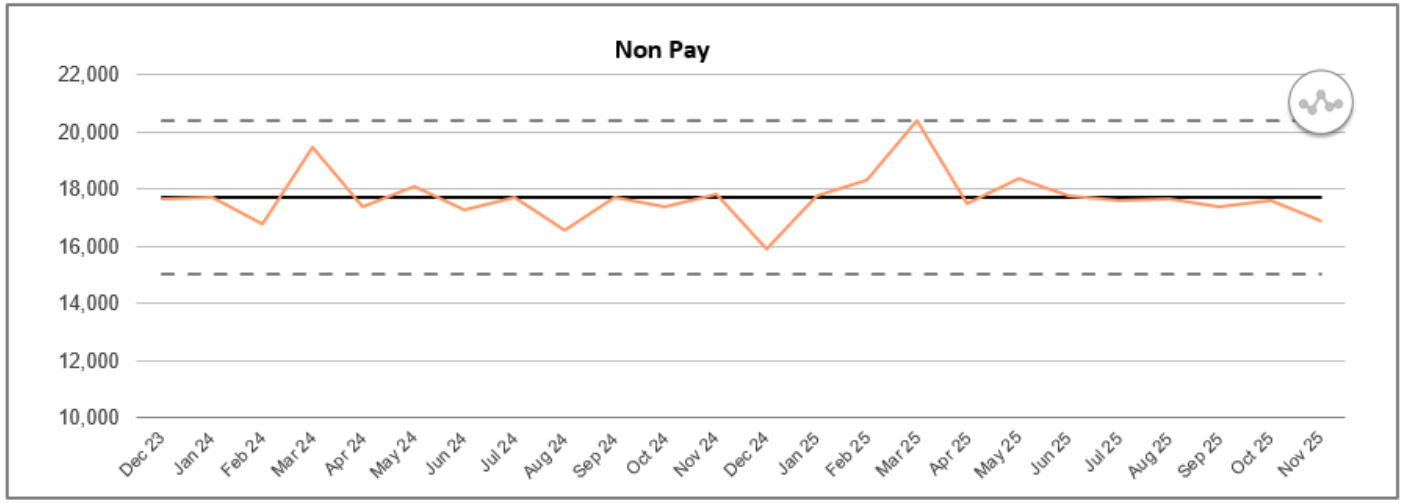
- Significant risk to staff morale and engagement due to current financial challenges, requirement to reduce our workforce, and organisational change.

2025/26 Breakthrough Objectives

Non-Pay run rate stabilisation and reduction

Great Western Hospitals NHS Foundation Trust

Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
15918	17764	18289	20422	17485	18390	17782	17611	17661	17385	17596	16912



Common cause - no significant change

Understanding the Data

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

We are driving this measure because...

The Trust has a £32.4m efficiency savings target for 25/26, which is £2.7m per month. As at M08 the Trust has delivered £12.4m of actual cash releasing savings, leading to an under delivery of £8.9m. Finding recurrent cash releasing savings is crucial if the Trust is to deliver on its savings programme and achieve a breakeven budget.

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

Performance

M08 non-pay costs were £0.6m lower than M07 driven by non-recurrent benefits taken in month. Without the benefits non-pay costs would be £0.7m higher than prior month, reflecting a provision for car parking VAT (£0.3m) and lower soft FM costs in M07 not repeated in M08.

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

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

Risks

The risks to achievement include:

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

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25	Trend
Concerns and Complaints	No. of concerns received	SPC	H	418	440	457	435	
IP&C	Klebsiella	2.17 (Int)	?	5	3	2	4	
FFT	ED & UTC Positive Responses	79% (Int)	?	78.5%	77.9%	76.7%	78.8%	
	Maternity Response Rate	44.7% (Int)	?	28.8%	25.6%	14.8%	18.4%	

Performance & Counter Measure

In November, the PALS service received 435 concerns, representing a slight reduction from the previous month. There was a Business Continuity incident in PALS relating to the IT system in November which resulted in small delays in addressing concerns. Targeted improvement work on communication, outpatient redesign, and streamlined booking processes is underway to reduce the volume of concerns by improving patient updates, reducing delays, and enhancing care coordination.

There were 4 Klebsiella bloodstream infection (BSI) cases in November, compared to 2 in October. Reviewing cases to understand contributing factors and strengthen prevention measures is underway. A recent audit of catheter practice was completed in October, and results are being actioned and shared to support improvement. Family and Friends Test (FFT) – A slight rise this month in the positive response rates for the Emergency Department and Urgent Treatment centre and a rise in the response rate for maternity services.

Recent changes to the processing of FFT cards may affect response rates. Where possible and appropriate, wards and departments are now using QR codes that link directly to the online portal to facilitate feedback.

Maternity services have made improvements to their triage assessment processes following feedback from patients. The Emergency Department are currently running a communication improvement project to ensure patient's needs are met, particularly for those waiting long periods of time for a bed to become available.

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

Risks

The risks around FFT procurement remain on the register with supplier provision of services and contractual changes . The risk has been escalated, and new managed services are now being explored.

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25
Harm	Patient safety incident investigation	SPC		0	2	0	3
	No. of Falls in month	SPC		73	83	86	76
	No. falls with moderate harm or above	SPC		0	1	4	1
	Medication incidents with moderate harm	SPC		2	1	1	3
	Pressure Ulcer (Hospital Acquired)	SPC	L	10	10	11	10
	No. of complaints received	SPC		66	75	72	106
	Number of reopened complaints	SPC		3	3	5	3
IP&C	C.Diff	4.50 (Int)	?	4	2	4	1
	MRSA	0 (Int)	?	1	0	0	0
	MSSA	1.92 (Int)	?	2	2	0	1
	E.coli	7.50 (Int)	?	9	7	11	7
	Pseudomonas	1.75 (Int)	?	4	1	2	0

Performance & Counter Measure

Three Patient Safety Incident Investigations (PSII) were reported in November. There are 21 PSII's in progress with 16 overdue against Trust internally set timelines. The Learning to Improve group now discusses the number of overdue PSII's at the start of each meeting. This supports increased oversight and provides support where traction to complete has been challenging.

The number of falls reported in month is 76 which is a decrease from the 86 reported in October. There has been 1 fall with moderate harm in month. A decrease from the 4 in October.

Hospital-acquired pressure ulcers have remained stable for the past four months. The rate per 1000 bed days is 0.56, and below the Trust's reduction trajectory. There were no category three or four pressure harms this month. 20 harms were recorded across 6 patients, with 4 device-related. Targeted education, training, and enhanced rounding guidance are being implemented to reduce these incidents.

There were 3 medication incidents recorded as moderate harm or above. All are under review, and the level of harm is therefore subject to change.

In November, the Trust received 107 new complaints, spread evenly across divisions. The predominant category was Clinical Care, relating to the quality and coordination of treatment. The Trust is addressing these by improving handover processes, enhancing discharge communication, and reinforcing staff training to ensure safe, patient-centred care.

The Trust remains above trajectory for E. Coli and Klebsiella bloodstream infection and is on target for Pseudomonas bloodstream infection. There has been 1 Methicillin-Susceptible Staphylococcus Aureus (MSSA) bloodstream infection. This bring the Trust to be nearly in line with the internal threshold trajectory.

A significant proportion of Gram-negative bloodstream infection cases were linked to urinary tract infections (UTIs). An external audit of catheter practice was completed in October; results will be shared ward-level in December 2025. Medicine and Surgery and Planned care continue to focus on improving cannula practice. Results from an external hand hygiene audit have been received and will be shared with divisions in December to drive compliance and improvement.

Risks

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

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

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25
Safer Staffing	Safer Staffing – average fill rate RN (%)	85.0% (Nat)	P	93.1%	91.8%	89.4%	92.9%
	Safer Staffing – average fill rate HCA (%)	85.0% (Nat)	P	112.6%	120.7%	111.2%	116.3%
FFT	Overall response rate (%)	29.9% (Int)	?	34.6%	33.6%	22.0%	21.2%
	Positive response (%)	90.0% (Int)	?	91.6%	91.3%	84.3%	84.0%
	ED & UTC Response Rate	19.4% (Int)	?	19.8%	19.9%	19.8%	18.4%
	Inpatients Response Rate	29% (Int)	?	31.4%	30.3%	28.7%	26.1%
	Inpatients Positive Responses	90.3% (Int)	?	92.3%	92.6%	90.6%	89.7%
	Daycases Response Rate	29.5% (Int)	?	30.4%	29.9%	31.2%	28.9%
	Daycases Positive Responses	95% (Int)	?	98.7%	96.6%	95.8%	94.8%
	Outpatients Positive Responses	93.6% (Int)	?	98.7%	98.4%	90.0%	78.8%
	Maternity Positive Responses	91.7% (Int)	?	96.0%	95.2%	91.6%	86.7%

Performance & Counter Measures

Safe Staffing fill rates has remained above the National target and are within safe parameters.

Friends and Family Test (FFT) – November response rates remained broadly stable but were slightly lower than previous months. This is likely due to operational pressures and disruption caused by the external supplier ceasing card production. Cards are currently excluded from national reporting, and this trend is expected to continue until a new supplier is secured.

Improvement work to address the key themes around communication, waiting times and clinical care include:

- Significant work is underway to reduce waiting times through improvements to processes, better use of IT communication systems, and increasing capacity.

- A project is underway in the ED to improve communications with patients regarding what is happening to them and their treatment/assessment pathway.

- A new discharge improvement working group has been set up with the initial task to ensure clarity on roles and responsibilities including good communication with patients and relatives about discharge plans.

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

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25	Trend
RTT	No. of >=18 weeks waiters		H	15869	15986	16401	16827	
	No. of >=52 weeks waiters		L	646	573	559	602	
DM01	No. of patients on DM01 waitlist		L	7254	7401	7755	One month behind	
	DM01 performance %	99% (Nat)	F	89.0%	90.2%	92.9%	One month behind	
	DM01 6 week wait breaches		L	797	724	554	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	F	65.6%	65.8%	66.7%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	89.8%	83.6%	91.1%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	48.4%	51.3%	54.3%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	F	65.6%	61.4%	63.9%	One month behind	

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

Service | Teamwork | Ambition | Respect

Performance & Counter Measure

Diagnostics

November's validated DM01 performance showed a slight dip in performance from 92.9% to 92.0%. This has been driven by the reduction of patients waiting under 6 weeks this month but the over 6 weeks remaining static. The number of patients on the waiting list has decreased by 252 to 7,201. There are now 553 patients waiting over 6 weeks vs 554 last month.

Counter measures: Radiology now have a specialist CT outsourcing provider to support on the mobile pads with complex scans which make up the majority of the long waiters (Cardiacs and Colons). Activity for the imaging vans on the CDC site is now achieving 100% utilisation for MRI and CT. Ultrasound still remains the largest issue with 2,353 on the waiting list and 208 over 6 weeks, but this is recovering well. Audiology continues to improve and still represents a risk to YE performance now delivering 83.66%. Endoscopy will be variable over the next few months as the team look to move from WLI in house to delivering a service at the new Endoscopy unit in west Swindon which opened on the 25th October.

Cancer

62 Day performance remains heavily impacted by pathway issues in Urology, where diagnostic reporting delays and all options nature of prostate patients means a large number of breaches continue. 29% of the 62.0 breaches allocated to GWH were on a Urology pathway

31D performance fell short in October due to capacity issues in outpatients. Of the 20 pathways that breaches, 15 were in Skin.

Cancer waiting times for first appointment remain below standard. Skin is the largest contributors with 49% of all breaches, with Breast next with 34%. Outpatient capacity was the main reason for breaches, being responsible for 81% of breaches.

Cancer Faster Diagnosis is heavily impacted by the capacity issues seen in the Skin & Colorectal pathways. Skin accounted for 46% of all breaches, where 98% related to outpatient capacity

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	67.8%	68.1%	69.9%	71.0%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	5.7%	7.4%	7.4%	7.5%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	48.3%	48.5%	49.0%	52.0%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	10.6%	14.3%	14.6%	14.0%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	89.6%	88.4%	91.8%	92.4%	
	Total ED Type 1 Attendances (all arrival methods)	SPC	H	5788	5926	6185	6142	
	Emergency Care - AED - Median Stay	240 (Int)	F	290	285	281	240	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4-hour performance (type 1 and 3) remained consistent at 71% (up 0.01%). This is below the 25/26 national target. The increase in overall performance relates to type 3 performance increasing over 90% over last few months (previously sustained at 95% or above) and Type increasing from an average of around 45%.

Total % over 12 hours (Type 1) decreased slightly by 0.6% from last month at 14.6%. This is over target. Any prolonged length of stay in ED leads to overcrowding and subsequent delays in ambulance offload.

Management of 'Timely Handover Process' with ambulance patients off-loaded into ED temporary escalation spaces, predominantly maintained as four trolley spaces: THP continues to be used consistently to support THP protocols with the ambulance services – Patients continue to move through THP to facilitate offloads in July, as formal ED cubicle known to be shortly available.
Counter measures remain in place within the Breakthrough objective slides and are now being refreshed as part of the Trust UEC and Flow programme reset around reducing non-elective length of stay.

Risks

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25
RTT	No. of >=78 weeks waiters	SPC		4	5	3	5
Cancer	No. of referrals received	SPC		1885	2181	2055	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.2%	0.1%	0.1%	0.0%
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC		88.9%	88.2%	88.3%	88.3%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		64.4%	58.7%	58.2%	60.8%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		60.2%	50.9%	51.6%	51.0%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	210	208	199	196
	Emergency Care - UTC - Median Stay	240 (Int)	P	153	165	153	149

Performance & Counter Measure

ED, CEU & UTC

ED – 4,832 CEU – 1,109, UTC – 5,731

Triage performance for ED for 15-minute increased 2.6% from 58.2 to 60.8%.

For Type 3 (UTC only) triage performance within 15 minutes decreased 0.6% from 51.6% to 51.0%.

Risks

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

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

Our Performance

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25
ED	Total Number of Ambulance Handovers	SPC		2268	2057	2285	2296
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		1171.56	1820.91	690.90	547.41
	Number of Ambulance Handover Over 15 Minute Waits	SPC		1548	1615	1655	1681
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC		68.3%	78.5%	72.4%	73.2%
	Number of Ambulance Handover 30 Minute Waits	SPC		914	1076	916	730
	Percentage of Ambulance Handover Over 30 Minutes	SPC		40.3%	52.3%	40.1%	31.8%
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		459	637	217	728
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		20%	31%	9%	32%
	Average hours lost to ambulance handover delays per day	SPC		38	61	22	18

Performance & Counter Measure

ED, CEU & UTC

Number of ambulance conveyances increased in November to 2296, an increase of 11 on October. Despite this, average daily hours lost reduced 18, a decrease of 4 from October.

Ambulance arrivals averaging 75 per day in November compared to 50 in November 2024

W45 Ambulance Offload protocol went live 6th October 2025 (offload in under 45 minutes) and has been extremely challenging throughout October & November, with an organisational response required. As a result, GWH W33 minute target was achieved in both October and November.

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		505	583	585	578
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		282	291	290	277
	Elective Patients Average Length of Stay (Days)	SPC		3.2	3.1	3.6	3.0
	Non-Elective Patients Average Length of Stay (Days)	SPC		6.1	6.5	6.4	6.6
	GWH Discharges by Noon (%)	SPC		16.5%	16.5%	14.8%	16.6%
	Number of Stranded Patients (over 14 days)	SPC		116	134	141	132
	Number of Super Stranded Patients (over 21 days)	SPC		62	80	86	78
	Adult general and acute type 1 bed occupancy	SPC		98.4%	99.0%	99.3%	97.2%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	H	22.3%	22.9%	21.2%	21.7%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.61%	96.09%	95.76%	95.88%
	The Number of Patients in Temporary Escalation Spaces within ED	SPC		24	27	28	29
	Total adult general and acute Temporary Escalation Space beds occupied	SPC		2	7	9	12
	Total paediatric general and acute Temporary Escalation Space beds occupied	SPC		0	0	0	0
	Total Temporary Escalation Space beds occupied	SPC		2	7	9	12

Performance & Counter Measure

Patient Flow

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

Risks

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

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

Use of Resources

Great Western Hospitals NHS Foundation Trust

Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25
Use of Resources	Capital Expenditure (£'000)	SPC	L	1085	774	-1723	1258
	Pay (£'000)	SPC	L	26768	27595	27286	28109
	Non Pay (£'000)	SPC		17661	17385	17596	16912

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

Performance & Counter Measure

Capital spend at M08 is £5.5m against a plan of £13.8m, giving an underspend against plan of £8.3m. The £5.5m includes a £2.6m disposal of community property. Other key underspend drivers are EPR (£1.5m), estate schemes (£0.7m) and equipment replacement (£0.8m) with the remainder due to divisional related CDEL scheme underspends. The Trust was advised to slow its capital schemes due to its revenue position in M02, which has also contributed to the profile of spend being behind plan.

M08 pay costs are £0.8m higher than M07 due to industrial action costs of £0.5m and higher escalation costs of £0.3m.

Non-Pay costs are £0.8m lower than M07 due to non-recurrent benefits relating to the closure of aged POs (£0.5m) and lower depreciation costs (£0.8m). Offsetting these were a £0.3m provision relating to car parking VAT.

Risks

The £8.9m shortfall on the Trust's cash releasing efficiency savings programme at M08 is a key driver behind the £12.1m adverse variance to budget. Delivering on the overall efficiency savings target of £32.4m through recurrent cash out schemes, particularly on pay with associated WTE reduction, is vital if the Trust if to achieve its breakeven plan in 25/26.

Our People

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Aug-25	Sep-25	Oct-25	Nov-25
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	13.1%	12.8%	11.4%	One month behind

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

Performance & Counter Measure

- Leavers within their 1st year of employment further decreased in October to 11.4% with performance consistently below the Trust KPI of 14.8%.
- The 2025 Staff Survey closed on 28th November with a final response rate of 66%

Risks

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

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

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Trend Vs	
																		Last Month	Nov-24
		Vacancy																	
	W	Vacancy Rate	%	7.00%	3.53%	3.44%	3.34%	3.06%	2.98%	4.28%	4.26%	4.18%	4.25%	3.67%	3.04%	2.40%	1.82%	↓	↓
	W	Vacancy Rate	WTE	-	192.27	187.54	182.32	167.40	162.89	215.93	215.09	210.64	214.60	185.13	153.23	120.97	91.70		
	W	All Nursing Vacancy	%	7.00%	1.5%	2.0%	1.8%	1.2%	1.0%	0.1%	0.1%	0.1%	0.0%	-0.7%	-1.4%	-1.8%	-2.7%	↓	↓
	W	All Nursing Vacancy (Reg & Unreg)	WTE	-	39.90	53.22	47.73	33.37	27.15	3.52	1.47	1.23	-1.17	-16.13	-33.00	-43.91	-65.00		
	W	All Registered Nursing Vacancy	WTE	-	-28.09	-24.47	-24.01	-10.00	-8.16	-10.86	-7.52	-9.24	-10.35	-17.41	-37.44	-52.63	-61.21		
	W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg	WTE	-	-41.52	-42.81	-41.32	-37.51	-33.85	-41.18	-38.96	-38.48	-40.30	-44.56	-61.01	-71.45	-74.96		
	W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	67.99	77.69	71.74	43.37	35.31	14.38	8.99	10.47	9.18	1.28	4.44	8.72	-3.79		
	W	Medical Vacancy	%	7.00%	6.37%	7.36%	8.01%	8.92%	8.25%	8.31%	8.05%	8.10%	8.00%	4.60%	2.55%	0.09%	0.08%	↓	↓
	W	Medical Vacancy	WTE	-	47.53	54.93	60.01	66.79	61.77	61.95	59.95	60.35	59.64	34.29	18.97	0.70	0.57		
	W	STT/AHP Vacancy	%	7.00%	3.7%	2.3%	2.2%	1.7%	1.9%	8.3%	7.7%	7.1%	7.4%	7.5%	6.4%	5.5%	4.6%	↓	↑
	W	STT/AHP Vacancy	WTE	-	31.82	19.62	19.03	14.42	16.50	66.18	61.87	56.78	59.15	59.90	51.32	44.34	37.17		
	W	SMA Vacancy	%	7.00%	6.2%	5.1%	4.7%	4.5%	4.9%	7.5%	8.2%	8.3%	8.7%	9.6%	10.4%	10.7%	10.7%	↓	↑
	W	SMA Vacancy	WTE	-	73.02	59.76	55.55	52.82	57.47	84.28	91.80	92.28	96.98	107.07	115.94	119.84	118.96		
	W	Recruitment Time to Hire - AFC	Days	46.00	41.40	39.50	42.19	44.30	33.60	34.80	36.40	39.70	37.70	41.30	40.30	39.10	36.20	↓	↓
	W	Recruitment Time to Hire - Bank	Days	46.00	42.90	37.50	42.90	42.70	38.30	40.00	18.00	40.20	61.10	51.70	28.50	26.50	18.80	↓	↓
	W	Recruitment Time to Hire - Medical	Days	46.00	44.50	36.80	45.02	41.00	36.50	38.00	37.40	40.20	49.00	40.10	39.50	35.50	39.10	↑	↓

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Trend Vs	
																		Last Month	Nov-24
		Workforce Utilisation																	
	W	Substantive WTE	WTE	-	5,255.94	5,270.32	5,276.50	5,303.02	5,307.53	4,827.81	4,828.65	4,833.10	4,829.14	4,858.61	4,890.51	4,922.77	4,952.04		
	W	Additional Substantive WTE	WTE	-	13.99	11.26	12.96	13.66	16.45	11.97	11.84	9.79	9.54	10.88	11.32	11.83	11.15		
	W	Bank WTE	WTE	-	289.89	270.37	325.49	305.77	413.99	311.69	306.31	270.91	287.37	304.15	241.73	274.78	298.19		
	W	Agency WTE	WTE	-	25.72	38.68	39.05	31.77	64.42	48.54	54.27	45.68	44.12	29.32	27.72	26.43	26.99		
	W	Total WTE Utilised	WTE	-	**5,585.54**	**5,590.63**	**5,654.00**	**5,654.22**	**5,802.39**	**5,200.01**	**5,201.07**	**5,159.48**	**5,170.17**	**5,202.96**	**5,171.28**	**5,235.82**	**5,288.37**		
	W	Planned Establishment WTE	WTE	-	5,448.21	5,457.86	5,458.82	5,470.42	5,470.42	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74		
	W	Variance to planned est	WTE	-	137.33	132.77	195.18	183.80	331.97	156.27	157.33	115.74	126.43	159.22	127.54	192.08	244.63		
	W	GL Funded Establishment WTE	WTE	-	5,448.21	5,457.86	5,458.82	5,470.42	5,470.42	5,043.74	5,043.74	5,043.74	5,043.74	5,215.77	5,204.43	5,202.37	5,200.96		
	W	Variance to GL funded	WTE	-	137.33	132.77	195.18	183.80	331.97	156.27	157.33	115.7	126.4	-12.8	-33.1	33.4	87.41		
	W	Planned Est, vs GL Funded	WTE	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-172.0	-160.7	-158.6	-157.22		
	W	Actual Worked vs Planned Establishment	%	-	102.52%	102.43%	103.58%	103.36%	106.07%	103.10%	103.12%	102.29%	102.51%	103.16%	102.53%	103.81%	104.85%		
	W	Total Workforce Cost £	£	-	£26.75M	£28.12M	£27.24M	£27.93M	£28.58M	£26.55M	£26.60M	£26.34M	£25.70M	£30.78M	£27.60M	£27.27M	£27.86M		
	W	Agency Spend as % of Total Spend	%	4.50%	1.64%	1.60%	2.52%	1.97%	2.14%	2.26%	2.40%	2.75%	1.82%	1.70%	1.78%	0.97%	1.05%	↑	↓
	W	Agency Spend £	£	-	£0.44M	£0.45M	£0.69M	£0.55M	£0.61M	£0.60M	£0.64M	£0.72M	£0.47M	£0.52M	£0.49M	£0.26M	£0.29M		
	W	Agency Target £	£		£0.42M	£0.41M	£0.39M	£0.37M	£0.36M	£0.20M	£0.19M	£0.18M	£0.17M	£0.16M	£0.16M	£0.15M	£0.14M		
	W	Agency Spend vs Target £	£ Diff	£0.00M	£0.01M	£0.04M	£0.30M	£0.18M	£0.25M	£0.40M	£0.45M	£0.55M	£0.30M	£0.36M	£0.33M	£0.12M	£0.15M	↑	↑
	W	Bank Spend £	£	-	£2.15M	£2.21M	£1.71M	£2.66M	£2.70M	£2.21M	£2.18M	£2.05M	£1.92M	£2.36M	£1.97M	£1.94M	£2.50M		
	W	Bank Target £	£		£1.65M	£1.57M	£1.50M	£1.42M	£1.34M	£2.90M	£2.56M	£2.22M	£1.88M	£1.53M	£1.19M	£1.31M	£1.38M		
	W	Bank Spend vs Target £	£ Diff	£0.00M	£0.50M	£0.64M	£0.22M	£1.24M	£1.36M	-£0.69M	-£0.38M	-£0.17M	£0.05M	£0.83M	£0.78M	£0.63M	£1.13M	↑	↑
		Retention																	
	W	All Turnover %	%	13.00%	11.14%	11.24%	11.08%	11.01%	11.26%	11.31%	11.16%	10.85%	10.74%	10.38%	10.20%	9.94%	-	↓	↓
	W	Voluntary Turnover %	%	11.00%	8.75%	8.78%	8.62%	8.48%	8.55%	8.41%	8.29%	8.13%	7.94%	7.68%	7.49%	7.19%	-	↓	↓
	W	Number of Leavers	Headcount	-	41	45	35	30	70	38	32	43	41	43	50	43	-		
	W	Number of RN Leavers	Headcount	-	13	14	9	8	12	8	8	11	9	9	13	11	-		
	W	Registered Nursing Vol Turnover	%	-	7.32%	7.47%	7.25%	7.28%	6.96%	6.51%	6.16%	6.01%	5.80%	5.46%	5.69%	5.50%	-		
	W	Number of Unreg Nursing Leavers	Headcount	-	8	12	1	5	9	6	10	9	8	8	8	8	-		
	W	Unregistered Nursing Vol Turnover	%	-	10.98%	10.97%	10.27%	9.77%	10.06%	9.45%	9.81%	9.21%	9.38%	9.49%	9.13%	8.94%	-		
	W	Leavers within 1st Year - Rolling 12 Month	%	-	9.68%	9.90%	9.02%	10.37%	10.94%	10.30%	11.68%	11.62%	11.93%	13.09%	12.84%	11.35%	-		
	W	Number of starters	Headcount	-	43	36	55	52	50	35	23	47	39	46	92	58	-		

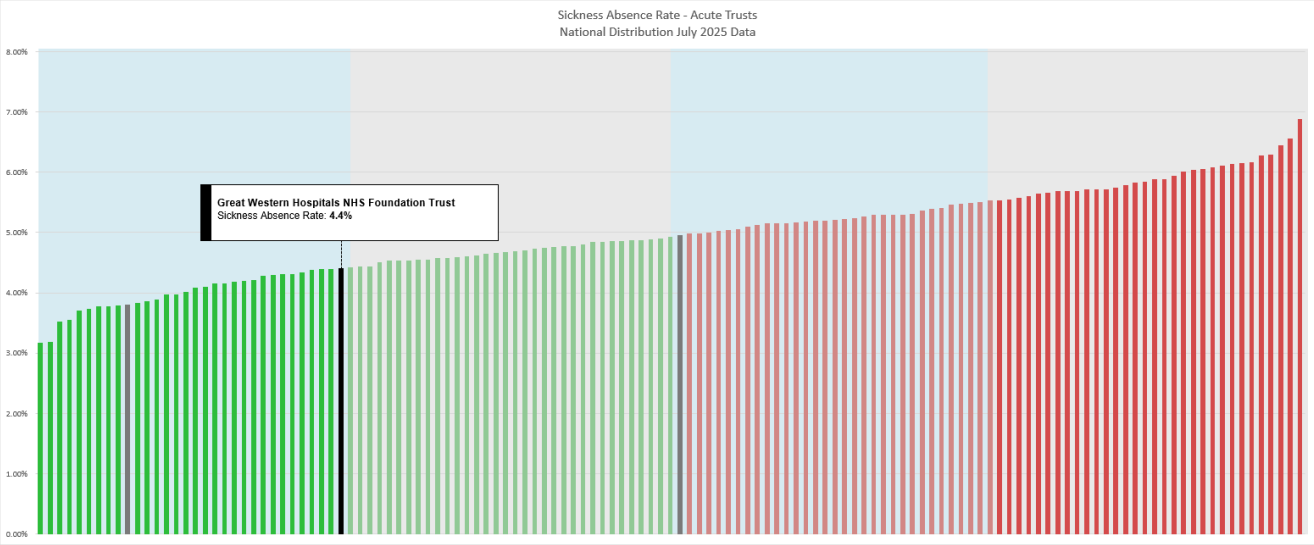
Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Trend Vs Last Month	Trend Vs Nov-24
		Absence																	
	D	Sickness Absence % Rolling 12 Month	%	3.50%	4.59%	4.59%	4.61%	4.65%	4.68%	4.68%	4.68%	4.65%	4.59%	4.57%	4.55%	4.51%	-	↓	↓
	D	Sickness Absence %	%	3.50%	4.88%	4.94%	5.14%	4.92%	4.49%	4.13%	4.11%	4.22%	4.44%	4.29%	4.08%	4.35%	-	↑	↓
	W	Long Term Sickness %	%	2.00%	2.26%	2.33%	2.12%	2.49%	2.22%	2.12%	2.09%	2.24%	2.30%	2.40%	2.05%	2.02%	-	↓	↓
	W	Short Term Sickness %	%	1.50%	2.62%	2.60%	3.02%	2.42%	2.26%	2.01%	2.02%	1.98%	2.14%	1.88%	2.03%	2.33%	-	↑	↓
	W	Sickness Absence Cost £	£	-	£860.3k	£866.9k	£897.5k	£773.1k	£815.5k	£681.0k	£702.2k	£685.5k	£769.3k	£760.1k	£742.3k	£791.4k	-		
	W	WTE Days Lost	WTE	-	7,725.1	8,081.5	8,414.0	7,299.3	7,397.7	5,979.0	6,159.6	6,117.3	6,674.6	6,456.8	5,979.9	6,638.5	-		
		Learning & Development																	
	W	Mandatory Training Compliance %	%	85.00%	89.79%	90.06%	90.27%	90.03%	90.03%	90.46%	90.94%	91.66%	91.60%	91.10%	91.38%	91.23%	91.55%	↑	↑
	W	Role Essential MT %	%	85.00%	88.86%	89.37%	89.79%	89.70%	89.86%	90.57%	90.95%	91.77%	91.95%	91.33%	91.70%	91.68%	92.05%	↑	↑
	W	CQC Safe MT %	%	85.00%	90.97%	90.95%	90.89%	90.45%	90.24%	90.33%	90.92%	91.52%	91.15%	90.79%	90.99%	90.67%	90.91%	↑	↓
	W	Bank-Only Mandatory Training Compliance %	%	85.00%	84.73%	85.86%	83.96%	81.72%	80.81%	65.69%	64.67%	64.11%	73.77%	79.71%	77.67%	76.14%	78.59%	↑	↓
	W	Appraisal Compliance %	%	85.00%	84.29%	83.46%	84.51%	84.35%	84.40%	83.88%	81.56%	80.36%	80.08%	80.91%	80.81%	79.02%	78.86%	↓	↓
	W	Non Medical Appraisal Compliance %	%	85.00%	84.60%	83.81%	84.63%	84.44%	84.24%	84.15%	82.14%	81.04%	80.45%	80.90%	80.30%	78.65%	78.80%	↑	↓
	W	Medical Appraisal Compliance %	%	85.00%	82.09%	80.94%	83.68%	83.68%	85.48%	82.08%	77.82%	76.02%	77.75%	80.99%	83.98%	81.21%	79.20%	↓	↓
		Demographics																	
	W	Staff in Leadership Roles % (B8a+)	%	-	4.30%	4.26%	4.29%	4.25%	4.27%	4.30%	4.36%	4.30%	4.20%	4.15%	4.14%	4.20%	4.27%		
	W	Staff in Leadership Roles WTE (B8a+)	WTE	-	277.00	275.00	278.00	276.00	277.00	255.00	259.00	256.00	252.00	248.00	249.00	254.00	260.00		
	W	% of Leadership Roles who are Female (B8a+)	%	-	70.40%	70.18%	70.50%	69.93%	69.68%	68.24%	68.34%	67.58%	67.86%	68.15%	68.67%	69.29%	69.23%		
	W	% of Leadership Roles who from BME (B8a+)	%	-	6.50%	6.55%	6.47%	6.52%	6.50%	5.88%	6.18%	5.47%	5.56%	5.65%	6.02%	6.30%	6.15%		
	W	Staff in Leadership Roles % (B8c+)	%	-	0.93%	0.93%	0.94%	0.94%	0.92%	1.01%	1.03%	1.01%	1.00%	1.00%	1.00%	1.01%	0.98%		
	W	Staff in Leadership Roles WTE (B8c+)	WTE	-	60.00	60.00	61.00	61.00	60.00	60.00	61.00	60.00	60.00	60.00	60.00	61.00	60.00		
	W	% of Leadership Roles who are Female (B8c+)	%	-	55.00%	55.00%	55.74%	54.10%	53.33%	53.33%	52.46%	51.67%	53.33%	53.33%	55.00%	57.38%	56.67%		
	W	% of Leadership Roles who from BME (B8c+)	%	-	5.00%	5.00%	4.92%	4.92%	6.67%	5.00%	4.92%	5.00%	5.00%	5.00%	5.00%	6.56%	5.00%		
	W	% of Leadership Roles who are disabled (B8c	%	-	3.33%	3.33%	3.28%	3.28%	3.33%	3.33%	3.28%	3.33%	3.33%	3.33%	3.33%	3.28%	3.33%		
	W	Male % of Workforce	%	-	18.46%	18.51%	18.58%	18.61%	18.67%	19.33%	19.44%	19.51%	19.67%	19.87%	20.00%	19.98%	20.06%		
	W	Female % of Workforce	%	-	81.54%	81.49%	81.42%	81.39%	81.33%	80.67%	80.56%	80.49%	80.33%	80.13%	80.00%	80.02%	79.94%		
	W	BME % of Workforce	%	-	28.40%	28.46%	28.67%	29.29%	29.43%	30.08%	30.30%	30.65%	30.66%	30.71%	31.50%	31.63%	31.75%		
	W	White % of Workforce	%	-	64.30%	64.17%	63.94%	63.48%	63.22%	62.05%	61.76%	61.35%	61.27%	60.43%	59.79%	60.38%	60.20%		
	W	ER Cases Closed	Number	-	48	58	54	33	41	56	47	52	48	48	56	66	51		

Our People



Performance & Counter Measure

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

Group Sickness Policy for Long-Term Health Conditions:

The BSW Group Long Term Health Conditions guidance has been collaboratively developed with care organisation colleagues. It includes a 'Reasonable Adjustment Form' to be completed by the manager and member of staff to record practical considerations to document how legal obligations, under the Equality Act 2010 and UK GDPR, are being met in the workplace. The draft guidance will be shared with Staff Side at the monthly EPF in December for further consultation followed by agreed Trust-wide communication.

Learning From National / Regional & Local Best Practice

Previously reported national and regional benchmarking discussions highlight the importance of continual promotion of health and wellbeing service and resources, to increase manager and staff awareness and engagement. To achieve this, the HWB and workstream leads are collaborating to strengthen the Trust-wide HWB communication, to promote a monthly focus. December will highlight the value of the 'wellbeing conversations', available training & links to Burnout prevention resources.

A successful trial in FASS where medical staff use a QR code to record sickness absence which alerts coordinators for action, is being extended to the DoM, with Divisional Director sponsorship. Progress updates will be reported to the group.

Key highlights from the last working group include:

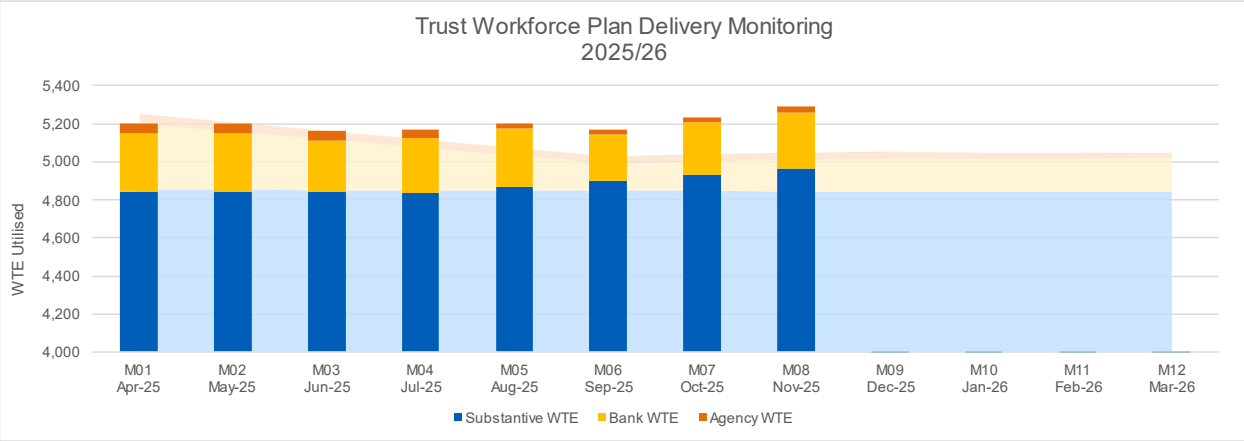
AMU and Childrens' Unit have been removed from the sickness hotspot list due to sustained improvements over 2-3 month period. Improvement initiatives shared at the working group include clarity on reporting and recording sickness absence process across the departments.

Matrons engaged in the working group are trialling the following improvement initiatives across their departments -- Burnout prevention plan & resources in SAU during December and January; reviewing options to increase attendance at the regular HWB drop-in sessions scheduled to support staff; in ED; rolling out MSK support sessions to support muscle flexibility and reduce MSK related incidents. Evaluation will be reported to the working group.

Our People

Workforce Delivery Plan

Great Western Hospitals NHS Foundation Trust



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

Performance & Counter Measure

In November we used 5,288 WTE to deliver our services against a planned 5,046 WTE. This represented an over plan position of +242 WTE and a further increase compared to the previous month of 53 WTE.

There was further growth to our contracted WTE position in M8, increasing to 4,63 WTE and above plan by +119 WTE. In-month growth is mostly attributed to Registered and Unregistered Nursing.

Temporary staffing is +124 WTE adverse to plan, remaining our primary pressure against our planned position. Enhanced care and sickness absence cover are driving most of the variance to plan, accounting for 101 WTE in November. A further 19 WTE is being used to cover seasonal/operational pressures.

Reviewing current performance against plan at staff group level:

- Nursing: +167 WTE to plan (of which 95 WTE for Unregistered Nursing)
- Medical: +76 WTE to plan
- AHP/STT: +25 WTE to plan

Impact on Workforce

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

Risks & Mitigations

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

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

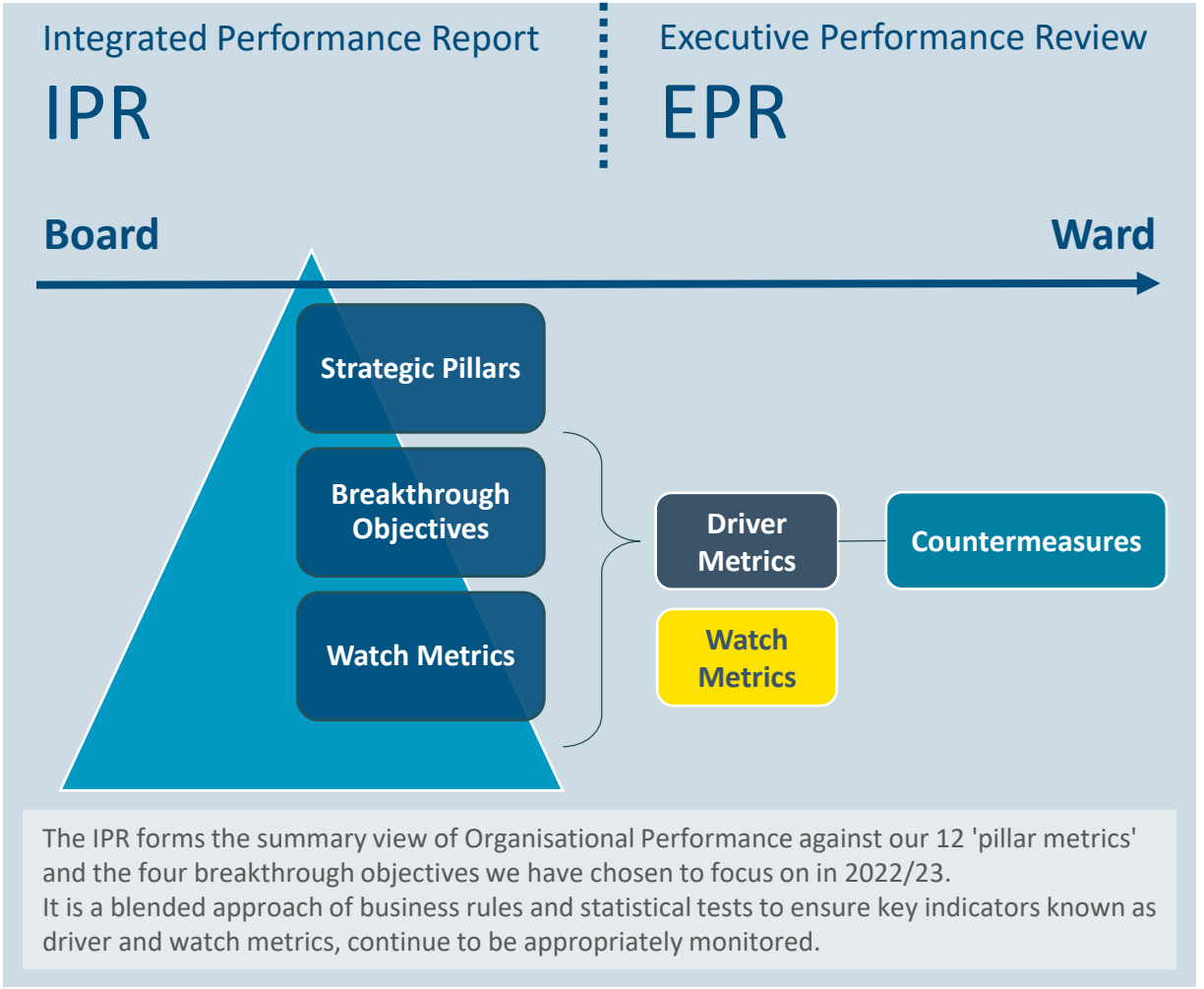
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Vision

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

Our four strategic pillars

Outstanding care

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

Valued teams

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

Better together

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

Sustainable future

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

25/26 Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust

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

1 Our four strategic pillars

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

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

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

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

4 Overlap

Corporate Projects

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

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

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

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

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Continuous Improvement on Drivers

Performance Management on Driver & Watch Metrics

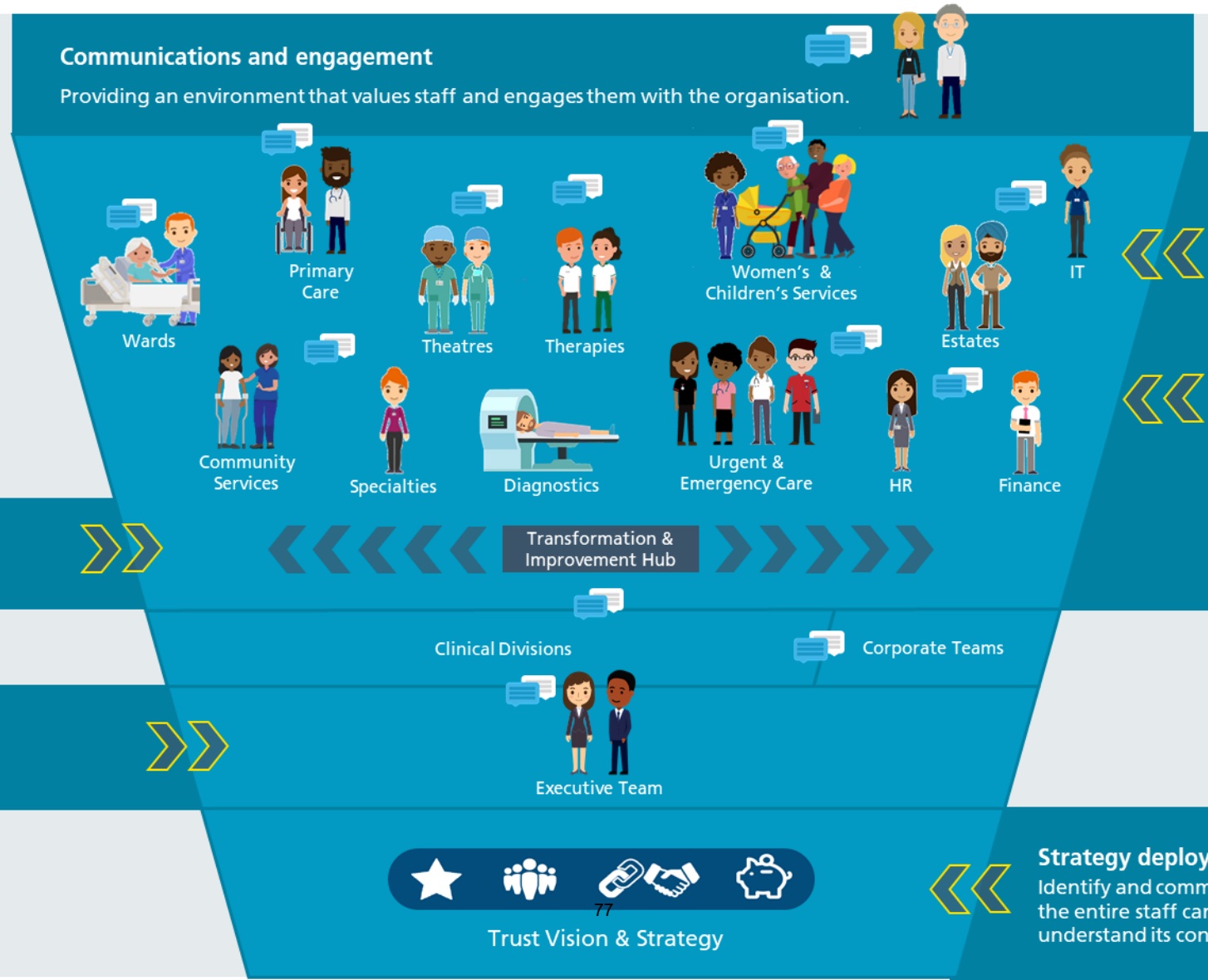
Level	Daily	Weekly	Monthly
Exec			Exec Performance Meeting
Division		Divisional Weekly Driver	Divisional Performance Meeting
Speciality		Speciality Weekly Driver	Speciality Performance Meeting
Frontline	Improvement Huddles		Frontline Performance Meeting

Information Flow

Information Flow

Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



Transformational projects
Using improvement methodology to create step-change improvement.

Operational Management System
A system of routines, behaviours and tools which ensure daily continuous improvement and performance excellence.

Transformation & Improvement Hub
Develop an internal capability to develop and sustain improvement journey.

Leadership behaviours
Develop new leadership styles at the top of the organisation, and capability to cascade this through management.

Strategy deployment
Identify and communicate a focused set of priorities to ensure the entire staff can align with the organisation's strategy and understand its contribution to achieving the strategy.

SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

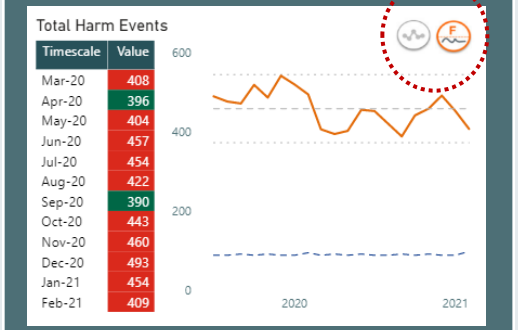
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

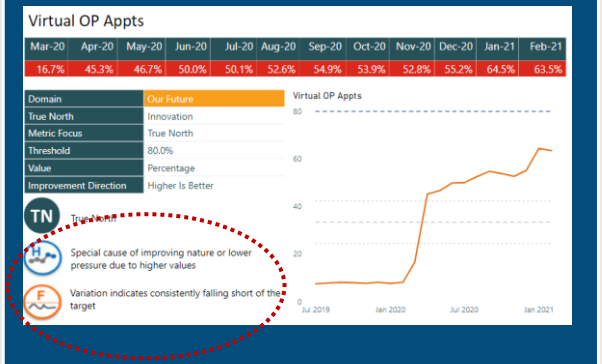
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Board Committee Assurance Report

Committee	**Quality & Safety Committee**	
Meeting Date	18.12.25	
Committee Chair	Claudia Paoloni, Non-Executive Director	
Link to Strategic Objective	Pillar 1 : Outstanding Care	
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality	
Improving Together Pillar Metrics	Reducing Harms	Patient Experience
Improving Together Breakthrough Objective	Falls Harm Prevention	

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Falls (IPR breakthrough objective). Falls	**Partial**	
2. IP&C (IPR breakthrough objective)	**Good**	
3. Complaint Response Rate (Breakthrough Objective)	**Partial**	
4. Deep Dive patient concerns and themes	**Partial**	
5. IPR Maternity	**Good**	
6. Learning from Deaths Report Q2	**Good**	

POINTS OF ESCALATION	**IPR: Reduction Total Harms:** • There has been an in month reduction in total harms in October from September and the trajectory continues to show overall reduction. **Going forwards the IPR report will detail patient numbers in corridors, which will be referred to as "corridor care" following a change in national guidance on terminology and will include the 'fifth' patient on a 4 bedded ward. This will also then assess against increased risk, longer wait times to care, patient suitability and the senior nurse assessment.** **IPR: Infection Control:** • Focussed work continues around E.Coli infections, which have reduced further in month, but still remain above our planned trajectory. • Theme still relates to urinary sources. Catheter care and hydration has been identified in relation to urinary tract infections. Results of an external audit report is awaited around catheter care and will be fed back to Q&S. • Pseudomonas infections have also increased slightly and related to catheter care. • A review of the estates piece around pseudomonas infection control confirms that there are no current estate deficiencies. • High levels of flu persist in the Trust. A robust action plan is in place including hand hygiene protocols, use of air scrubbers and mandatory mask use. **IPR: Breakthrough Objective: Falls** • This was highlighted as an area of concern with increasing numbers of falls and with harm. • Work is ongoing around whether this reflects the extra demand and patients overloading the capacity of the staff with the stretch in staff ratios. • Further A3 work to ensure maximum mitigations are in place with existing staff pressures. • Actions continue to focus on balance and strength support, cognitive and motor impairment, medication related factors, environmental factors such as ward moves at night, and additional training on the wards for nurses and registered health care support workers. • Hospital acquired pressure ulcers, which remain stable with one area recognised as having extra incidence and requiring additional support.

	Pressure Ulcers: • The number has remained static at 10. The highest ward contributor has been identified and found to be a high turnover ward suffering from a period without a ward manager and requiring extra support. This has now been addressed through the appointment of a new ward manager.

	Complaints and Concerns Response Rate
	• The complaint response rate has slightly declined to 62%.
	
	DEEP DIVE REVIEW: Patient Concerns, trends and themes
	• There has been a significant increase in complaints and concerns over the past 6 months.
	• Themes remain around patient experience and especially response times and communications.
	
	Main issues raised:
	• Waiting times and access to hospital (time to appointments and treatments)
	  ○ long delays to diagnosis and cancer waits
	  ○ **WAITING WELL** initiative has been created, with A3 plan and more
	  ○ proactive communication, as cannot wait for implementation of automation
	  ○ through new EPR
	• Communications (patients feel 'lost in system' or 'forgotten')
	• Poor phone answering
	• Care NOT being/feeling co-ordinated
	• Behaviour/attitude of staff (although this is also theme of compliments)
	• Concerns raised around clinical pathways and missed or delayed diagnoses with poor coordination/inclusion/communication and admin errors
	• Review has demonstrated a multifactorial cause form admin errors to lack of coordination, capacity pressures, fragmented care pathways, rising patient expectations.
	• Response to concerns by medics and team is also slow and needs addressing.
	
	Mitigation Plan includes more specific break through objective monitoring and response around patient concerns and complaints through A3 response, which includes clinical care pathway strengthening, outpatient service redesign, improving booking consistency, better triage pathways, updating audit processes and implementing measures to improve patient experience (e.g. falls reduction and better sleep environments)
	
	The committee has also cross referenced to PPPC to see whether delays to diagnosis and treatment is being seen with and increase in more advance cancers/disease and inoperability or poorer outcomes.

	Maternity Integrated Performance Report • Sustained performance in staffing metrics, reflecting the effectiveness of the escalation policy in ensuring safe care,1:1 care had been maintained in all cases. • 5 notifiable deaths in November, no common themes or trends noted on rapid review. • Patient Quality Surveillance update has focused in November on reducing the number of overdue Datix resulting in a 50% reduction. • Also deep dive into Uterine rupture cases underway – so far no common themes identified. • The committee received assurance around a position of compliance against all ten safety actions of CNST 6. • CNST 7 was released in April 2025. The committee received a paper and assurance that the Trust position was full compliance.

	• Progress on addressing health inequalities was noted by the committee to be slower than anticipated and reasoning identified as due to limited dedicated resources.
	• The committee received an initial paper report on the initial reflections and impressions from the independent investigation into maternity services and neonatal services in England. The full report with recommendations will not be released until Spring 2026, at which point the committee will receive a more complete action plan aligned with its findings.
	Learning from Deaths (LfD) Q2 • The latest SHMI data reports the Trust to be as expected following addressing the coding backlog. • Coding will remain up to date until the end of the year but cannot be guaranteed into next year with withdrawal additional funding, risking a risk in SHMI in 2026. • No new mortality alerts. • Themes remain around discharge issues, patient monitoring, and recognition and basic care around deteriorating patients. • Deaths reported this quarter were less than same period 2024/25. • Outcomes from service judgement reviews indicate high levels of good and or excellent care across all phases of care, with isolated episodes for improvement. • No avoidable deaths reported. • LfD team currently supporting orthopaedics team in relation to a mortality alert received in relation to hip and knee surgery.
	CQC Preparedness and Progress Report • The Trust continues to demonstrate a strong commitment to CQC compliance through proactive quality improvement initiatives, action planning, and strategic alignment with regulatory expectations. • Despite recent inspections highlighting areas for improvement there has been clear learning and system wide engagement. Changes within the national setting of CQC leadership will likely result in more change within the CQC domain, which the Trust will need to engage with which may impact in increased workload.
	Integrated Front Door Quality report- • The committee received a comprehensive report on the overview of patient safety, quality and patient experience across the integrated front door, encompassing the Emergency Dept, Urgent Treatment Centre, and Medical Assessment unit, where quality indicators are reviewed in the context of ongoing operational pressures, ambulance off loading delays, overcrowding and in patient flow challenges. • The improvement plan following the recent CQC visit was also reviewed. • Key issues lie around the use of temporary escalation spaces and seated areas in ambulatory measures. Prolonged periods within these areas impact patients in multiple ways from increased risk of harm and poor patient experience. • There have been multiple external visits into these areas including by NHSE, GIRFT and CQC. There has been strengthening in senior staffing governance and oversight of all areas but increasing demand, poor outward flow, and use of areas not fit for purpose (medical assessment Unit being housed in old building with insufficient facilities for use limit the effectiveness of the mitigations put in place).
	Quality Account Priorities Report- Significant progress in all 3 priority areas: Patient Safety, Patient Experience and Clinical Effectiveness. • **Priority 1: Patient Safety- Sepsis 6 bundle** • There has been a lot of work to improve compliance, with good focus around the speed to administration of antibiotics, these have resulted in some improvement

	although there is still challenge in this area around taking blood cultures and monitoring urine output. This is repeating the audit cycle to ensure more learnings can be found and actions put in place. • **Priority 2: Patient Experience-Putting the Hospital to bed** • This has been a focus of the senior team, including senior staff walk rounds at night. • Eye mask and ear plug initiatives have improved conditions and estate works around 'noisy estate'. However night moves remain a significant problem. 30-40% of bed moves happen at night. • **Priority 3: Clinical effectiveness-supporting self-administration of Medication** • There has been very positive work in this area with the introduction of a successful standard operating procedure, and new infrastructure such as the introduction of patient calibrated lockers to hold own medicines with personalised wristbands which activate opening.
KEY AREAS TO NOTE	
BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	Performance, Population & Place Committee - looking for assurance around delayed access to diagnostics and procedure date and impact on disease progression with risk of inoperability or poorer/more limited outcomes.

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

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

Report Title	**GWH CNST Year 7 Submission – Compliance Report**				
Meeting	**Trust Board**				
Date	**15/01/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Luisa Goddard (Chief Nurse)				
Report Author	Kat Simpson (Head of Midwifery and Neonatal Services) Laura Little (Project Coordinator for Midwifery & Neonatal Services)				
Appendices					

Purpose

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

Assurance Level

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

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

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

Established governance review process and detailed evidence base to provide assurance of Trust compliance across ten safety actions

Report

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

The purpose is to notify Trust Board that NHS Resolution (NHSR) is operating a seventh year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

This presentation provides a final compliance position update to the Board to demonstrate the achievement of all ten safety actions. Three safety actions are compliant with supporting

action plans which have been approved by the Quality and Safety Committee (18th December 2025).

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

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

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

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

Explanation of above analysis:

CNST safety action seven demonstrates the co-production of a maternity service which has an emphasis on prioritising hearing the voices of families from minority ethnic groups and areas of deprivation alongside our Maternity & Neonatal Voice Partnership.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Approve the final CNST compliance position for GWH in preparation for the NHSR Declaration form to be submitted on 3rd March 2026.

Accountable Lead Signature	Luisa Goddard.
Date	**05/01/2026**

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NHS Foundation Trust

Maternity Incentive Scheme (CNST) Year 7 Submission
GWH Compliance Report

Kat Simpson — Director of Midwifery and Neonatal Services

Chantal Woog — Head of Midwifery and Neonatal Services

GWH MIS CNST Year 7 Declaration of Compliance Position

Great Western Hospitals NHS Foundation Trust

- Trust will be declaring compliance with all ten Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Safety Actions in Year 7 of the scheme.
- The NHSR declaration process allows safety actions to be categorised as:
  - Fully Compliant (able to declare as compliant on NHSR declaration form)
  - Compliant with supporting action plan (able to declare as compliant on NHSR declaration form)
  - Non-compliant (Trusts declare as Non-Compliant on NHSR declaration form and submit bid for proportion of incentive funding for reinvestment in service)

CNST Year 4
Compliant across all 10 safety actions

CNST Year 5
Non-compliant in 3 safety actions (PMRT, Clinical Workforce & SBLv3)

CNST Year 6
Compliant across all 10 safety actions (with three supporting action plans)

CNST Year 7
Compliant across all 10 safety actions (with three supporting action plans)

- GWH maternity and neonatal services continues to be on a journey of improvement throughout every CNST reporting cycle to reinvest funding to meet targets that are stretched annually to implement national learning and extend ambitions for Maternity services

GWH MIS CNST Year 7 Compliance Across NHSR Ten Safety Actions

Great Western Hospitals NHS Foundation Trust

	Criteria	Initial Self Assessment RAG (April 2025)	Submission RAG (Jan 2026)	Key Commentary
1.	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1st December 2024 to 30th November 2025 to the required standard?			• All elements of this safety action have been met by the Trust; all cases have been reported and reviewed within the required timescales. This data set is externally verified. • The use of the PMRT tool is embedded in the governance processes with a quarterly update provided to the Quality and Safety Committee.
2.	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			• All elements compliant based on data activity in July 2025 with results published by NHS England in October 2025. • The summary tool provides assurance that the Trust is compliant with data quality submissions for the 2 data metrics required. These are valid birthweight information (100%) and valid ethnic category for the mother at booking (100%).
3.	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		Compliant with supporting action plan	• One element of safety action is compliant with a supporting action plan; all other elements have been met by the Trust. • Trust compliance status is supported by a robust action plan which details the final implementation of the pathway to reduce separation of mothers and babies from 34 weeks gestation, by expanding the transitional care provision at Great Western Hospitals. This is aligned with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice for both late preterm and term babies. • A transitional care lead has been appointed who started in post in January 2025, this has had a considerable impact on the consolidation of the previous year action plan and provided strong clinical leadership. The service acknowledges a delay from the year six action plan in establishing this care pathway. This was an active decision to defer caring for babies at the youngest gestations in transitional care until the neonatal/paediatric split rota was fully recruited to. • A Quality Improvement project was launched in 2024 by the Lead ANNP, introducing a new identification tool designed using a traffic light system to ensure all infants are correctly identified at birth for care criteria and commenced on the appropriate pathway. The learning from the first year of this initiative has been shared with the Safety Champion team at GWH, with a further opportunity for system wide learning undertaken by sharing with the Local Maternity and Neonatal System (LMNS) safety group.
4.	Can you demonstrate an effective system of clinical workforce planning to the required standard?		Compliant with supporting action plan	• Two workforce elements of safety action are compliant with supporting action plans; all other elements have been met by the Trust. • Guidance is in place to support locum doctors and compensatory rest for the obstetric team on call. • A system is in place to monitor and provide assurance of consultant attendance in line with guidance published by the Royal College of Obstetricians and Gynaecologists (RCOG). A minimum attendance of 80% of applicable situations is mandated within year 7 of the MIS which has been achieved. • Oversight of these actions is achieved by noting through the Quarterly Safety Report at Quality and Safety Committee. • Continued compliance has been demonstrated with the required anaesthetic workforce in place. • Significant progress can be demonstrated against action plans for Neonatal medical workforce recruitment and neonatal nursing meeting BAPM standards. All action plans have received Operational Delivery Network (ODN) and LMNS approval.
5.	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		Compliant with supporting action plan	• One element of safety action is compliant with a supporting action plan; all other elements have been met by the Trust. • The action plan details prioritisation of the care provision for one-to-one care in labour and compliance is monitored through maternity governance with cases reviewed to identify improvement actions, and oversight through Quality and Safety Committee. • The risk of non-compliance is considered low with one family being impacted during the last quarter. Mitigation of this risk is supported by the action plan.

GWH MIS CNST Year 7 Compliance Across NHSR Ten Safety Actions

Great Western Hospitals NHS Foundation Trust

	Criteria	Initial Self Assessment RAG (April 2025)	Submission RAG (Jan 2026)	Key Commentary
6.	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?			• All elements of this safety action have been met by the Trust. • The Trust position of 96% of actions implemented has been confirmed as meeting this requirement by the LMNS and ICS. • A quarterly update is presented to Board with an in-depth review of the full report discussed quarterly in the Safety Champions meetings. • Quarterly quality improvement discussion took place with the LMNS to provide an oversight of progress have continued with opportunities for system wide learning shared through the LMNS safety meetings. Themes and trends are monitored in line with PSIRF to identified further targeted actions to support the care bundle and reducing perinatal morbidity and mortality.
7.	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.			• All elements of this safety action have been met by the Trust; however, this action is compliant with recognition of the risk being held at both Trust and ICB level. • The guidance states that Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the national guidance for MNVPs. Whilst the Trust are engaged with the LMNS/ICB to achieve this, it is recognised that the MNVP is not sustainably commissioned and funded across BSW. • The risk that inadequate infrastructure, commissioning, and funding for the MNVP may lead to reduced service user engagement, and missed opportunities for service improvement is recognised on both the Trust and the ICB risk registers with controls in place.
8.	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?			• All elements of this safety action have been met by the Trust. • Training compliance for all staff groups meets the 90% target across all elements of the Core Competency Framework in fetal surveillance, maternity emergencies and Neonatal Basic Life Support training. • A minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised have been confirmed to hold a valid Resuscitation Council UK Neonatal Life Support certification or local assessment equivalent in line with BAPM basic capability guidance.
9.	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?			• All elements of this safety action have been met which supports the robust, established Board reporting processes to provide assurance to the Board on maternity and neonatal safety and quality issues. • There is an embedded Maternity and Neonatal Safety Champions model supported by established meetings and Board visibility. • An established safety intelligence reporting process from ward to Board is underpinned by improved triangulation of staff and service user feedback. • The Patient Safety Incident Response Framework (PSIRF) framework is fully embedded and establishment of the perinatal quadrumvirate using the NHS England Perinatal Culture and Leadership framework further supports achievement of this safety action. • The Trust have a fully embedded Perinatal Quality Surveillance Model (PQSM) via the Integrated Performance Report and are actively working towards implementing the newly introduced Perinatal Quality Oversight Model (PQOM).
10.	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1st December 2024 to 30th November 2025?			• All elements of this safety action have been met by the Trust. • Evidence supporting this achievement includes established internal databases that monitor qualifying cases and associated actions including Duty of Candour and family information, embedded processes between the governance and legal team and an additional audit process to ensure all qualifying cases are identified.

Assurance of Governance Process for Compliance Against NHSR Safety Actions

Great Western Hospitals NHS Foundation Trust

- Throughout the Year 7 reporting period there has been a strong focus on embedding a visible and consistent strategy for safety in Maternity & Neonatal care.
- The implementation of consistent monitoring, guidance and visibility from ward to board has shaped our local governance framework and reporting to the wider system

1. **Maternity Governance meetings** (monthly)
2. **Family and Specialist Services Divisional Board**
3. **Monthly Perinatal Quality Slides** (reviewed & discussed at Maternity Governance, Quality & Safety Committee & FaSS Division Board)
4. **Quarterly Maternity & Neonatal Safety Report** (reviewed & discussed at Quality & Safety Committee)
5. **Maternity & Neonatal Safety Champions meeting** (bi-monthly)
6. **Local Maternity & Neonatal System** (LMNS) & **Integrated Care System** (ICS) meeting

Timeline For GWH Chief Executive Sign Off	
15th December 2025	CNST Evidence check & challenge meeting with Luisa Goddard *(Chief Nurse & Board Level Maternity & Neonatal Safety Champion)*, Claudia Paoloni *(Non-Exec Director & Board Level Maternity & Neonatal Safety Champion)* & Gill May *(ICS Accountable Officer)*
15th December 2025	CNST Year 7 final compliance report presented at FaSS Quality Oversight Group
18th December 2025	CNST Year 7 final compliance report presented at Quality & Safety Committee
18th December 2025	CNST Year 7 final compliance report presented at Local Maternity and Neonatal System Programme Board
15th January 2026	Presentation of final compliance position to Trust Board
February 2026 (Date TBC)	Formal declaration form sign off meeting by Cara Charles-Barks *(Chief Exec.)* & Gill May *(Accountable Officer)*
3rd March 2026 (Noon)	Final deadline for completed Declaration Form (signed by Chief Exec. and Accountable Officer) to be submitted to NHS Resolution

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Report Title	**Safe Staffing 6 month review for Nursing, Midwifery and AHP**				
Meeting	**Trust Board**				
Date	**15/01/2026**	**Part 1 - Public**	✓	**Part 2 - Private**	☐
Accountable Lead	Luisa Goddard, Chief Nurse				
Report Author	Ana Gardete Deputy Chief Nurse, Kat Simpson Director of Midwifery and Neonatal Services; Juliette Sherrington Associate Director of Allied Health Professionals				
Appendices					

Purpose

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

Assurance Level

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

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

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

The report gives the committee assurance of safe staffing processes for Nursing, Midwifery and AHP within the Trust and highlights areas of concern.

Report

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

This report aims to provide the Quality and Safety Committee with assurance that staffing has been managed over the past 6 months in line with the National Quality Board guidance and Developing Workforce standards.

It makes recommendations for maintaining a safe sustainable nursing, midwifery and allied health professional (AHP) workforce through the triangulation of professional judgment and professional evidenced based acuity tools.

The Trust Board last received a Safe Staffing Paper in April 2025.

This report covers:

- Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations,
- Safe staffing related to AHP
- Nurse staffing compliance with national guidance

The **Acute Nursing** report highlights the compliance against the National Quality Board Safe, Sustainable and Productive staffing recommendations of Right Staff, Right Skills and Right Place and Time. The Trust remains positioned within Quartile 3 overall for CHPPD for both registered and unregistered nursing and midwifery staff. The Trust reports a total nursing and midwifery Care Hours Per Patient Day (CHPPD) value of 9.8, compared with a peer median of 9. For registered nursing and midwifery staff, the Trust sits in Quartile 4 with a CHPPD of 5.6, while for healthcare support workers the position is Quartile 3 with a CHPPD of 4.0 (peer median 3.8). While this represents a broadly positive position, it is important to note that Model Hospital data has recognised limitations and may not fully reflect local operational realities, particularly temporary escalation areas, fluctuating bed occupancy, and increased requirements for enhanced care provision.

It is important to note that September 2025 data demonstrates that, when considering total full-time equivalent (FTE) nursing and midwifery workforce, the Trust remains within Quartile 2 (as illustrated in Figure 2). This suggests a relatively stable and sustainable staffing position; however, local triangulation with quality indicators and professional judgement remains essential in line with National Quality Board guidance to ensure establishments continue to meet the acuity and dependency needs of patients safely and effectively.

The report also highlights that all wards remain funded to be compliant with the 1 nurse to 8 patient ratios. However, data shows that on over one-third of shifts, wards were not fully staffed with the required number of registered nurses and/or healthcare support workers, usually due to short term absence meaning that they worked on a 1:10 ratio or above.

Advanced Practitioners play a critical role in delivering safe, effective, and sustainable care across the NHS. As of September 2025, there are currently 44 qualified Advanced Clinical Practitioners (ACPs) actively contributing to service delivery across the organisation, providing expert clinical care, leadership, education, and research in line with the four pillars of advanced practice. In addition, 27 staff members are currently undertaking ACP training, reflecting a strong pipeline of future advanced practitioners. In response to the NHS England (NHSE) demand and capacity scoping exercise for 2025/2026, a further 10 staff have been identified to commence ACP training.

Maternity and Neonatal Safe Staffing

The report covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report. It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing has continued to improve over the last six months by identifying different staffing models, and recruitment. The key metrics of Supernumerary status of the Delivery Suite Coordinator, one-to-one care in Labour and midwife to birth ratio are reported and discussed. Although there is ongoing work to ensure compliance, there are no specific areas of immediate concern.

The neonatal unit at Great Western Hospital (GWH) is classed as a local neonatal unit (LNU). Babies cared for, are those who require short term intensive care (ITU) up to 48

hours, high dependency (HDU) care and low dependency care. The report describes the position against the British Association of Perinatal Medicine (BAPM) standards (2010).

Allied Health Professionals
The AHP workforce remains in a strong position. A long-term workforce plan (1-3 years) is in place, focusing on training, retention, and workforce reform. As of now, Great Western Hospitals NHS Foundation Trust employs 362.5 Whole Time Equivalent (WTE) AHPs. This reflects a reduction of 109.5 WTE since March 2025, following the transfer of the community contract to HCRG. Despite this change, GWH continues to provide services across nine of the fourteen recognised AHP professions.

Family and specialist services (FASS) represent the majority of the AHP workforce at GWH. Some rationalisation of their management structure has occurred in the last 6 months because of reduced sized teams. Management of Occupational Therapy (OT), Physiotherapy, SALT and Dietetics is now provided by a Senior AHP Lead who is from a dietetic background. Outside FASS, imaging, including diagnostic radiographers, sonographers and mammographers is the next biggest AHP workforce. Given that AHP services operate across multiple divisions, governance and activity tracking remain complex and should be considered when formulating business cases.

Conclusion
The Trust continues to make good progress in delivering safe staffing across Acute, Midwifery and AHP safe staffing. The work on recruitment and retention is demonstrated in improvements in the workforce metrics and is supporting the drive to improve patient care.

There is good governance and oversight of staffing and escalation processes in place for any concerns.

To further strengthen staffing sustainability and service quality, the following actions are recommended:

- Continue to implement and monitor robust recruitment and retention plans, particularly for registered nursing and senior AHP roles.
- Complete the Safer Nursing Care Tool (SNCT) data collection across all inpatient areas in February 2026 to inform future establishment reviews.
- Triangulate SNCT findings with October 2025 establishment reviews to ensure staffing levels align with patient acuity and service demand.
- Expand apprenticeship and ‘grow your own’ workforce pipelines across nursing, midwifery, and AHP services to address long-term supply challenges.
- Strengthen career development pathways, including Advanced Clinical Practitioner roles, to improve retention and support progression.
- Maintain oversight of neonatal staffing compliance with BAPM standards and continue QIS training efforts to meet the 70% target by Q4 2025/26.
- Embed job planning and capacity mapping tools across AHP teams to support safe staffing and improve visibility of clinical and professional activity.

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

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

Risk + Oversight		Risk Score
Key risks – risk number & description (Link to BAF / Risk Register)	Risk 500 There is a risk of poor-quality metrics and reduced staff morale/high turnover due to inpatient wards working at a ratio of 1:10 for registered and unregistered staff. This is against the national guidance of 1:8 or below.	9
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Nursing, Midwifery and AHP workforce group, Trust Management Committee	
Next Steps		

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

Explanation of above analysis:

While this paper focuses on the governance of safe staffing across the Trust, it is important to acknowledge the contribution of our diverse workforce. A large proportion of Nursing, Midwifery, and Allied Health Professional staff are from BAME backgrounds, including many internationally educated colleagues. The Trust remains committed to fostering an inclusive environment and has implemented targeted initiatives to support experience, development, and progression, particularly through enhanced induction, pastoral support, and upskilling programmes.

Recommendation / Action Required	
The Board/Committee/Group is requested to:	
The committee is asked to note the recommendations of the report.	
Accountable Lead Signature	Luisa Goddard.
Date	**05/01/2026**

1. Introduction

Following publication of the Francis Report (2013) and the subsequent “Hard Truths” (2014) document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels.

These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward. This is published on the NHS Choices website.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift
- Provide a six-monthly report on nurse and midwifery staffing to the Board of Directors.

The Royal College of Nursing (RCN) Workforce Standards (2021) report has also been fully reviewed and compliance continues to improve with actions in place to support best practice.

The Board of Directors is expected to confirm their staffing governance processes are safe and sustainable. This report aims to provide the committee with assurance that staffing has been managed over the past 6 months in line with national recommendations and to highlight areas that are not compliant or need further work to improve compliance. The report will make

recommendations to the committee regarding actions required to achieve a sustainable and effective nursing and midwifery workforce.

The Board last received a Safe Staffing Paper in April 2025.

The report covers:

- Maternity and Neonatal staffing to ensure compliance with CNST and Ockenden recommendations,
- Safe staffing related to AHP
- Acute Wards compliance with national guidance and the Emergency Department Safer Nursing care Tool review.

1.1 Background

The NHS Improvement 'Developing Workforce Safeguards' (October 2018) supports Trusts to use best practice in effective staff deployment and workforce planning utilising evidence-based tools and professional judgement to ensure the right staff, with the right skills are in the right place at the right time. Using this approach will ensure that safe staffing levels are determined on patient needs, acuity and risks and can be monitored from 'ward to board'. This triangulated approach to staffing decisions is also supported by the CQC.

Table 1- NQB: Safe, Sustainable and Productive Staffing

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

For the acute inpatient wards, this report will focus the updates in the structure of Right Staff, Right skills and Right place and time.

2.0 Right Staff

To support professional judgement, evidence-based workforce planning includes Care Hours per Patient Day, Safer Nursing Care Tool, Fill rates (planned vs actual staffing) and Model Hospital benchmarking.

2.1 Fill Rates – Nursing staff planned vs Actual (in-patient beds)

The Trust submits monthly returns to the Department of Health via the NHS National return. This return details the overall Trust position with actual hours worked versus hours expected for all inpatient areas. The percentage fill rate for registered nurses and health care support workers for day and night shifts together with the overall Trust percentage fill rate. This return also includes CHPPD.

The fill rates report is presented monthly to Quality and Safety Committee, highlighting areas for improvement.

The fill rates have remained above the expected benchmark of 85% for the months reported. It should be noted that there remains a level of fluctuation in the fill rates related to recruitment, the need for enhanced care and additional patients on wards due to operational pressure.

Table 2- Trust wide Fill Rates

	Safer Staffing – average fill rate RN (%)	Safer Staffing – average fill rate HCA (%)
April 25	100.6%	107.6%
May 25	100.3%	109.1%
June 25	99.2%	102.8%
July 25	95.9%	113%
Aug 25	93.1%	112.6%
Sep 25	91.8%	120%

2.2 Care Hours Per Patient Day (CHPPD)

The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone.

Every month the hours worked during day shifts and night shifts by registered nurses and by health care assistants are added together. Each day the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate the average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day.

The Model Health System is a digital tool provided by NHSE which provides national benchmarking on productivity and quality. CHPPD is available as a benchmark against other Trusts, it is produced from actual wholetime equivalents worked i.e. not funded establishments.

The latest Model Hospital data (September 2025) indicates that for both registered and unregistered nursing and midwifery staff, the Trust remains positioned within Quartile 3 overall. The Trust reports a total nursing and midwifery Care Hours Per Patient Day (CHPPD) value of 9.8, compared with a peer median of 9. For registered nursing and midwifery staff, the Trust sits in Quartile 4 with a CHPPD of 5.6, while for healthcare support workers the position is Quartile 3 with a CHPPD of 4.0 (peer median 3.8). While this represents a broadly positive position, it is important to note that Model Hospital data has recognised limitations and may not fully reflect local operational realities, particularly temporary escalation areas, fluctuating bed occupancy, and increased requirements for enhanced care provision.

In addition, September 2025 data demonstrates that, when considering total full-time equivalent (FTE) nursing and midwifery workforce, the Trust remains within Quartile 2 (as illustrated in Figure 2). This suggests a relatively stable and sustainable staffing position; however, local triangulation with quality indicators and professional judgement remains essential in line with National Quality Board guidance to ensure establishments continue to meet the acuity and dependency needs of patients safely and effectively.

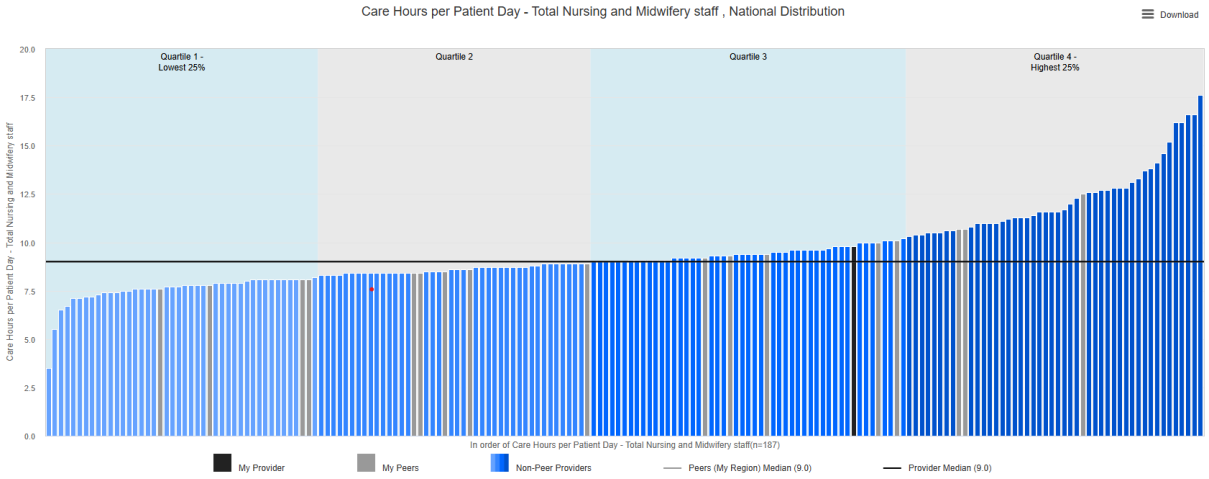


Figure 1- CHPPD for total Nursing and Midwifery staff

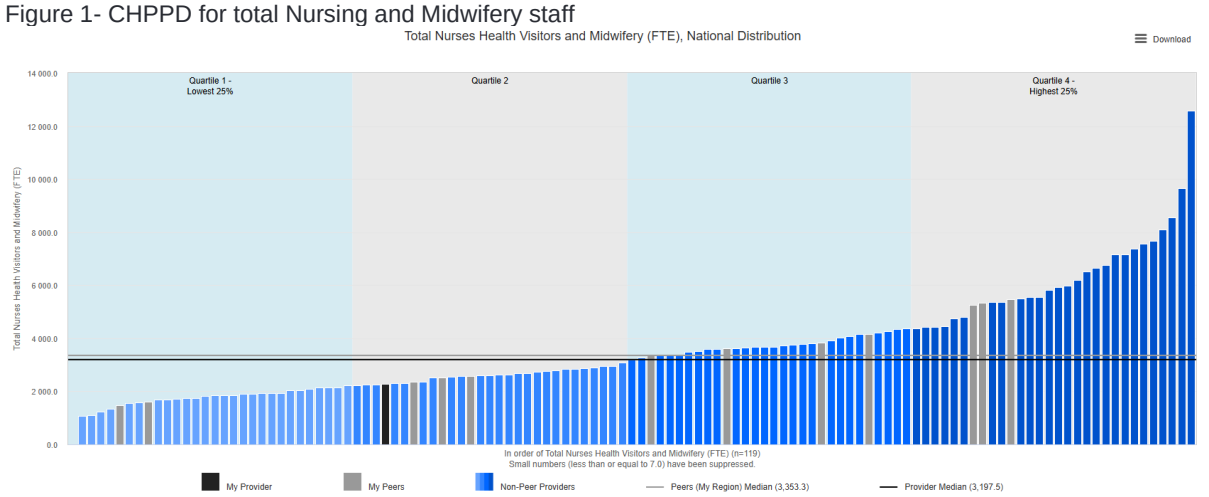


Figure 2- Total Nursing and Midwifery FTE

2.3 Safer Nursing Care Tool

The Safer Nursing Care Tool (SNCT) is a nationally endorsed, evidence-based methodology that supports the assessment of patient acuity and dependency, ensuring nursing establishments are aligned to patient need. By incorporating a validated staffing multiplier, the tool enables organisations to set establishments that reflect safe and sustainable nurse-to-patient ratios in accordance with national standards and professional judgement.

It is recommended that the SNCT is applied at least annually to inform establishment reviews and to promote consistency in workforce planning across clinical areas. In line with this, the National Safer Staffing Team will be delivering further training over the coming months to ensure all inpatient wards are fully prepared for the next data collection scheduled for February 2026.

The data gathered during this period, together with the findings from the establishment reviews taking place throughout October 2025, will provide a robust evidence base to inform decisions on nursing and midwifery establishments. It is anticipated that specialist areas, including Paediatrics, will also participate in the next SNCT cycle to ensure comprehensive coverage.
Over the past year, the Trust has observed an increase in patient acuity and dependency, particularly in relation to mental health needs and enhanced care requirements. These emerging trends further reinforce the importance of using SNCT data, triangulated with professional judgement and quality indicators, to ensure that staffing levels remain responsive, safe, and aligned to the complexity of patient care.

The Emergency Department (ED) completed its Safer Nursing Care Tool (SNCT) data collection during June 2025. The process presented some challenges in ensuring fair representation of the department's full activity, as the current SNCT methodology does not yet account for factors such as prolonged patient waits, rapid assessment areas, or observation units.

Despite these limitations, the results indicate that the current nursing establishment is sufficient to meet patient needs. However, the Trust recognises that the existing SNCT framework does not fully reflect the operational complexity and intensity of emergency care settings. This limitation has been echoed nationally by a number of organisations, and an updated version of the tool, incorporating revisions to better capture emergency and urgent care activity, is currently under review by the Shelford Group.

The Trust will continue to engage with national developments and incorporate learning from the revised tool once released, to ensure future establishment reviews within ED are based on the most accurate and representative data available.

2.4 Nurse to Patient Ratios

The fundamental importance of having enough registered nurses present to deliver care is well supported by evidence. Lower registered nurse staffing levels are associated with higher risks to patients and poorer quality care. There have been many studies that demonstrate the relationship, including systematic reviews.

A key paper published in *The Lancet* (Aiken et al., 2014) found that each additional patient added to a registered nurse's workload increased the likelihood of inpatient mortality by 7%. The same study also demonstrated that hospitals with a higher proportion of degree-educated

nurses had significantly lower case-mix–adjusted mortality rates, further emphasising the critical impact of nursing skill mix and education on patient safety.
National guidance since the *Francis Report* (2013), including NICE safe staffing recommendations and the updated *CQC Fundamental Standards*, sets a clear expectation that general ward nurse-to-patient ratios should not exceed 1:8. A growing body of evidence links ratios greater than 1:8 with increased mortality, higher incidence of nurse-sensitive indicators (such as falls and pressure ulcers), and poorer patient experience outcomes.

Following the Trust's agreed three-year safer staffing investment plan, all inpatient wards are now funded in line with these national standards. Establishment reviews led by the Chief Nurse have provided assurance that the funded establishments support delivery of care within a 1:8 ratio. However, it should be noted that on occasion, particularly during periods of short-notice absence or unplanned escalation, actual staffing ratios may temporarily exceed this level.

A snapshot review covering the period April to August 2025 shows that, of 18,887 rostered shifts (day and night), 6,809 shifts (36%) were recorded as operating at amber or red staffing levels (Figure 4 & Table 3). This indicates that on over one-third of shifts, wards were not fully staffed with the required number of registered nurses and/or healthcare support workers.

This position is actively monitored and managed through the Trust's three-times-daily safe staffing meetings, where real-time data is reviewed, and mitigations are implemented to maintain patient safety. It should also be noted that this dataset does not include additional staffing requirements for patients requiring enhanced care, suggesting that the true proportion of shifts operating at suboptimal staffing levels is likely to be higher.

While mitigations are in place to safeguard care delivery, the data highlights the ongoing operational challenge of sustaining safe staffing levels within the current funded establishment, particularly during periods of high demand, absence, or escalation.

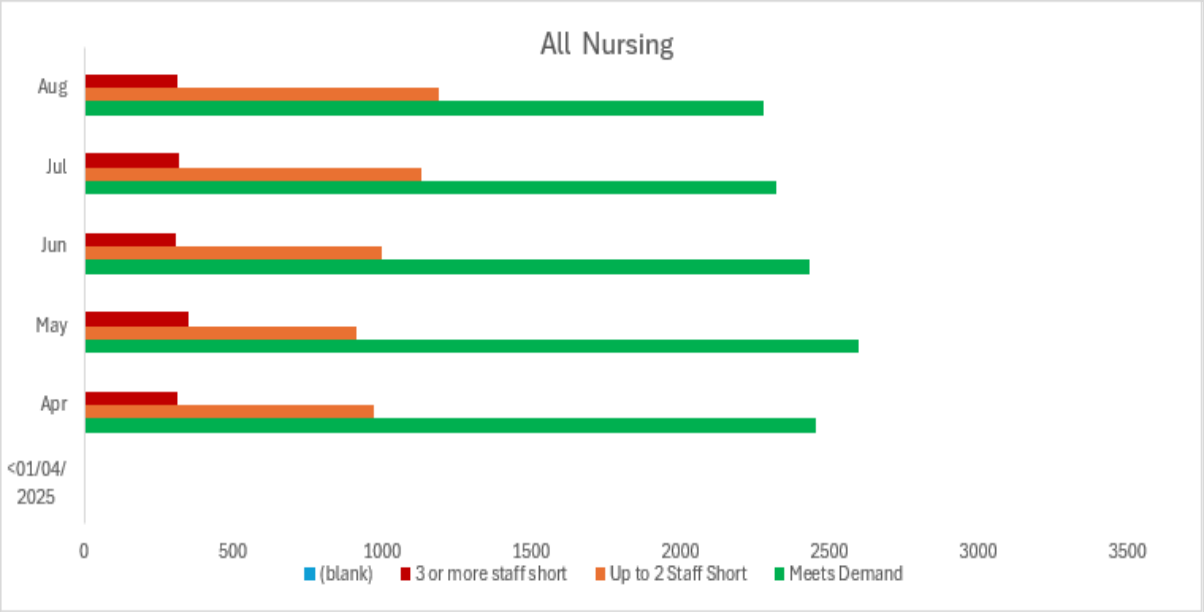


Figure 3- All Nursing shifts (Red, Amber, Green staffing)

Month	Meets Demand	Up to 2 Staff Short	3 or more staff short
Apr	2452	971	315
May	2595	916	349
Jun	2433	999	308
Jul	2319	1132	318
Aug	2279	1188	313
Total	12078	5206	1603

Table 3- Breakdown of number of shifts

3.0 Right Skills

3.1 Recruitment and Retention

3.1.1 Vacancies and turnover for nurses

The reduction in Registered Nursing and Health Care support worker vacancies has been maintained and although there was an increase in the number of vacancies over the past few months, particularly in front door areas, this has reduced significantly with 47.6 WTE newly qualified nurses joining the Trust over the months of August and October.

The average leaver rate for Band 5 registered nurses has reduced to 4.5 WTE per month (previously 6.09 WTE in early 2025 and 7.76 WTE in 2024). The table below describes the Trust turnover rates for registered and unregistered staff.

Staff Group	Average HC	All Leavers HC	All Turnover	Vol Leavers HC	Vol Turnover
Registered Nursing and Midwifery	1,813	122	6.73%	96	5.30%
Unregistered Nursing and Midwifery	875	101	11.54%	83	9.49%
Trust Total	5,076	527	10.38%	390	7.68%

Table 4- Turnover

Recruitment of Healthcare Support Workers continues to be successful and in order to improve retention in this group we have strengthen the career pathways available, with further education and development to band 4 and band 5 roles. In addition, the Trust continues to support developmental off site “Away days” which reiterates our organisational commitment to staff.

Current Recruitment initiatives include; supporting local students to have a positive placement experience at the Trust and student recruitment events to support them into the Trust, continuing the ‘SIFE’ process which supports HCSW who have an overseas registration to gain NMC registration and complete a ‘return to acute’ course; continuing the Nursing Associate Higher Apprenticeship with subsequent support to the Registered Nurse degree apprenticeship for those who want to progress and regular bespoke open days / recruitment events for clinical areas.

3.1.2 Areas with highest vacancies

Vacancies and turnover are reviewed at the Nursing, Midwifery and AHP Workforce Group, where divisional data is scrutinised to identify areas of concern and monitor trends over time. Divisions with higher vacancy or turnover rates are discussed in depth, with targeted recruitment and retention plans presented for assurance and oversight. In addition, the

Recruitment Manager provides tailored support through bespoke recruitment strategies designed to address the specific challenges within individual clinical areas. This structured approach ensures that workforce risks are actively managed, recruitment activity remains aligned to service needs, and progress is monitored through a clear governance framework.

3.2 Advanced Practice

Advanced Practitioners play a critical role in delivering safe, effective, and sustainable care across the NHS. Working at a high level of clinical autonomy and decision-making, Advanced Practitioners provide expert assessment, diagnosis, and management of patients, supporting service delivery, improving access to care, and enhancing patient outcomes. National guidance from NHS England and the former Health Education England (HEE) defines Advanced Practice as a level of practice, underpinned by a master's-level qualification, encompassing four pillars: clinical practice, leadership and management, education, and research.

The Nursing and Midwifery Council (NMC) recognises that nurses practising at an advanced level demonstrate expert knowledge, complex clinical reasoning, and the ability to lead and influence practice and service improvement. Investing in Advanced Practice roles supports workforce transformation by strengthening clinical leadership, reducing variation in care, and helping to address workforce gaps, particularly in areas with high demand or medical workforce shortages. Embedding Advanced Practitioners within establishment planning therefore provides both capacity and capability, contributing to safer staffing, improved continuity of care, and the delivery of high-quality, patient-centred services.

The Trust continues to support this field and is focusing on the following elements:

- Implementation of a structured governance framework for Advanced Practice, ensuring roles are aligned to national standards and the four pillars of advanced practice (clinical, leadership and management, education, and research).
- Advanced Practitioners are embedded within clinical services to enhance patient care, provide senior clinical decision-making, and support service transformation.
- The Trust is maintaining an ACP register, providing professional supervision, and supporting education and competency development through accredited programmes.
- Regular reporting and evaluation processes are in place to ensure consistency, quality, and assurance of ACP roles across all divisions.

Main areas of focus:

- Strengthening governance and professional accountability for ACP roles.
- Ensuring education, capability, and supervision are consistent with national frameworks.
- Expanding ACP roles strategically to meet service needs and address workforce gaps.
- Measuring the impact of Advanced Practice on patient outcomes, service quality, and workforce sustainability.

As of September 2025, there are currently 44 qualified Advanced Clinical Practitioners (ACPs) actively contributing to service delivery across the organisation, providing expert clinical care, leadership, education, and research in line with the four pillars of advanced practice. In addition, 27 staff members are currently undertaking ACP training, reflecting a strong pipeline of future advanced practitioners. In response to the NHS England (NHSE) demand and capacity scoping exercise for 2025/2026, a further 10 staff have been identified to commence ACP training.

4.0 Right Place and Time

4.1 Safe staffing process

The Trust continues to have 3 times a day safe staffing meetings chaired by a divisional director of nursing or deputy. This ensures that no ward is left on a 'red shift' and there is effective deployment of staff.

There is a monthly Nursing, Midwifery and AHP workforce group that reviews the workforce metrics including compliance with roster metrics and any recruitment and retention plans.
A monthly report to the Quality and Safety Committee details areas of concern as well as reporting the fill rates.

An annual establishment review is undertaken by the Chief Nurse in collaboration with Ward Managers to ensure a clear *ward-to-board* line of sight on staffing, supporting both assurance and understanding of how safe staffing is experienced within clinical areas. These reviews provide an opportunity to triangulate workforce data, quality indicators, and professional judgement, enabling a comprehensive assessment of whether current establishments continue to meet patient acuity and dependency needs. The 2025 reviews are currently being conducted throughout October, with a summary paper and recommendations to be presented upon completion.

5.0 Maternity staffing

5.1 National / regional context

This section covers the requirement set out in the Maternity Incentive Scheme to submit a midwifery staffing oversight report that covers staffing/safety issues to the Board on a six-monthly basis, (MIS-Year-7-guidance.pdf).

Maternity staffing is reviewed using Birthrate Plus (BR+) which is a nationally recognised tool to calculate Midwifery staffing levels. The methodology underpinning the tool is the total midwifery time required to care for women on a 1:1 basis, throughout established labour. The principles underpinning BR+ methodology is consistent with the recommendations in the NICE Safe staffing guidelines for Maternity settings and have been endorsed by the Royal College of Midwives and the Royal College of Obstetrics and Gynaecologists. Following the full Ockenden report, an immediate and essential action mandated that 'The feasibility and accuracy of the BirthRate Plus tool (BR+) and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.' The Trust will continue to utilise the BR+ methodology pending the findings of the national review.

Trusts are expected to commission a BR+ report every 2-3 years, and a revised report was received by GWH in June 2025, which identified an additional 0.19 WTE Band 3-7 within the budgeted clinical workforce compared to the calculated workforce requirement. The report also reviewed specialist roles and management WTE, some of which have both a clinical and non-clinical component. Currently there are 14.40 WTE Specialist Midwives in substantive funded posts of which 5.60 WTE is allocated to the clinical total (please note, report refers to 5.80 WTE but 0.2WTE moved budgets between data submission and report finalisation).

BR+ recommends that consideration should be given to recommendations from national reports such as Ockenden 2022 with regards to new roles to support the safety of service provision. Additional reports that have been published, which further recommend the requirements for specialist midwifery posts, have informed the recommendation by BR+ that 12% of the budgeted whole time clinical workforce is used as guidance to calculate the senior leadership and specialist roles required for safe and effective service provision. On this basis the recommendation is that the funded baseline establishment has an overall deficit of 4.88wte in the non-clinical midwifery requirement when combining all roles. The senior team at GWH requested that the workforce results apply 10% to the Birthrate Plus clinical WTE to inform local workforce strategy (Table 5).

Current Funded Clinical, Specialist, Management WTE	Proposed Additional Specialist & Management Calculation	Birth Rate Plus WTE	WTE Variance
176.68 WTE	10% Applied	178.51 WTE	1.83 WTE
176.68 WTE	12% Applied	181.56 WTE	4.88 WTE

Table 5

The 2025 BR+ report is reflective of a 24% uplift in maternity services. Following the Ockenden report there is a requirement to reflect a workforce that can accommodate increased levels of training. This requires a 28% uplift (including maternity leave) to achieve this training requirement. Further analysis of the workforce across the LMNS is in progress to develop a system wide approach to a sustainable headroom uplift.

5.2 Current midwifery staffing position / vacancies / maternity leave / sickness absence

It is recognised that Midwifery staffing is challenged nationally with high numbers of vacancies. The Trust's midwifery staffing continues to improve through identification of different staffing models and ongoing recruitment.

The embedded recruitment plan continues to ensure a rolling planned model of recruitment to ensure that there is a constant pipeline of new starters, and to ensure availability of posts for newly qualified registrants.

A recruitment and retention lead is in place utilising NHS England funding to provide a robust orientation and preceptorship program with an aim to improve retention in the first year after qualification and reduce the time taken to consolidate the enhanced skills to support them working in all areas of the service.

All areas of the services have been successful with recruitment, with the vacancies within clinical areas reducing. A rolling recruitment program is in place which supports new staff to join the Trust via a comprehensive preceptorship program. This recruitment has been supported by the introduction of rotational posts for midwives qualified for less than 3 years. Newly qualified midwives are recruited to the inpatient areas to offer the opportunity to consolidate their skills and progress from band 5 to band 6. With the introduction of rotational posts, members of the teams are offered the opportunity to rotate from their inpatient post to all areas of the services taking into consideration their preferences, flexible working arrangements, their progress in consolidating their extended skills and the vacancies across the services. The hub-based nature of community midwifery provides the opportunity to experience this model of care without the isolation that may have been associated with working out of GP practices. The recruitment strategy for experienced midwives has been reviewed to allocate staff to their area of service on appointment, which enables the areas of the greatest service need to be prioritised.

The table below illustrates staff turnover across departments on a monthly basis between September 2024 and August 2025. The increased turnover observed within the Hazel and Delivery Midwife group reflects a combination of geographical relocation and challenges in retaining newly qualified midwives within their first 12 months of employment. Following the implementation of the enhanced preceptorship programme, data monitoring indicates a significant improvement, with turnover in this group reducing from 13.8% to 1.3%. This positive trend is expected to contribute to a further reduction in the overall turnover rate during 2025/26. In addition, sickness absence within this group has decreased from 12.23% in September 2024 to 1.51% in July 2025, with an associated cost reduction of approximately £137,534 as a result of these improvements.

Department	Avg HC	All Leavers	All Turnover	Vol Leavers	Vol Turnover
Ante-Natal Screening - J65919	6	0	0.00%	0	0.00%
Birthing Centre - J65921	19	1	5.26%	1	5.26%
Community Midwifery - J65918	51	5	9.90%	2	3.96%
Continuity of Carer - Midwives - J65922	8	0	0.00%	0	0.00%
Day Assessment Unit - J65910	24	1	4.26%	1	4.26%
Hazel & Delivery Staff - J65914	143	23	16.08%	19	13.29%
Specialist Midwives - J65920	25	2	8.00%	2	8.00%

Table 6- Turnover

There is an increased sickness rate within both Antenatal Screening and Continuity of Carer - Midwives teams, these are small teams and therefore the absence percentage appears higher in comparison to other areas of Midwifery (Table 7). These absence rates relate predominately to long term sick leave. The ward manager teams are working with the Trust wide working group to ensure that supportive steps are in place for staff both to receive calls to notify sickness and in welcoming colleagues back to work following absence. The increased sickness within the community staff relates to long term sickness with mitigations in place including staff support to return to work.

Sickness Rates as of August 2025			
Department	ST	LT	% Sick
Ante-Natal Screening - J65919	1.17%	49.94%	51.11%
Birthing Centre - J65921	4.12%	0.00%	4.12%
Community Midwifery - J65918	2.65%	6.98%	9.63%
Continuity of Carer - Midwives - J65922	6.23%	9.85%	16.09%
Day Assessment Unit - J65910	1.55%	3.38%	4.93%
Hazel & Delivery Staff - J65914	2.61%	3.19%	5.80%
Specialist Midwives - J65920	0.80%	0.00%	0.80%

Table 7- Sickness

5.3 One-to-one care in Labour and Midwife to birth ratio

The NICE clinical standard (QS105 updated 2017) indicates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee Midwife under direct supervision. This is audited monthly, and the data demonstrates that there is fluctuation between 95.2% and 100% compliance over the 6-month period (Figure 4). Each case where 1:1 care is not fully achieved is reviewed to ensure that escalation processes have been utilised to minimise the impact on the family, and to provide opportunities to develop escalation pathways to prioritise labour care in line with the Maternity Incentive Scheme (CNST) safety action 5, with a detailed action plan in place to support achieving 100%

compliance. There have been no patient safety concerns associated with occasions where the 1:1 care was not achieved; however, it is important to recognise that this has been a theme in concerns and the maternity inpatient survey which the teams are actively addressing.

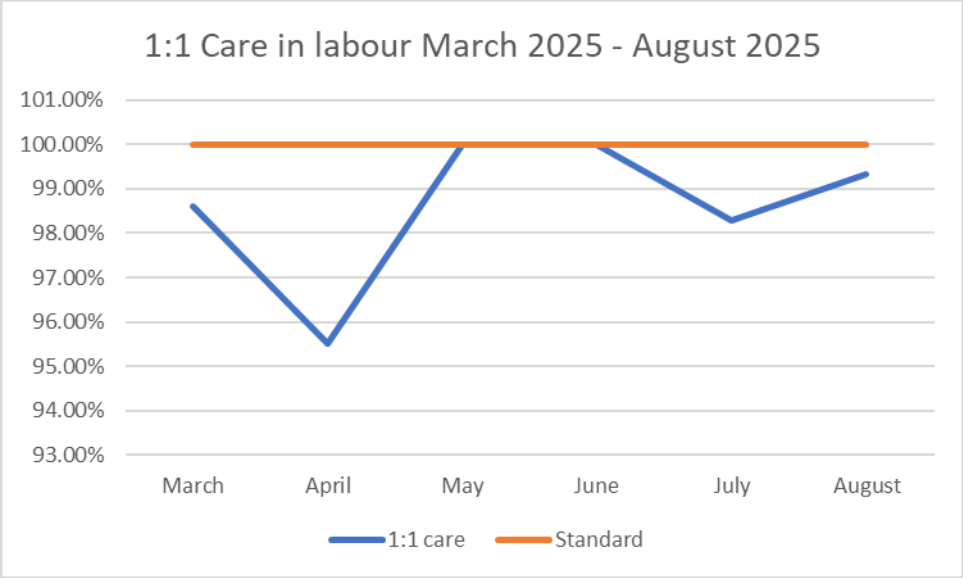


Figure 4- 1:1 care in labour

The Maternity Service monitors and reports the Midwife to Birth ratio monthly. The ratios are reviewed against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 28 births as recommended by the Royal Collage of Midwives and Safer Childbirth (2007). The midwife to birth ratio is calculated using the funded establishment rather than the actual staffing numbers in line with national guidance. The table below demonstrates a fluctuation in the midwife to birth ratio which is impacted by variable birth numbers month on month and the vacancy factor in the community midwifery team.

Trust	June 2025	July 2025	August 2025
Standard aim:	1:28	1:28	1:28
Great Western Hospital	1:27	1:28	1:26
Royal United Hospital Bath	1:26	Data not available	Data not available
Salisbury Foundation Trust	1:28	Data not available	Data not available

Table 8

5.4 Supernumerary status of the Delivery Suite Coordinator

The midwifery coordinator in charge of the Delivery Suite must have supernumerary status to ensure there is an oversight of all birth activity within the service. This is defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift to ensure there is an oversight of all birth activity within the service, which is specified within the Maternity Incentive Scheme (MIS). Over the period March 2025 – August 2025 100% compliance was achieved (Figure 5). One exception was reported through maternity governance where the supernumerary status had been reported as not achieved. When explored it was evident that this was a misunderstanding from the member

of staff completing the data and confirmed that the supernumerary status had been maintained. The continued focus is on maintaining 100% compliance.

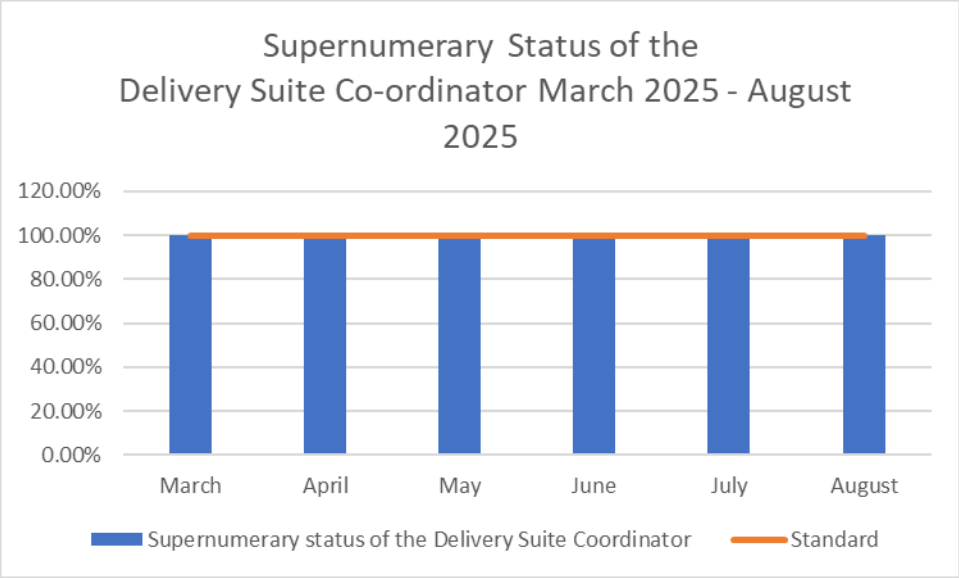


Figure 5

5.5 Red Flags

The Maternity unit uses a 'Red Flag' indicator system, captured via BR+, to identify critically low staffed shifts. It has identified 10 red flags which trigger escalation and follow a procedure for mitigation. This takes an overview of staffing across Maternity and relocates staff to areas of need as required.

The red flags are defined as:

- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes for suturing)
- Missed medication during an admission to hospital or midwifery-led unit (for example diabetes medication)
- Delay of more than 30 minutes in providing pain relief
- Delay of more than 30 minutes between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay of 2 hours or more between admission for induction and beginning of process
- Delay recognition of and action on abnormal vital signs (for example, sepsis or urine output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
- Other clinical and management actions are captured to represent to activity within the service including redeployment of staff to other services/sites/wards based on acuity.

The data below in Figure 6, shows the periods of March 2025 to August 2025 when 20 red flags were recorded.

A decrease in red flags related to "Delay of 2 hours or more between admission for induction and beginning of process" was reported on 8 occasions. This was due to acuity and flow, and no harm occurred as a result. This continues to feed into the A3 around reducing the length of stay, which will consequently improve the flow through Maternity services.

The Acute Unit Midwifery on call system is now embedded in the service to minimise the impact of red flag triggers on service delivery. During the reporting period, the Acute Midwife On call has been utilised on 10 occasions. The Acute Unit On Call system has had a further impact on reducing the need to call the community teams into the unit; this has meant that we have continued to offer a home birth service.

Number of Red Flags recorded
01/03/2025 to 31/08/2025

Red Flags	Breakdown of Red Flags	Times occurred
RF1	Delayed or cancelled time critical activity	5
RF2	Missed or delayed care (for example, delay of 60 minutes for suturing)	1
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0
RF4	Delay of more than 30 minutes in providing pain relief	0
RF5	Delay of more than 30 minutes between presentation and triage	5
RF6	Full clinical examination not carried out when presenting in labour	0
RF7	Delay of 2 hours or more between admission for induction and beginning of process	8
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1
RF10	Supernumerary status of Delivery Suite coordinator not achieved	5

Figure 6

5.6 Recruitment and retention

The service improvement plan in place has focused on:

- Introduction of the Midwifery Degree Apprenticeship Program (MDAP). Four members of the existing midwifery support worker team have initiated the MDAP with Winchester University.
- The retention funding via NHS England has been confirmed to be continuing for a further 12-month period.
- An extended supernumerary period for newly qualified midwives is in place, utilising nationally available funding.
- Scheduled meet and greets with divisional staff, new starters and students.
- Review and refresh of preceptorship package.
- Working with Universities to increase student midwife places.
- Return to practice programme.
- Successful completion of the education program for Internationally Educated Midwives.
- NHSE funding for nurses to undertake 2-year Midwifery course.
- Close working with Swindon College, supporting T level student placements.

- Health and well-being programme.
- Apprenticeship and Nurse Associate model to 'grow our own'.

Funding has been secured to enhance the Professional Midwifery and Nurse Advocate model, with a particular focus on strengthening restorative supervision. This improved model is being implemented alongside the use of funded training places for newly appointed Professional Midwifery Advocates. Together, these initiatives aim to expand access to advocacy services for staff, ensuring support is available in line with the national framework and best practice standards.

5.7 Continuity of carer

One of the key areas of focus identified in the Better Births report (2016) to improve outcomes of maternity services, was identified as continuity of carer. Two teams were initiated at Great Western Hospital (GWH) in 2022 with an aim to deliver the model of care to the most vulnerable families. The CORE20PLUS5 approach identified these families to include women or birthing people from Black, Asian and minority ethnic communities and the most deprived groups defined by the national index of deprivation.

The Continuity of Carer (CoCr) model has proven unsustainable locally due to the significant work/life balance demands it places on staff. Despite offering financial incentives, the Trust has been unable to maintain this model of care. Following ongoing recruitment challenges, the CoCr model was paused in December 2023. Mitigation measures were put in place to minimise the impact of this change on women and birthing people. At present, the current workforce levels do not support full implementation of Continuity of Carer. Therefore, the Trust continues to prioritise antenatal and postnatal continuity within community settings, in line with national guidance and available resources.

6.0 Neonatal staffing

The neonatal unit at Great Western Hospital (GWH) is classed as a local neonatal unit (LNU). Babies cared for at the unit, are those who require short term intensive care (ITU), up to 48 hours, high dependency (HDU) care and low dependency care. The unit comprises of 8 HDU/ITU cots plus 10 low dependency cots. Neonatal units have an unpredictable and fluctuating activity level and so should aim to operate at 80% capacity to allow for times of high acuity. National standards for neonatal nursing care, and medical provision have been developed to safeguard patient safety, and we have a duty to comply with these standards. The neonatal unit at GWH works within the Southwest Neonatal Network to provide the right level of high-quality care to each baby as close to home as possible.

The provision of adequate neonatal nursing staffing, including neonatal transitional care services, are core requirements for the CNST (Clinical Negligence Scheme for Trusts) Maternity Incentive Scheme with Trusts required to evidence that the neonatal unit meets the BAPM neonatal nursing standards. Work is currently ongoing to review neonatal staffing levels following analysis of the past three years of cot occupancy data, which demonstrates that occupancy consistently exceeds the 80% threshold set out in the British Association of Perinatal Medicine (BAPM) standards. While the associated risk is currently mitigated through a robust escalation policy, this often relies on temporary staffing to maintain safe cover. This will also review if it is more cost effective to staff substantively to a higher occupancy / establishment than rely on temporary staffing during peaks in activity.

In 2010, the British Association of Perinatal Medicine (BAPM) published the third edition of BAPM Service Standards for Hospitals providing Neonatal Care.

In 2017, BAPM published Neonatal Transitional Care, a framework for Practice. These documents inform the NHS England Service Specification for Neonatal Critical Care Services which states the minimum nurse to patient staffing ratios based on an average unit occupancy of 80% for neonatal services should be:

- 1:1 for Intensive Care (1 Qualified in Speciality (QIS) nurse to 1 patient, with no other responsibilities for that nurse)
- 1:2 for High Dependency
- 1:4 for Special Care.
- 1:4 for Transitional Care

These care levels are defined in specific detail by nationally set criteria. To meet BAPM/NHSE standards with the unit at full cot capacity staffing levels on each shift should be:

- 2 nurses for 2 Intensive Care cots
- 2 nurses for 4 High Dependency cots
- 3 nurses for 12 Special Care cots
- 1.5 nurses for 6 Transitional Care cots
- 1 Supernumerary Shift coordinator on each shift

Staffing requirements will fluctuate with acuity and therefore staffing to an average cot occupancy result in staffing being set at 7.0 WTE per shift. Staffing data is reported on a monthly basis to demonstrate both the skill mix on a shift to shift basis and amongst the whole neonatal nursing workforce. The cot capacity data is under review following a period of increased acuity over the last 12 months which has been mitigated primarily with bank staff and the need for agency use at times of greater need. This review will inform business planning for FY 2026/27 with an aim to generate a staffing model based on a 100% capacity to generate a self-sufficiency model mitigating all agency use and a stepwise reduction in bank usage with an aim to mitigating this in full.

The current budgeted staffing establishment meets the BAPM neonatal nursing standards, based on an average cot occupancy of 80%. The proportion of staff who are Qualified in Specialty (QIS) is monitored monthly through the Perinatal Quality Surveillance model and reported in the Integrated Performance Report (see Table 9). Although the percentage of QIS-trained staff has not yet reached the 70% target, a robust plan is in place to achieve this by the end of Q4 2025/26. The shortfall is primarily due to an influx of new staff who are not yet QIS-trained, as well as the retirement or relocation of experienced staff.

To mitigate any impact on care quality, a clear escalation pathway is in place. Recently, five staff members completed the 9-month QIS course at Birmingham University, two are already counted as QIS-trained, and three are awaiting final sign-off, expected by October 2025. This progress continues to strengthen the proportion of QIS-trained staff.

Further training opportunities are being supported by the South West Neonatal Operational Delivery Network (ODN), which will offer the QIS course from Bridgewater starting in September 2025. Two staff members are already enrolled for this intake, with two more scheduled to begin in December 2025. This course builds on the Foundation Programme and includes a requirement of 150 supernumerary hours caring for babies needing Level 1 intensive care.

	Target	Threshold		March 2025	April 2025	May 2025	June 2025	July 2025	August 2025
Percentage of shifts staffed to BAPM QIS recommendations	90%	≥90%	<90%	72.5%	78.3%	91.9%	90.0%	91.9%	79.0%
Percentage of Registered Nurse or Midwifery staff who hold Qualified in Speciality (QIS)	70%	≥70%	<70%	61.6%	59.6%	60.0%	60.0%	64.7%	63.2%

Table 9: Proportion of QIS trained staff on shift

The reduction of agency staff has been sustained and has not impacted the skill mix on a shift-to-shift basis. There is a robust action plan in place with oversight by the Operational Delivery Network (ODN) to support achieving full compliance with CNST safety action 4.

The funded establishment meets the BAPM standards for neonatal nursing staff based on the cot capacity and activity (on 80% occupancy). This has been reviewed and approved in collaboration with the Operation Delivery Network (ODN).

6.1 Recruitment and Turnover in The Neonatal Unit

Turnover Rates – Sep 2024 – Aug 2025					
Department	Avg HC	All Leavers	All Turnover	Vol Leavers	Vol Turnover
Neonatal Unit - J65931	51	5	9.90%	4	7.92%

Table 10- turnover

Sickness Rates as of August 2025			
Department	ST	LT	% Sick
Neonatal Unit - J65931	4.89%	3.12%	8.01%

Table 11- sickness

The sickness (Table 11) has increased from 5.71% in the previous reporting period to 8.01% in the current period and reporting at higher than this time last year. Short term sickness has increased, whilst long term absence has slightly decreased from 3.42% to 3.12%.

Recruitment into Band 5 nursing posts for staff who are not yet Qualified in Specialty (QIS) has been successful, with continued focus on supporting these nurses through a structured preceptorship programme and enhanced educational pathways. The Trust has increased its annual intake of nurses onto the QIS education programme, which commenced in January 2024 and is led by the local Neonatal Practice Educator. The programme has been positively

evaluated by staff and has contributed to a measurable improvement in retention and a reduction in turnover over the past six months (Table 10).

The Lead Advanced Neonatal Nurse Practitioner (ANNP) is now fully embedded within the team, supported by one qualified ANNP and three trainees currently in their final year of training, due to qualify in September 2026. A further two trainees commenced the ANNP programme in September 2025. Once qualified, these practitioners will enhance local service provision, strengthen education and mentorship across the neonatal nursing workforce, and provide additional clinical and leadership support to the medical team.

These roles are integral to developing a sustainable workforce model by providing clear career progression pathways and reducing dependency on medical staffing. With the current pipeline of qualified and trainee practitioners, a fully staffed rota comprising trained and trainee ANNPs is anticipated by 2026, subject to all team members taking up substantive posts.

7.0 Allied Health Professionals report

7.1 Workforce Overview

Allied Health Professionals (AHPs) are degree-qualified clinicians who play a vital role in delivering care across health and social care settings, encompassing assessment, diagnostics, treatment, discharge planning, and rehabilitation. Nationally, AHPs represent the third largest clinical workforce and are central to achieving the goals outlined in both the NHS Long Term Workforce Plan (2023) and the AHPs Deliver Strategy (2022–2027), which focus on workforce expansion, retention, advanced practice, and integrated care delivery.

As of now, Great Western Hospitals NHS Foundation Trust employs 362.5 Whole Time Equivalent (WTE) AHPs. This reflects a reduction of 109.5 WTE since March 2025, following the transfer of the community contract to HCRG. Despite this change, GWH continues to provide services across nine of the fourteen recognised AHP professions.

- Dietitians
- Occupational Therapists
- Operating Department Practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Podiatrists
- Radiographers
- Speech and Language Therapists

The workforce comprises registered practitioners regulated by the HCPC, supported by unregistered staff at a 3:1 ratio. There isn’t currently nationally set guidance in relation to staffing ratios and it is recognised that this varies hugely across the different AHP professions.

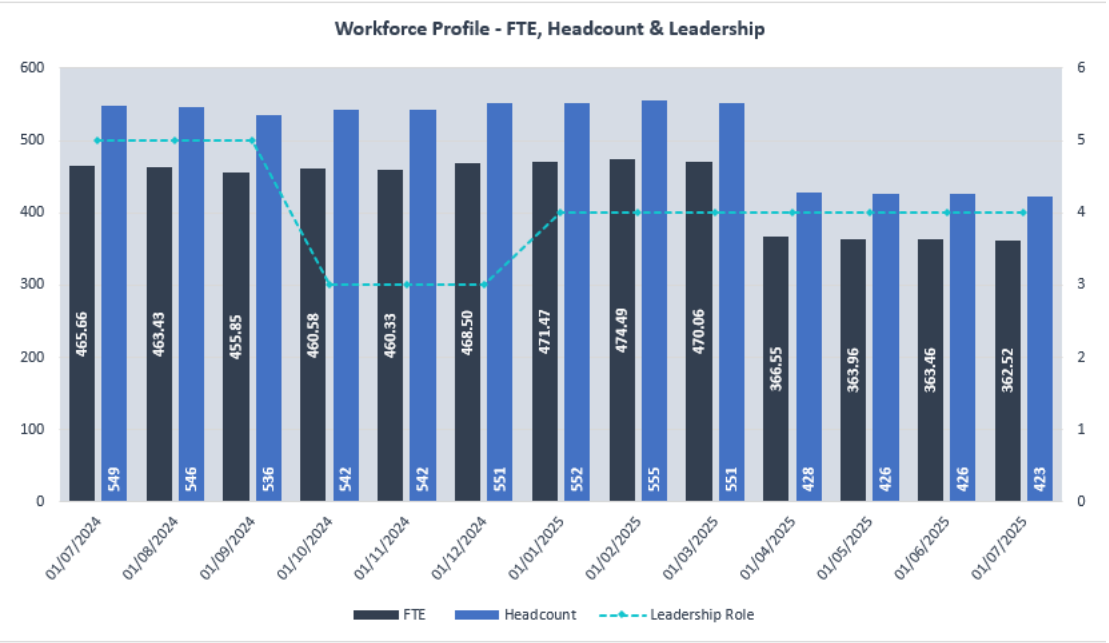


Figure 7- FTE, Headcount and Leadership

Family and specialist services (FASS) represent the majority of the AHP workforce at GWH. Some rationalisation of their management structure has occurred in the last 6 months because of reduced sized teams. Management of Occupational Therapy (OT), Physiotherapy, SALT and Dietetics is now provided by a Senior AHP Lead who is from a dietetic background. Outside FASS, imaging, including diagnostic radiographers, sonographers and mammographers is the next biggest AHP workforce. Given that AHP services operate across multiple divisions, governance and activity tracking remain complex and should be considered when formulating business cases.

Some AHPs undertake extended roles beyond traditional clinical practice, such as leadership positions or work in urgent treatment centres (UTCs). The Associate Director of AHPs maintains regular engagement with all registered staff.

7.2 Workforce Diversity

The Allied Health Professional (AHP) workforce at Great Western Hospitals NHS Foundation Trust reflects national demographic trends, being predominantly female and white. Notably, there is a proportionately higher representation of Asian and Black staff compared to the general Swindon population, indicating positive progress in workforce diversity (Figure 8). However, rates of sexual orientation disclosure remain lower than national averages, which may reflect cultural sensitivities or concerns around privacy (Figure 9).

In response, targeted inclusion initiatives are ongoing, aligned with the NHS Equality, Diversity and Inclusion Improvement Plan (2023). These efforts aim to foster a more inclusive and supportive environment, encouraging greater confidence in self-disclosure and ensuring equitable representation across all protected characteristics.

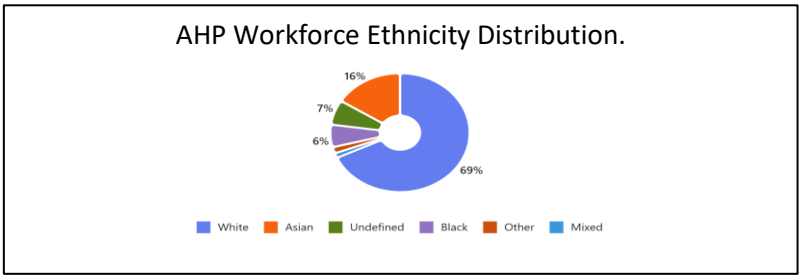


Figure 8

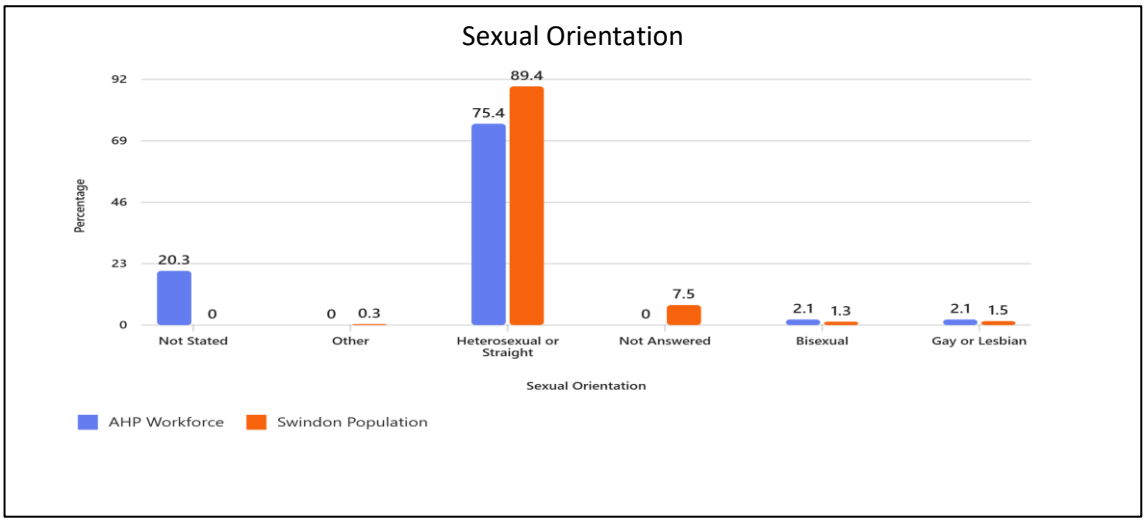


Figure 9

7.3 Workforce Supply

7.3.1 Vacancies

Vacancies and workforce pressures within the AHP services are closely monitored through regular one-to-one leadership sessions. While vacancy rates had been steadily declining, a sharp increase was observed in May 2025 (Figure 10). This rise appears to be linked to the transfer of the community contract and discrepancies in newly applied workforce metrics. Clarification has been requested from the Workforce Intelligence Team, as this significant data shift is not reflected in other performance indicators.

If the current data is accurate, it suggests a sustained and escalating vacancy challenge across AHP services. Key observations include:

- A marked increase in vacancies following the community contract transfer, particularly affecting smaller teams such as podiatry, speech and language therapy (SALT), and dietetics, where staff previously held hybrid acute/community roles.
- Band 3–6 vacancies in Occupational Therapy and Physiotherapy remain the most difficult to fill.
- In response, the Trust is expanding apprenticeship programmes and ‘grow your own’ workforce pipelines, in alignment with the NHS Long Term Workforce Plan. These initiatives aim to strengthen recruitment through non-traditional routes and build a more resilient workforce.

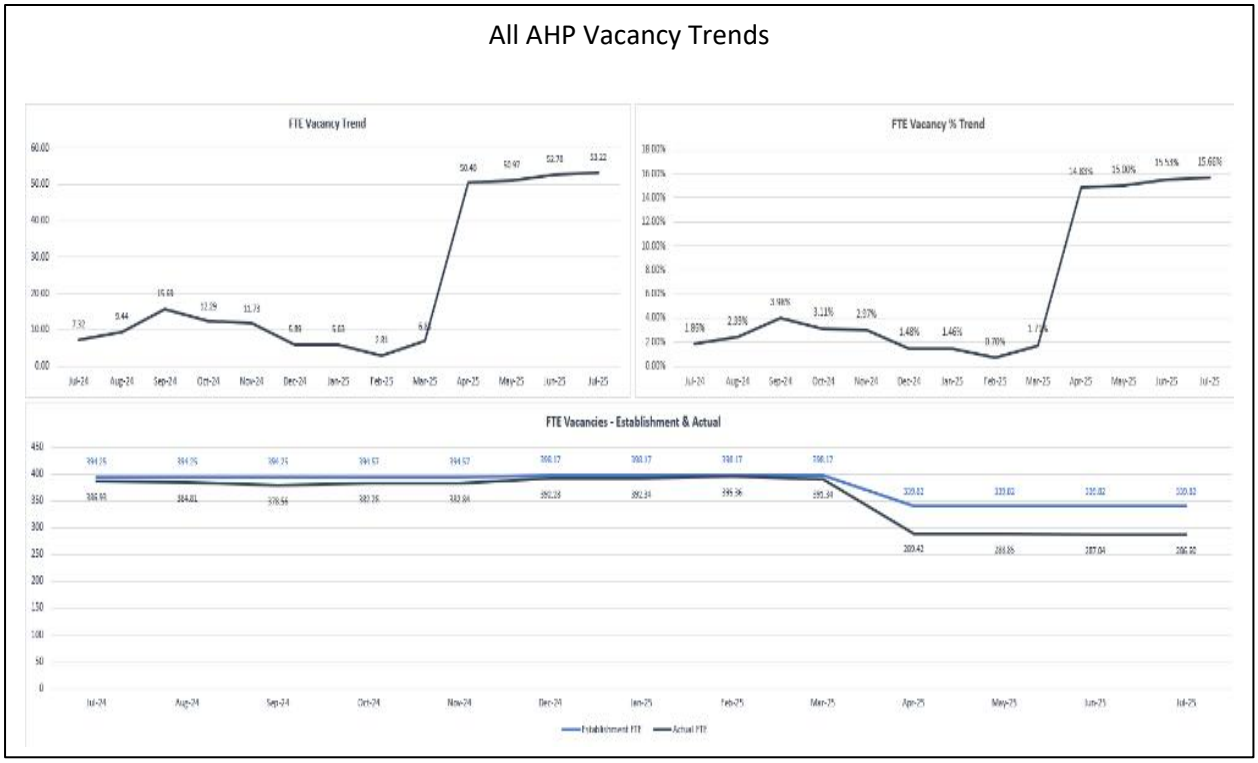


Figure 10

Recruitment is in place alongside skill mix contingency plans should services fail to recruit. Earlier this year, a proposal was submitted and approved to implement a recruit-to-turnover model for Occupational Therapy and Physiotherapy. This approach has enabled both services to successfully eliminate Band 5 vacancies. However, current workforce data does not yet reflect this improvement due to the recent timing of physiotherapy recruitment and the ongoing onboarding process (Figure 11). Updated metrics are expected to show the full impact once new staff are fully integrated into the workforce.

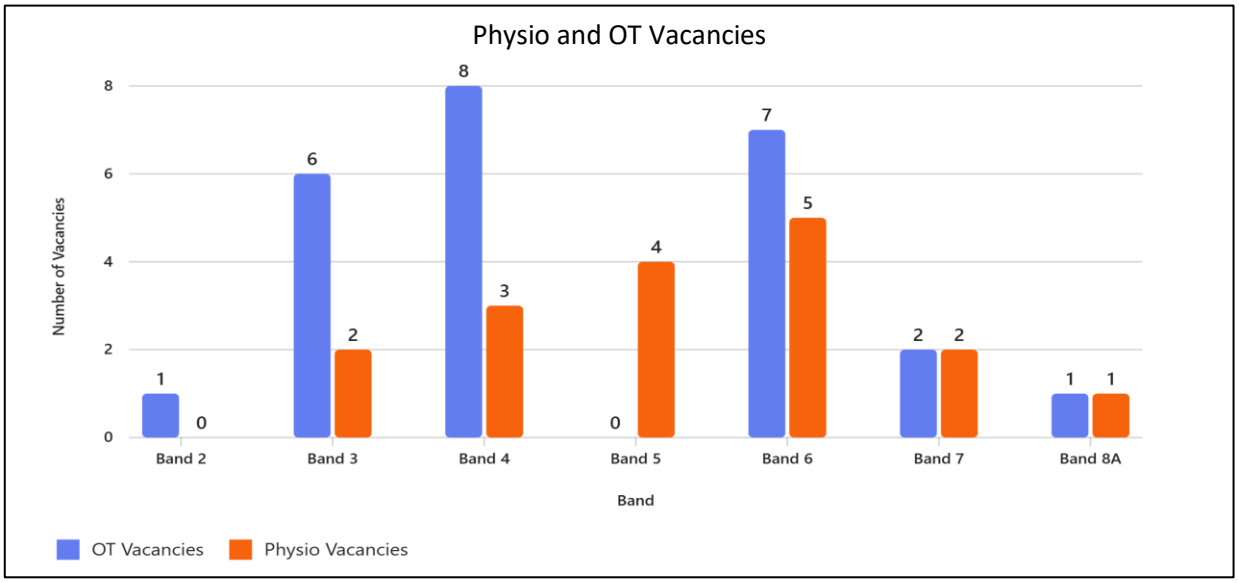


Figure 11

Nationally the picture for physio is improved with new graduates exceeding demand. Although this reduces pressure on band 5 vacancies. Band 6 and 7 vacancies for both services vacancies are high, indicating a shortage of experienced practitioners who are essential for training junior staff and autonomous clinical decision-making and supervision. Further work is required to support the senior vacancy position through recruitment and career development investment. Lack of career progression remains the primary reason for staff departure at senior level, prompting further development of enhanced and Advanced Clinical Practitioner opportunities.

7.3.2 Turnover

- Overall AHP turnover (Figure 12) remains stable but consistently above the NHS benchmark of 9%.
- Therapies (OT and Physiotherapy) are of greatest concern, with turnover 3× higher than the GWH AHP average (Figure 13 & 14).
- Contributing factors include winter pressures, burnout, lack of career development, and external competition.
- A recruit-to-turnover model for Band 5 therapy staff has been implemented to increase resilience and reduce lag time in filling vacancies. Early indicators are positive.

Turnover within Dietetics, SALT and podiatry remain stable. Current data sets do not enable the capture of ODP's and orthoptics turnover data individually due to the department mix in budget codes. However recent workforce planning within both services has stabilised these workforces and there are no current concerns with turnover.

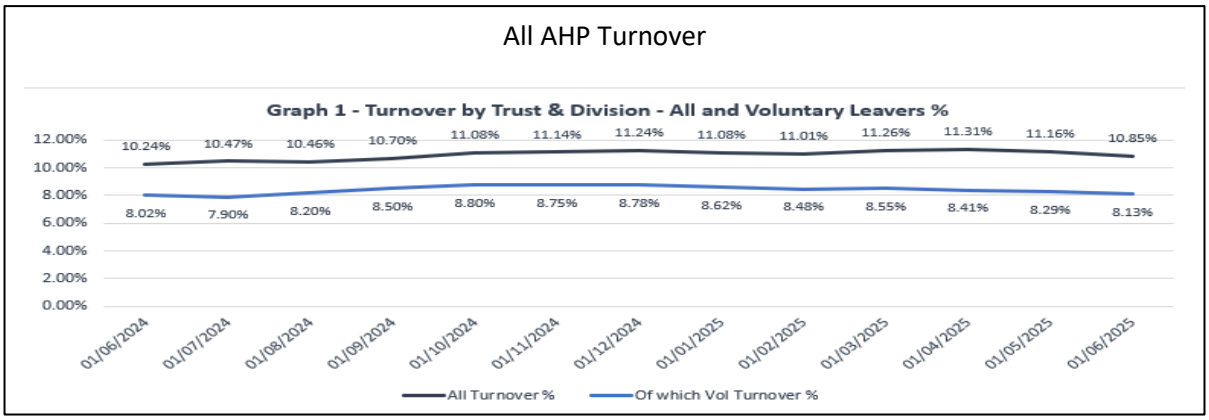


Figure 12

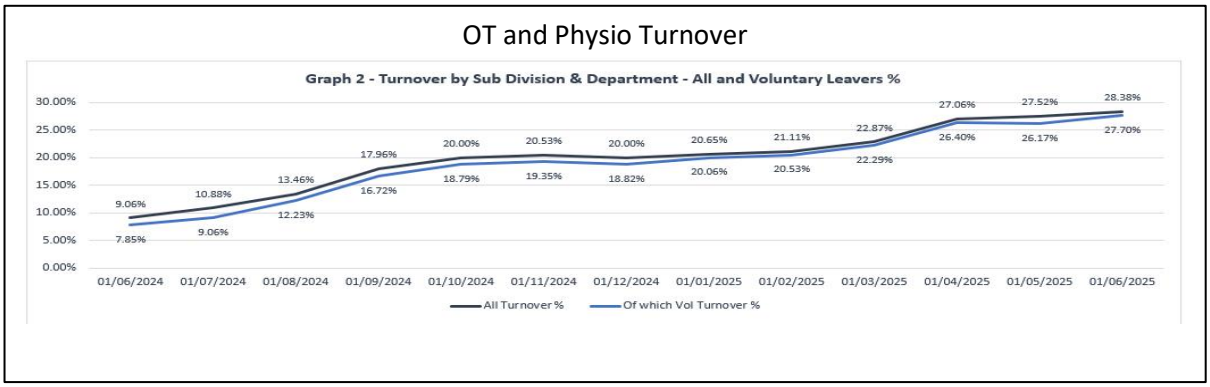


Figure 13

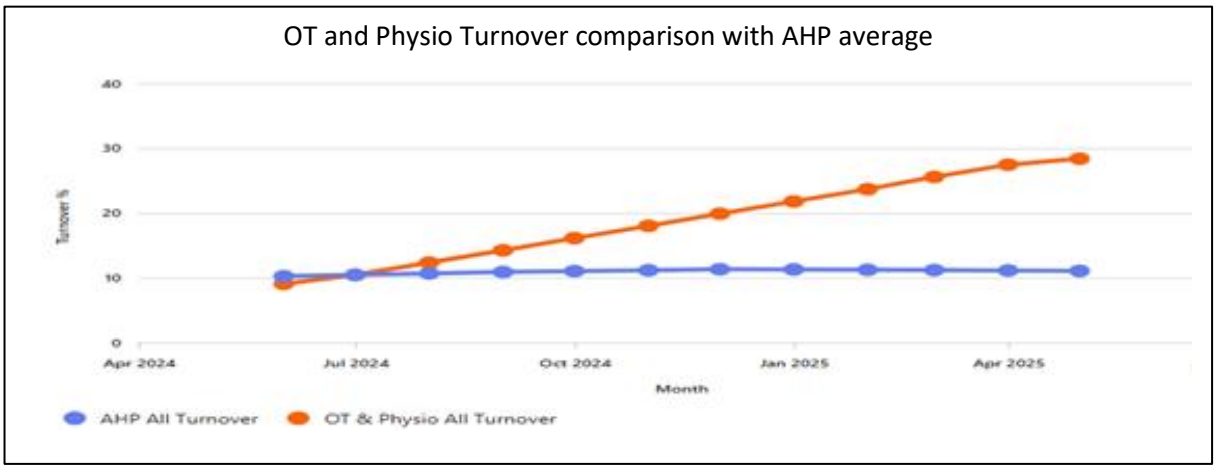


Figure 14

7.3.3 Sickness

While the overall sickness average appears stable, this masks higher sickness levels within specific areas, particularly Imaging and some Therapy teams (Figure 15). These elevated rates correlate with workforce shortages and lower staff satisfaction, as reported locally. Exceptionally low sickness rates in other AHP teams are currently offsetting these figures in the aggregated data.

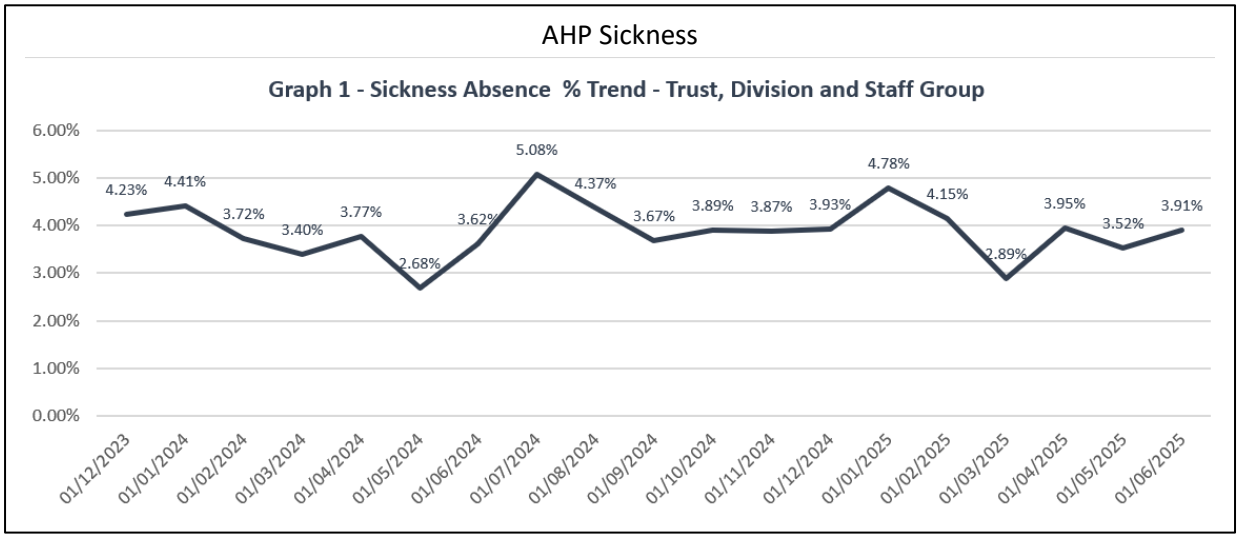


Figure 15

7.4 Workforce Safety and Effectiveness

There is currently no mandated reporting framework for AHP workforce safety or effectiveness. Despite national efforts to standardise workforce reporting since 2016, progress has been limited. To address this gap, all AHP teams at GWH have been tasked with developing capacity and demand tools to support future workforce planning. These tools are now in place for Imaging, Therapies, and Podiatric Surgery, with development underway in Speech and Language Therapy (SALT) and Orthoptics.

Paper-based job planning has been initiated across all AHP teams, with completion targeted for August 2026. This tool, developed through a regional AHP collaborative, will enable shared data insights to inform safe staffing levels and provide a clear breakdown of direct clinical care and supporting professional activities (SPA). Feedback from leavers and career clinics indicates that AHP staff at GWH currently receive limited SPA time, which negatively impacts staff development, service innovation, and wellbeing. Once job planning is fully implemented, it will provide a clearer picture of how time is allocated between clinical duties and supporting activities. This will help identify areas where additional SPA time is needed and assess the impact on clinical care, further strengthening workforce planning.

Job planning and capacity mapping are also being developed across the hospital group to ensure consistency and enable benchmarking.

7.5 Pipeline Supply

GWH has taken a proactive approach to developing its AHP workforce through apprenticeships. With 60% of AHP areas engaged in Level 6 apprenticeship programmes, the Trust is building a sustainable pipeline of registered professionals. The first cohort of apprentices transitioned into registered roles this September.

However, increased educational demands have led to signs of educational fatigue among staff. To mitigate this and support retention, clinical practice educators have been introduced in Imaging and Therapies.

The Student Team continues to promote AHP careers locally, including through events such as the summer “Dare to AHP” showcase, which generated strong interest in apprenticeship pathways.

Feedback from career clinics indicates frustration among unregistered staff due to limited apprenticeship opportunities. In response, a clear strategy has been implemented:

- Smaller teams (SALT, Dietetics, Orthoptics, and Podiatry) have committed to maintaining a continuous apprenticeship cycle, onboarding one apprentice every three years to support Band 5 vacancies and early career development.
- Larger teams (Occupational Therapy, Physiotherapy, Radiography, and ODPs) will recruit at least one new apprentice annually.

These roles will be offered to existing staff or through the T-level offer, or dare to AHP programme, supporting workforce development in the local area.

This approach supports workforce planning, career progression, and retention by investing in local talent.

Undergraduate activity is also increasing. Last year’s NETS results and Band 5 recruitment data indicate a positive student experience, which has translated into high conversion rates from student placements to graduate employment**.** Ongoing work to increase the AHP undergraduate offer is in place with some transformational placement offers planned for the new year, this will see increased student activity alongside reduced clinical burden.

7.6 Ongoing Work

Action	Timeline	Lead
Implement imaging workforce shift pattern changes to reduce bank reliance	Q3 2025–26	Imaging Lead / AHP AD
Embed recruit-to-turnover model across therapies	Complete for Band 5, expand to Band 6	Therapies Lead
Complete job planning for all AHP teams	August 2026	AHP Leadership
Expand apprenticeship routes and targeted workforce campaigns	Ongoing	AHP Education Lead
Develop senior career progression offers (ACP / enhanced roles) to address Band 6–7 shortages	2025–27	AHP Workforce Group

7.7 Risks

Risk	Impact	Mitigation
Workforce shortages	Service delivery, patient flow, quality	Recruit-to-turnover models, apprenticeships, regional recruitment
Retention challenges	Quality, training capacity, professional development opportunities and burnout and high turnover	Career development pathways, advanced practice roles, informed workforce modelling

Financial pressure from agency reliance	Overspend, instability	Imaging shift review, regional agency rate agreements, workforce pipeline growth

8. Trust Risk Register

As per NQB guidance, the Nursing and Midwifery staffing risks are on the Trust Risk Register. There are 2 of note.

Risk 500 - Nurse to patient ratios - safe nurse staffing - Score 9
There is a risk of poor quality metrics and reduced staff morale / high turnover due to the inpatient wards working at a ratio of 1:10 for registered and unregistered staff. Wards can work to 1:10 when short notice gaps occur. This is against the national guidance of 1:8 or below.

Risk 1132 Financial affordability of high quality patient care if nursing and midwifery temporary staffing costs are not reduced - Score 9

There is a risk to the financial affordability of high quality patient care if nursing and midwifery temporary staffing costs are not reduced, this would impact on ability to maintain safer staffing levels and the Trust's financial recovery plan.

9. Conclusion

The Trust continues to demonstrate strong progress in delivering safe and sustainable staffing across nursing, midwifery, and AHP services. Improvements in recruitment and retention strategies are reflected in workforce metrics, with notable success in reducing Band 5 vacancies and expanding apprenticeship pathways. Governance structures, including daily staffing reviews and monthly workforce oversight, provide assurance that staffing risks are actively managed. While challenges remain, particularly in maintaining optimal staffing ratios, meeting QIS targets in neonatal care, and addressing AHP turnover, mitigation plans and strategic workforce initiatives are in place to support service resilience and quality care delivery.

10. Recommendations

To further strengthen staffing sustainability and service quality, the following actions are recommended:

- Continue to implement and monitor robust recruitment and retention plans, particularly for registered nursing and senior AHP roles.
- Complete the Safer Nursing Care Tool (SNCT) data collection across all inpatient areas in February 2026 to inform future establishment reviews.
- Triangulate SNCT findings with October 2025 establishment reviews to ensure staffing levels align with patient acuity and service demand.
- Expand apprenticeship and ‘grow your own’ workforce pipelines across nursing, midwifery, and AHP services to address long-term supply challenges.
- Strengthen career development pathways, including Advanced Clinical Practitioner roles, to improve retention and support progression.

- Maintain oversight of neonatal staffing compliance with BAPM standards and continue QIS training efforts to meet the 70% target by Q4 2025/26.
- Embed job planning and capacity mapping tools across AHP teams to support safe staffing and improve visibility of clinical and professional activity.

Report Title	**Cyber Security Framework – Board Assurance Report**				
Meeting	**Trust Board**				
Date	**15/01/2026**	**Part 1 - Public**	☐	**Part 2 - Private**	☐
Accountable Lead	Jonathan Hinchliffe, Group Chief Transformation & Innovation Officer (Interim)				
Report Author	Jon Burwell, Chief Information Officer Glyn Rowe, Head of IT Security and Configuration				
Appendices					

Purpose

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

Assurance Level

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

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

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

The Trust is reporting strong performance for the Data Security and Protection Toolkit (DSPT), with strong evidence provided. Cyber is regarded as a key priority for the Trust with investment in a range of controls and risk mitigations. Risk is well understood and routinely reviewed. Improvements have been identified throughout the report below which will be undertaken in the coming year.

Report

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

The cyber security framework has been developed to provide a single overview of cyber security for Great Western Hospitals NHS Foundation Trust (GWH) which will be updated annually for approval by Trust Board. Any improvement activities identified and assurance on routine cyber controls will

continue through the cyber report provided to Finance, Infrastructure and Digital Committee (FIDC) quarterly.

The report outlines the current national picture on cyber security and the national recommendation on key areas of focus. The approach for national assurance of local organisations is through the Data Security and Protection Toolkit (DSPT). This was migrated to the Cyber Assurance Framework content and approach for 2024/25 onward, aligned with the national cyber strategy for healthcare.

The report outlines a range of improvements activities that are underway across the different elements of cyber security controls. Noting cyber security continuously evolves and therefore assessment and investment in cyber posture will always be required, the intent is to have a very high standard of cyber posture across the Trust that will now expand as the BSW Hospitals Group aligns more closely, acknowledging the current position remains strong.

With the Trust having gone through a range of live events over the last 12 months, the Trust has been able to test in real time their preparedness for resilience. Further testing is still needed however to test and improve the Trust's preparedness for longer term downtime such those see in recent cyber-attacks and improve resilience of expertise to support the Trust a cyber event.

The Trust continues to work closely with ICS partners to collectively build capability and have consistent controls in place.

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

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

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	359 – Cyber Security – Location & Environmental	12
	382 – It Infrastructure – Aging Equipment – impact for patient care and service	16
	512 – Continued investment in IT Infrastructure	12
	1212 - Websites breach / Denial of Service	12
	1214 - Cyber Attack on 3rd Party Supplier	20
	1216 – Outdated Systems	15
	1220 – Medical Equipment	12
	1222 – Lack of ICS Cyber lead	15
	1223 - Ransomware breaching an ICS network	15
	1224 – Staff Training / Awareness	12
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Reviewed at FIDC	
Next Steps	Quarterly FIDC reporting will assure on improvement activities	

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

Explanation of above analysis:

Invariably, cyber attacks do not differentiate or impact any protected groups differently to any other group, with activities undertaken by the Trust consistent for all to protect all. Cyber security activities promotes equality through consistency of application.

Recommendation / Action Required

The Board is requested to:	
- Note the contents of this paper, in particular the national position on cyber and the specific areas of collective focus - Note the areas of improvement outlines in the report, noting that this will be overseen at the weekly TechOps meetings and assured through Digital Steering Group, up to FIDC in the existing quarterly cyber report - Note the intent to refresh this report annually for Trust Board approval.	
Accountable Lead Signature	
Date	**06/01/2026**

Cyber Security Framework – Board Assurance Report

1 Executive Summary

Cyber security is one of the highest priorities for the NHS and requires constant investment of time, resources and funding to maintain a good level of standards and compliance. Regardless of this, there is always an inherent risk of a cyber-attack whether direct or indirect on the organisation, which requires preparing for and routine testing to ensure patient care is impacted as little as possible.

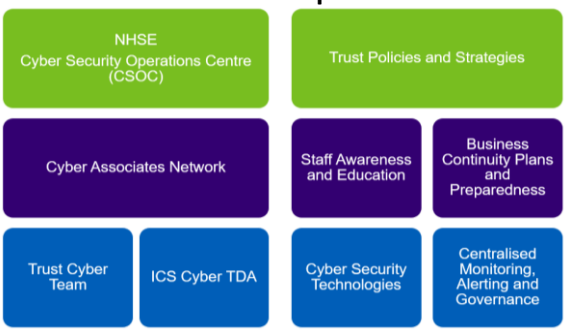
For the purposes of this framework, the term cyber security is defined as ***the practice of protecting networks, applications, confidential or sensitive data, and users from cyber-attacks.*** Cyber-attacks are malicious attempts by individuals or groups to gain unauthorised access to computer systems, networks, and devices in order to steal information, disrupt operations, or launch larger attacks.

This document provides a summary position of the current cyber landscape, the national strategy that we need to comply with and Great Western Hospitals NHS Foundation Trust's (GWH) approach to cyber security including oversight, controls in place and improvement plans to respond to gaps and current risks.

Over the last five years GWH has taken significant steps to improve our controls, team structure and posture. Whilst GWH has not directly experienced a successful cyber-attack, we have had to respond to indirect attacks on other NHS organisations and the wider supply chain providing services to the NHS.

The details below summarise key aspects of the cyber posture and focus areas to minimise the opportunity for cyber-attacks to take place and should they occur key process and investment areas required to minimise the level of impact and disruption a cyber-attack will have.

How we keep safe?



Current assurance levels and focus areas.

Focus	Local	ICS	National	Assurance Level
NHSE Cyber Security Operation Centre (CSOC)	n	n	Y	
NHSE Cyber Asscoaited Network (CAN)	Y	Y	Y	
Cyber Security Technologies	Y	Y	Y	
Cyber Monitoring and Alerting	Y	Y	Y	
Trust Policies and Strategies	Y	Y	Y	
Trust Cyber Team	Y	n	n	
Business Continuity Plans, Preparedness, Testing	Y	n	n	
Staff Awareness	Y	n	n	
Staff Training	Y	n	n	

2 Current cyber landscape and how we engage.

The National Cyber Security Centre (NCSC) provides expert guidance and support to the UK, including incident response, network security, and threat intelligence. Working in conjunction with NHS England, the NCSC routinely provides the NHS with threat intelligence updates, enabling us to consider how best to respond.
The NCSC's Annual Review 2025 (covering September 2024 to August 2025) and associated November 2025 updates highlight a landscape of escalating threats and significant legislative changes designed to improve the resilience of Critical National Infrastructure (CNI), which includes the health and social care sector.

Key Threat Insights (NCSC Annual Review 2025 & November 2025 Updates):

- Increased National Significance of Attacks: The NCSC reported handling a record number of nationally significant cyber attacks in the year to September 2025, averaging around four per week. These incidents are increasingly designed to cause real, tangible disruption and impact, not just steal data.
- Ransomware Remains the Primary Disruptive Threat: Ransomware almost certainly remains the largest and most likely disruptive threat to the UK health and social care sector. The NCSC has observed attackers improving their ability to inflict pain on organizations, emphasizing the need for robust preparation and resilience.
- State Actors and Espionage: Hostile state actors continue to pose a significant threat. China remains a highly capable threat actor, with its intelligence services likely targeting the UK health and social care sector for data and intellectual property. Russian groups are also capable of launching "destructive and disruptive attacks" on CNI, which necessitates a high state of alert.
- Supply Chain as a Key Vector: Cyber actors almost certainly continue to target the UK health and social care sector supply chain to facilitate their operations and access multiple victims simultaneously. This has led to a focus on regulating IT service providers.
- AI Reshaping the Landscape: Artificial intelligence (AI) is reshaping both offensive and defensive cyber capabilities. The NCSC emphasizes the need for security measures and regulation that can keep pace with this changing landscape.

Regulatory Changes & Government Response (November 2025)
In response to the escalating threats, the UK government is implementing significant changes:

- Cyber Security and Resilience Bill: New, tough laws are being introduced via the Cyber Security and Resilience Bill to strengthen cyber defences for essential services like healthcare.
- Mandatory Reporting: Under the proposed laws, organisations suffering "more harmful" attacks will be required to report incidents to their regulator and the NCSC within 24 hours, with a full report following within 72 hours, to ensure a faster national response.
- Regulation of IT Service Providers: For the first time, medium and large IT service providers to the public sector will be regulated, requiring them to report significant incidents and maintain robust response plans.

The following table provides examples of recent significant cyber events impacting healthcare services across the UK, illustrating these threats in practice.

Nov-24	**Alder Hey Children's NHS Foundation Trust & others**	Data Breach	Information was illegally obtained from shared systems and published online. The Trust's services remained operational, but a police investigation was launched.
Nov-24	**Wirral University Teaching Hospitals NHS Foundation Trust**	Targeted Cyberattack	A "major incident" was declared, systems were isolated, and the Trust reverted to manual processes to minimize impact on patient care.

Mar-25	**NHS Dumfries and Galloway** (Scotland)	Ransomware and Data Breach	A major attack that led to the theft of 3 terabytes of data, including confidential patient records. When the ransom was refused, the data was published online, and around 150,000 households were warned of potential exposure.
Apr-25	**Legal Aid Agency (LAA)**	Data Breach	One of the most severe UK government data breaches, potentially exposing 2.1 million data points and sensitive records spanning 15 years.

Lessons Learned and National Priorities (November 2025)

Throughout the last twelve months (November 2024 - November 2025), NHS England's cyber security team has intensified national efforts to enhance the health sector's resilience. The core message across all NHS England updates and NCSC guidance remains consistent: many significant cyber incidents could be prevented by rigorously implementing fundamental security controls.

Following analysis of numerous 'near misses' and major incidents across the UK health sector, NHS England published updated guidance in Spring 2025 that identified key recurring weaknesses. The following table summarises the critical activities that, if comprehensively adhered to, would likely prevent over 99% of all attacks, including the major incidents seen in the last 12 months (e.g., the Synnovis and NHS Dumfries & Galloway breaches):

Area of Weakness	**Description of Vulnerability**	**National/Trust Activity & Prioritisation (Last 12 Months)**
Multi-Factor Authentication (MFA)	Lack of mandated MFA for remote access, administrative accounts, and clinical systems allows attackers to exploit compromised passwords easily.	Mandatory Policy Implementation: The NCSC/NHSE MFA policy has been the primary focus nationally. This Trust achieved 98% compliance for remote access by Q2 2025.
Patch Management	Failure to promptly apply security updates for known software vulnerabilities, particularly on internet-facing systems and legacy medical devices.	Proactive Monitoring: Enhanced vulnerability scanning and a targeted program to patch or segment legacy systems where updates are impossible.
Incident Response Planning	Plans are often outdated, untested, or rely on systems that are unavailable during an attack (e.g., digital contact lists).	Mandatory Testing: NHSE strongly mandated tabletop exercises, which this Trust completed in June and September 2025.
Third-Party/Supply Chain Access	Weak security controls and oversight of suppliers who connect to internal systems.	Supplier Assurance: Mandatory DSPT assessments for critical suppliers and the introduction of new supply chain regulations (as noted in Section 2).

Basic Cyber Hygiene	Poor password management, outdated backups (or untested restore procedures), and failure to disable inactive user accounts.	Continuous Auditing: Regular audits of access controls, mandatory staff training, and weekly testing of all backup restoration processes.

The "how you can prevent attacks" outlined above has been the focus of nationally driven activities over the last 12 months, including the rigorous enforcement of the new multi-factor authentication policy and mandatory incident reporting frameworks now passing into law.

2.1 Cyber Events with 'local' impact

Over the last 12 months a single cyber event occurred that impacted local organisations.

ICS Partners / Community service

HCRG Care Group (formerly Virgin Care) was significantly impacted by a major cyber event in February 2025.
A serious cyber attack attributed to the Medusa ransomware group in February 2025.
Key Details:

- Nature of Attack: The Medusa ransomware group claimed responsibility for the breach and threatened to publish stolen data unless a ransom of approximately £1.6 million ($2 million) was paid.
- Data Stolen: The attackers claimed to have exfiltrated more than 2.2 terabytes (TB) of sensitive data. Samples published on the dark web revealed a huge amount of personal and sensitive information, including:

HCRG stated its healthcare services remained operational, and patients with appointments were advised to attend as usual. However, systems were reportedly down, and staff experienced difficulties accessing electronic patient record systems for a period.

HCRG engaged external forensic specialists, implemented immediate containment measures, and reported the incident to the Information Commissioner's Office (ICO) and other regulators. The company also obtained a High Court injunction to prevent further publication of the stolen data.

For both events information was shared quickly with appropriate responses and actions taken. The approach taken for each event ensured minimal service impact occurred and with all ICS partners well informed they could assess the risk and actions required for their organisation.

2.2 Forums we engage with to understand cyber threats.

It is important that the Trust engages with a range of forums to get a comprehensive understanding of cyber threats, increasing the knowledge, skills and capabilities of the organisation to proactively respond to risks and improve controls. Below outlines the main forums Trust colleagues are engaged with external to the organisation:

NHSE – National – Cyber Executive Network and Cyber Associates Network (CAN)

The CIO is an active member of the Cyber Executive Network that provides direct access to senior digital leaders across England and within NHSE as well as specialist engagement from organisations such as NCSC. The executive network has only met once in the last 12 months however is expected to increase frequency over 2026. The CAN has matured significantly since its inception to be a forum where members share key information and knowledge about security alerts, software issues, vendor alerts and possible solutions/fixes aiding faster and more holistic assessment and response to emerging threats that may impact local organisations. GWH regularly use this intelligence to update proxy servers and firewalls based on intelligence received.

Threat Intelligence Sharing Platform

The Threat Intelligence Sharing Platform (TISP) provides real-time information, enabling healthcare organisations to rapidly receive and share threat intelligence to enable an informed cyber threat response. Users will be able to access threat intelligence from NHS England's CSOC, our commercial providers and partners, and share threat intelligence to the centre through a single central platform. The TISP can be accessed by users to access a suite of written intelligence products and query our indicators of compromise (IOCs). TISP acts as a central hub where local, regional and national threat intelligence is gathered, curated, and redistributed seamlessly across the health and social care system. The platform is the go-to repository for indicators of compromise, written human-readable intelligence reports and alerts, and two-way intelligence sharing.

This solution has provided advance awareness of cyber risks throughout the year allowing for improved awareness and faster responses when deploying fixes or confirming when issues don't impact GWH.

NHSE – Regional
Led by the NHSE regional cyber lead, this forum ensures that NHSE gain insight into the issues and challenges affecting more than one organisation and/or ICS. The Head of IT Security and Configuration from GWH is a member of the regional steering group and the IT security specialist is part of the regional user group. This membership provides access to peers in other ICS regions that enables sharing of issues, good practice and resolutions.

Monthly one to one meeting with the NHSE Regional Cyber lead takes place that provides direct feedback related to local organisation issues, developments and improvements.

ICS – Technical Design Authority (TDA)
All providers within the ICS are active members of this group and work to agree common toolsets, policies and approaches. This is part of the 'defend as one' strategy and through increased information sharing and awareness mutual aid will become easier to achieve in the future. Further standardisation around toolsets is planned across the BSW Hospitals Group, with an external assessment to recommend how we converge underway. A default principle for the ICS is to maximise the investment made in national product sets.

ICS – Cyber TDA
This subgroup of the ICS TDA focuses on cyber related activity, working collaboratively to achieve common goals. All partners use the NHSE provided solutions - MDE and BitSight - that help to provide security posture and assurance awareness. These are reviewed monthly to assess current performance and with the 'defend as one' actively employed the group share information about improvements being made in their area and how these were achieved. Where an organisation is not currently meeting the required standard, support is provided by other partners to understand any challenges and how these could be overcome.

This collaborative approach means our ICS has achieved and sustained the 'Advanced' BitSight rating for public facing services. This globally recognised security service independently checks each organisation and is used by NHSE as a key cyber security marker when assessing risk. Through the collective and sustained efforts of all partners, BSW remains one of the top scoring ICSs within the Southwest.

ICS - Cyber Technical Advice Cell (CTAC)
The ICS has created a CTAC approach with the primary purpose to be available to offer support and advice to other ICS partners out of hours, providing additional cover in the event a cyber-attack. This solution requires time to mature with the vision to offer a 'first responder' solution to conduct initial triage before any escalation is required to the NHSE Cyber Security Operations Centre (CSOC). The CTAC does not replace the need for each ICS member to have their own resource and robust plans to respond to an event but is seen as complimentary.

As the BSW Hospitals Group cyber services align more closely there could be opportunities to enhance this facility.

3 Cyber Strategies

3.1 NHSE Cyber Strategy

The strategic objectives for a cyber resilient health and adult social care system in England are set out in the cyber security strategy to 2030 launched in March 2023 (cyber security strategy). The Strategy explains the criticality of building and maintaining cyber defences, treating it as a core foundation of everyday business to ensure patient and service use safety.

The Strategy is broken down into five pillars to help focus on a consistent approach on the key areas that will best respond to the risk themes, whilst enabling us to adapt as the cyber threat evolves in the future. The five pillars are:

- **Pillar 1:** focus on the greatest risks and harms
- **Pillar 2:** defend as one.
- **Pillar 3:** people and culture
- **Pillar 4:** build secure for the future.
- **Pillar 5:** exemplary response and recovery

The national approach to ensuring progress against the NHSE Cyber Strategy will predominantly be through the Data Security and Protection Toolkit (DSPT). This is being restructured to more closely align with the Cyber Assessment Framework which underpins the national strategy.

3.2 ICS Strategy

The ICS cyber strategy was updated and enhanced in 2025 by the ICS cyber technical design authority group and approved by the ICB Digital Board in September 2025. Working collaboratively the key focus areas are:

- Identify & record risks within the ICS, including supplier cyber risks, that affect the local system's ability to function
- Engage with a plan at ICS level to mitigate risks, invest and review progress.
- Ensure cyber risk is reviewed as part of broader corporate risk management.
- Ensure providers maintain an understanding of their suppliers' cyber security controls & risks.

4 How we monitor and protect the Trust from cyber attacks

4.1 National monitoring

There are a series of controls in place to help monitor and protect the Trust, working closely with the forums described above such as the Cyber Associates Network. The national offering provided to the Trust free of charge include:

NHSE - Cyber Alerting and High Severity Alerting (HSA)

NHSE provides regular information and alerts related to cyber risks. Through the use of HSA's organisations are informed of critical issues that need to be addressed. Once a HSA is issued, organisations have 48 hours to acknowledge and if the alert is applicable have 14 days to remediate the risk. Where a risk cannot be remediated within the 14 days, a report is written and shared CIO as deputy SIRO (nominated lead on behalf of the Chief Transformation and Innovation Officer as SIRO) that explains the reason for non-compliance, the mitigation/remediation plan and where accepted, this risk is signed off on the NHSE Cyber Alerts site.

NHSE - Cyber Threat Intelligence Services (including TISP and Cyware)

NHS England provides a variety of central threat intelligence services for health and social care organisations. Cyber threat intelligence (CTI) plays a critical role in defending organisations across the health and social care system against cyber threats. CTI ensures decision makers are kept informed of the latest threats and that network defenders are empowered to detect and respond to events as they occur. Without a view of the cyber threat landscape organisations run the risk of defending against too little or trying to constantly defend against too much without a view of which are the most relevant threats.

The CTI services use NHS England's National CSOC's advanced healthcare telemetry, which processes over 33 billion security signals daily, as well as integrating centrally procured threat intelligence from suppliers like CrowdStrike Falcon Intelligence, Microsoft Defender Threat Intelligence, Health-ISAC, and many more. This extensive intelligence is distributed into both national and local security systems, and now also offered directly to network defenders across the system through the robust suite of services described below.

NCSC Active Cyber Defence (ACD)

This seeks to reduce the harm from commodity cyber-attacks by providing tools and services that protect from a range of attacks. The aim of ACD is to "Protect the majority of people in the UK from the majority of the harm caused by the

majority of the cyber-attacks the majority of the time." This is undertaken through a wide range of mechanisms, which at their core have the ability to provide protection at scale.

ACD is intended to tackle the high-volume commodity attacks that affect people's everyday lives, rather than the highly sophisticated and targeted attacks, which NCSC deal with in other ways.

NCSC Early Warning
Early Warning is a free NCSC service designed to inform organisations of potential cyber-attacks on their network, as soon as possible. The service uses a variety of information feeds from the NCSC, trusted public, commercial and closed sources, which includes several privileged feeds which are not available elsewhere.

Early Warning filters millions of events that the NCSC receives every day and, using the IP and domain names organisations provide, correlates those which are relevant to the organisation into daily notifications for the nominated contacts via the Early Warning portal.

NCSC Web Check
Web Check checks websites for common web vulnerabilities and misconfigurations. The checks are designed to impose low load on sites and to avoid damaging them. Web Check tells you: what you need to worry about, when you need to worry about it and what you need to do about it.

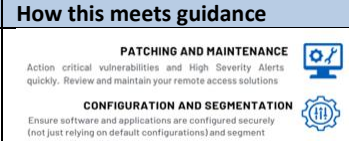
NHS - Cyber Security Operation Centre (CSOC)
The CSOC is part of the central cyber security team for the NHS and leads on the national support for cyber incidents, the HSA alerting approach and threat intelligence. They protect healthcare systems from cyber-attacks and monitor for new threats 24 hours a day. They act as an enabler, helping leaders and employees across the system to deliver better cyber security within their health and care organisations. Their deep cyber expertise keeps healthcare systems available, and the team includes sophisticated analysts, threat-hunters and intelligence gatherers.

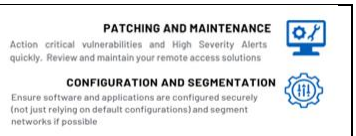
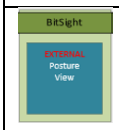
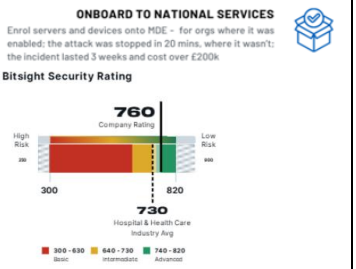
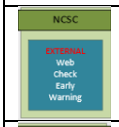
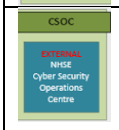
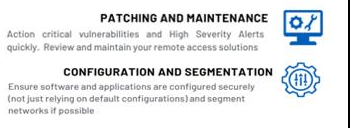
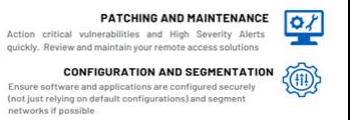
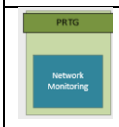
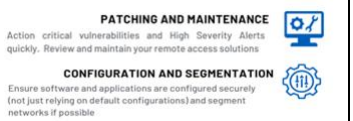
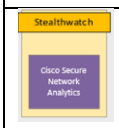
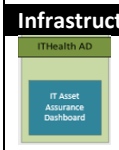
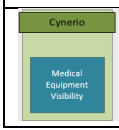
The services offered by the CSOC include protection of central products such as NHSmail, Microsoft Defender for Endpoint (MDE), Secure Boundary, The Health and Social Care Network (HSCN) and NHS England's nationally hosted services. This covers areas such as monitoring of feeds, triage alerts, collate intelligence, and raise incidents as needed. The Trust ensures all devices are visible on the MDE platform to benefit from CSOC oversight.

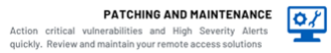
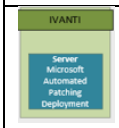
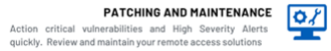
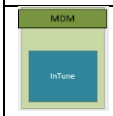
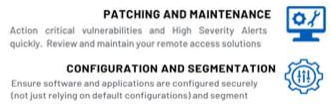
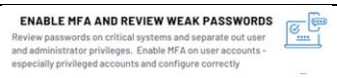
4.2 Local Protections and Monitoring

The following toolsets are used to monitor, alert and control our cyber security posture. Some solutions are provided centrally with some locally funded.

The table below provides further information about each toolset, what function it performs, how it is supplied and utilised as part of our comprehensive portfolio to 'Identify, Protect, Detect, Respond, Recover'.

Cyber Security Monitoring				
Protection	**Funded**	**Function**	**Description**	**How this meets guidance**
	Local	Identify Detect Protect	Trend is used as our primary anti-malware protection system. The solution also provides Intrusion detection and protection functionality along with 'virtual patching' capabilities providing enhanced protections.	
	Local	Identify Detect Protect	**Trend** The proxy controls access to web-based services externally hosted A 'hybrid cloud' approach is configured. This configuration ensures that devices 'off' the corporate network are still under the same proxy controls.	

	Local	Identify Detect	**Nessus/Tenable** This is used to scan internal servers for security risks.	
	Local	Identify Detect	**LOG360** Used to store log information from other systems for further reporting and analysis. Actively used to monitor / alert unusual behaviour on monitored systems.	
	NHSE	Identify Detect Protect	**MDE/ATP** Used to alert unusual behaviour on desktop/server. Alerting is sent to IT Security and TechOps teams. who will respond and remediate. **See also CSOC.** ** We are onboarding devices to allow CSOC to quarantine devices **	
	NHSE	Identify Detect	**BitSight** This tests our 'Internet facing' posture, providing information about risks and issues, giving guidance and support on how to resolve these. GWH current score sharing below. **Ransomware:** Your risk is **similar** to companies rated 750+. Learn more **Security Incidents:** Your risk is **similar** to companies rated 750+. Learn more	
	NHSE	Identify Detect	**NSCS web check** This facility allows us check websites we are using to ensure they are safe and where needed updated to mitigate advertised risks.	
	NHSE	Identify Detect Protect Respond Recover	**CSOC** This solution provides 24x7x365 monitoring of the NHS system for security incidents, using tools such as NHSmail, Microsoft XDR, MDE Secure Boundary, HSCN, and NHS England's nationally hosted services.	
Networking				
	Local	Identify Detect Protect	**Resilient Cisco Firewalls** Inbound / Outbound connectivity blocked by default. Intrusion Detection, Protection and Anti-Malware in place Systems regularly patched	
	Local	Identify Detect Protect	**Resilient Cisco security solutions** Network access control system (NAC) Policy controls in place to segment / control access	
	Local	Identify	**PRTG** Network view and monitoring solution. Primarily used for operational network monitoring	
	Local	Identify	**Stealth watch** Provides Network Detection and Response (NDR) to detect insider threats and identify anomalous behaviour. *** Investment required to enable the solution safely ***	
Infrastructure				
	Local	Identify Detect Protect	**ITHealth / Lansweeper (Locally Funded)** This is used for device, software visibility, software and patching deployment, security and assurance dashboards for areas such as HSAs. This is a primary information and management toolset.	
	Local	Identify Detect Protect	**Cynerio** Medical and IoT device and software visibility Security assessment and recommended manual fixes. *** Further investment needed for additional modules***	

	Local	Protect	**WSUS** This toolset is used to patch our desktop and laptops. A controlled deployment approach is adopted using test devices. Following field testing with no impact, patches are then released to all remaining devices.	
	Local	Protect	**Ivanti (Shavlik)** This toolset is used to patch our servers. Patches are tested before being available through the system. A controlled deployment approach is used.	
	NHSE	Protect	**InTune** We have deployed the Mobile Device Management (MDM) of corporate assets as part of the upgrades for iPods to Zebra handheld devices, as part of the Cerer Oracle preparatory works	
	Local	Protect	**SpecOps** This password security solution is used by all three Acute Trusts. We use this to promote and control better user password security when for logging onto the network.	

Patching

End user compute devices, operating system and application patching are deployed using WSUS to circa 400 devices that are part of the test group. These devices are located in different service areas providing a cross section of usage. Following the successful deployment to this test group and with no reported issue within 7 days, patches will then be deployed to the rest of the estate until all circa 4600 devices have been patched. Where there is a need to patch systems in relation to a HSA, we will always update the test group first but shorten the testing time to ensure that we can meet the 14-day deployment window. Consideration of disabling non-complaint devices and reducing the disabling of devices not seen on the network from 45 days to 14 days in line with the Trust's patching policy will be considered depending on the level of risk to the organisation of the HAS.

For our server estate, operating system and application patching is deployed using the Ivanti toolset. This solution tests and signs off the patches prior to them being available, so patches released have undergone full testing prior to us receiving them for local deployment. This service / approach has resulted in numerous occasions where a bad patch has been picked up by Ivanti and GWH therefore does not suffer from bad patches and the rollback remediations required.
For our virtual machines the system takes a snapshot prior to the server being patched allowing for easier rollback should this be required (extremely rare). We stagger the updating of our servers across a three-week period, with some servers automatically rebooted and some manually rebooted with human assistance and monitoring in place.

5 Non-Cyber Protections

Whilst technical cyber protections play a vital part in minimising the impact and risk of a cyber attack, there are a number of non technical activities that collectively help to reduce the risk.

5.1 Asset Lifecycle and Replacement Programme

Through the use of our core information systems – ITHealth Assurance Dashboard (ITH) and Cynerio - we are able to identify our device estate, understand its current capabilities and use this data to drive replacement programme and investment for compliance.

During 2025 there has been significant focus on the implementation of Windows 11, in conjunction with the implementation of Microsoft Defender for AV (MDAV) and the Shared Tenant Intune product for Mobile Device Management. The migration to these platforms has taken place during 2025 further improving the security and controls adopted by the Trust. Since migrating from Trend ApexOne our Microsoft Defender for Endpoint (MDE) scores have improved significantly, complimented by our Windows 11 migration.

We utilise ITHealth to help us forecast the capital investment programme required to ensure the Trust provides and maintains the equipment needed. The table below shares the current device numbers for a range of devices and the likely expansion forecast.

Type	2025	2026	2027	Comments
Desktop	2200	2200	2300	Numbers likely to grow each year as digital access become ever more necessary.
Laptop	2400	2400	2500	More devices require increased investment for device refresh.
Handheld Device	1500	1600	1700	Acutes agreed to use the same handheld device to align with Oracle Health Cerner.
Handheld Printer	300	300	300	This figure may grow as part of the EPR deployment.
Printer	550	500	500	We are looking to reduce physical A4 printers over the next few years with a formal review in 2025.
Mobile Phone (Trust)	1000	800	600	Through introduction of BYOD, we would anticipate a drop in corporate devices
BYOD (with controls)	10	200	400	Staff are using personal devices to access some services – E-mail, O365 With InTune we will have improved ability to provide MAM controls to improve security, but also to provide increased opportunities for staff to use personal devices subject to policy approvals. Potential changes to replacing bleeps in the coming years will also likely see an increase in BYOD uptake.

Windows 11

Mainstream support for Windows 10 ended in October 2025. GWH, like many others, were focused throughout 2025 on upgrading our end user compute devices to Windows 11.

Whilst each individual partner within the BSW Hospitals group had their own project, locally funded and resourced we adopted a single progress tracking file approach. The screen shot below provides the current completion position along with how many devices each partner has/is applying Extended Security Units (ESU) against to meet the compliance requirements. The use of ESU's is a recognised compliance approach and supported by NHS England and Microsoft.

Main Page

BSW HOSPITALS GROUP

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

	Total (In Scope)	Upgraded (AD)	Complete	Remaining (In Scope)	ESU/LTS Being Applied "Estimated"	Completion Forecast
GWH	4223	4209	99.67%	0.33%	380	End of Oct 2025
RUH	5095	5090	99.90%	0.10%	450	End of Oct 2025
SFT	3875	3825	98.71%	1.29%	200	End of Oct 2025
Group	**13193**	**13124**	**99.48%**	**0.52%**	**1030**	End of Oct 2025

All partners continue with their Windows 11 device upgrades and are utilising the ESU approach for 12 months.

5.2 Supply Chain Assurance

The most significant risk to the Trust currently is an attack on our supply chain, as highlighted in many of the recent cyber-attacks impacting the NHS. The initial opportunity to seek assurance that suppliers are cyber proficient is at the procurement stage. The digital team work closely with procurement to ensure that Digital Technology Assessment Criteria (DTAC) is completed up front. The DTAC provides the initial high-level assurance that a supplier meets key requirements on cyber security, clinical safety and data protection. With the increasing requirement for technologies such as medical devices to be connected to the network and/or integrated with digital systems, the use of DTAC assessments will increase. It is important to recognise that this invariably takes time for the Trust to receive sufficient assurance and evidence through the DTAC process, often causing up to a three-month delay in procurement given suppliers are not prepared to provide the necessary assurance. The uptake of the DTAC approach is still in its infancy. The uptake of the DTAC approach is still maturing but the policy "Third Party and Supply Chain Policy" now references DTAC specifically.

A number of technologies currently in use at the Trust did not go through the DTAC assessment. We are continue to work with procurement colleagues, Information Asset Administrators (IAA), Information Asset Owners (IAO) and suppliers to undertake DTAC assessments based on renewal and importance. There is a need to ensure that all staff involved in these processes are providing the correct training and guidance. This work will continue and is also linked to the wider MFA and supplier cyber assurances being undertaken with all our IT system providers.

Noting nationally there are discussions on how to further assurance the NHS of supply chain resilience and preparedness, locally the Trust is also working with ICS procurement on a number of actions alongside the DTAC review and locally the EPRR team are working to improve BIA (Business Impact Assessment) with asset owners, noting this will take time to complete. The key areas further assurance is being sought on is for any significant changes since contract award that has not be notified to us, third party contractor cyber/resilience assurance and more confidence on MFA plans.

We are working with a cyber technology partner to assess a cloud-based solution that could enhance our visibility of our critical suppliers through independent monitoring and assessments. The case for investment in a cloud-based solution is being assessed against any existing or future NHSE provided services. We will need to locally or ICS wide enhance our critical supply chain risks, so through collective engagement we look to drive improvements from our suppliers.

Further information can be found via this link:
Digital Technology Assessment Criteria (DTAC) - Key tools and information - NHS Transformation Directorate (england.nhs.uk)

5.3 Staff Awareness and Training

Information Governance
All staff are required to complete their IG training annually as part of their mandatory and statutory compliance. Since 2018/19, the IG training module has included information on data protection and cyber security. In order to pass the training, employees are required to read a selection of key information, including trends and learning from incidents, before a test of comprehension can be attempted. This test must be repeated if they do not reach the pass mark of 80%.

In 2018, the Data Security and Protection Toolkit (DSPT) replaced the old IG Toolkit. Between 2018-2023, the Trust has met the strict requirements of the DSPT to ensure that 95% of staff have been trained annually, as a minimum. This requirement was relaxed slightly in 2024 and the Trust was able to meet the new compliance rates. This meant that the Trust has maintained our 'Standards Met' status since the new DSPT came into force. Any member of staff who has not completed IG training in the last 2 years will be contacted to inform them that they must complete their IG training. Failure to do so will result in notification to their manager and their system access being disabled. This process will be repeated as more staff reach the 2 year period since they were last trained.

In addition to the mandatory training that all staff must undertake, the IG team complete a Training Needs Analysis (TNA) annually to identify staff or groups of staff that require additional training. The TNA has highlighted that the SIRO, Caldicott Guardian, Information Asset Owners (IAOs), Information Asset Administrators (IAAs) and those with specific roles such as members of the IG Steering Group must complete additional training on cyber security or information risk. This is one off training, but can be 'refreshed'.

In order to raise awareness to staff, the Trust uses the following mechanisms:
- Careflow displays a disclaimer upon every login stating that staff are subject to the common law duty of confidentiality and that their access is monitored
- Staff contracts, including bank staff and volunteers, have clauses which state that they are subject to the various data protection legislation and computer monitoring
- All Staff Communications are sent for specific awareness campaigns. There are ones sent routinely on a cycle, which includes password security. There are also bespoke messages sent when particular news articles need to be shared.
- There is a bi-monthly Information Governance Steering Group meeting which includes a 'Regulatory Landscape' report as a standing item. This lists news and guidance from the Information Commissioner's Office (ICO), as well as other

sources, and includes incident and cyber incident trends, and learning from enforcement action. Where necessary, these case studies are used in SWIFT or Learning Zone posters.

- Systems routinely force users to change their passwords for security reasons
- A message is displayed at the top of emails which are being sent to external parties

Cyber Security Awareness

Alongside the annual IG training and audits undertaken, the digital team work closely with the Trust's communications team to provide routine awareness. The 'Keep I.T. Confidential' campaign driven by NHSE provides a range of helpful materials which the Trust utilises such as videos to help provide staff with awareness. The simple and consistent messaging is designed to help staff play their part in protecting our data and systems from cyber-attack. The following summarises some examples of the key messages that are shared.

Awareness materials are provided by NHSE incorporating a range of helpful detail and graphics that the Trust utilises such as posters and videos; these materials help provide staff with a national cyber awareness. The simple and consistent NHS messaging is designed to help staff play their part in protecting our data and systems from cyber-attack. The Appendix "**Appendix Cyber Security October review**" includes the key messages that were shared throughout October 2025.

Awareness Area	Actions and Awareness
	MFA has already been implemented for NHS Mail and O365 services. SpecOps password control software has been deployed with 98% of staff now enrolled. The solution inform staff if their password is deemed to be weak and/or the password used is recorded on a global password breach list. This targeted communication helps staff adopt a stronger password approach for accessing the network. *Working with the Trust communications team we have provided awareness and guidance to staff.*
	**Phishing - "fishy" e-mails** This is when hackers and criminals send unsolicited emails that contain attachments or links to try and trick people into providing access to information. As NHS Mail system users, we benefit from the 'safer links' facility. IT proactively monitor for new phishing campaigns using both local and CAN as information sources. Any new alerts allow us to update our proxy services to block access. *Working with the Trust communications team we have provided awareness and guidance to staff.*
	**Ransomware** This is a type of malicious software, or malware, which prevents you from accessing your computer files, systems, or networks and demands you pay a ransom for their return. Ransomware attacks can cause costly disruptions to operations and the loss of critical information and data. You can unknowingly

	download ransomware onto a computer by opening an email attachment, clicking an ad, following a link, or even visiting a website that's embedded with malware. *Working with the Trust communications team we have provided awareness and guidance to staff.*

6 How our cyber security controls are assessed.

The main route for assessment of cyber security controls is the Cyber Assurance Framework (CAF) also known and referred to as the Data Security and Protection Toolkit (DSPT). This is an annual self-assessment toolkit where the Trust collates evidence against the mandatory and non-mandatory assertions to provide assurance that the expected controls are in place. An internal audit is undertaken each year based on a national scope to provide an independent assessment as to whether the Trust's local scoring of assertions is appropriate and advise whether there are further opportunities for improvements based on the auditor's view of what is deemed best practice.

6.1 2024/25 CAF / DSPT return and internal audit findings

The DSPT assessment was submitted in June 2025 to 'Standards Met'. This was version 7 of the DSPT and represents the Trust continuing to meet the required standards within the assessment.

Internal audit findings were 'Significant assurance with minor improvement opportunities. The following recommendations were provided in the report:

1. The Trust's Record of Processing Activities/Information Asset Register does not include retention periods, impact of loss for information assets and technical and organisational security measures in place.
2. The Procurement Policy does not include a requirement to document the roles and responsibilities for handling personal information. Roles and responsibilities for technical security controls were not included within supplier contracts.
3. Policies or procedures are not available for business continuity, auto run or the Trust's approach to managing security risks associated with connected devices.
4. Firewall rulesets are not regularly reviewed on a regular basis to ensure they remain appropriate and effective in securing the Trust's network.

Cyber Assessment Framework

In 2024/25 the DSPT was aligned to the Cyber Assessment Framework (CAF) which underpins the national cyber strategy. This was a significant change in approach and will be phased in as we transition from the DSPT to the CAF approach. Those elements being phased in will allow for partial compliance during the transition period, with the remainder requiring 'full compliance' achievement from the outset. The level of evidence required to provide the assurances sought is also increasing. The tables below show the areas that will be assessed.

NA	Not Achieved
PA	Partially Achieved
A	Achieved

Health and care CAF element		Profile		
Principle	Outcome	NA	PA	A
Objective A - Managing risk				
Governance	A1.a Board direction			A
	A1.b Roles and responsibilities			A
	A1.c Decision-making			A
Risk management	A2.a Risk management process		PA	A
	A2.b Assurance			
Asset management	A3.a Asset management			A
Supply chain	A4.a Supply chain		PA	

Health and care CAF element		Profile		
Principle	Outcome	NA	PA	A
Objective B - Protecting against cyber attack and data breaches				
Policies, processes and procedures	B1.a Policy, process and procedure development		PA	
	B1.b Policy, process and procedure implementation		PA	
Identity and access control	B2.a Identity verification, authentication and authorisation		PA	
	B2.b Device management	NA		
	B2.c Privileged user management	NA		
	B2.d Identity and access management (IdAM)		PA	
Data security	B3.a Understanding data		PA	
	B3.b Data in transit		PA	
	B3.c Stored data		PA	
	B3.d Mobile data		PA	
	B3.e Media / equipment sanitisation		PA	
System security	B4.a Secure by design		PA	
	B4.b Secure configuration		PA	
	B4.c Secure management		PA	
	B4.d Vulnerability management		PA	
Resilient networks and systems	B5.a Resilience preparation		PA	
	B5.b Design for resilience	NA		
	B5.c Backups			A
Staff awareness and training	B6.a Culture		PA	
	B6.b Training			A

Health and care CAF element		Profile		
Principle	Outcome	NA	PA	A
Objective C - Detecting cyber security events				
Security monitoring	C1.a Monitoring coverage		PA	
	C1.b Securing logs		PA	
	C1.c Generating alerts		PA	
	C1.d Identifying security incidents		PA	
	C1.e Monitoring tools and skills	NA		
Proactive security event discovery	C2.a System abnormalities for attack detection	NA		
	C2.b Proactive attack discovery	NA		

Health and care CAF element		Profile		
Principle	Outcome	NA	PA	A
Objective D - Minimising the impact of incidents				
Response and recovery planning	D1.a Response plan		PA	
	D1.b Response and recovery capability			A
	D1.c Testing and exercising			A
Lessons learned	D2.a Incident root cause analysis			A
	D2.b Using incidents and near misses to drive improvements			A

Health and care CAF element		Profile		
Principle	Outcome	NA	PA	A
Objective E - Using and sharing information appropriately				
Transparency	E1.a Privacy and transparency information		PA	
Upholding the rights of individuals	E2.a Managing data subject rights under UK GDPR			A
	E2.b Consent			A
	E2.c National data opt-out policy			A
Using and sharing information	E3.a Using and sharing information for direct care			A
	E3.b Using and sharing information for other purposes			A
Records management	E4.a Managing records			A
	E4.b Clinical coding			A

Acute Trusts are required to complete their interim submissions by 31st December 2025. All Hospitals Group Trusts are working collaboratively to ensure that a consistent approach is adopted so that our evidence and assurance is consistent for the CAF submission. The evidence provided undergoes a full internal review by our Head of Information Governance/Data Protection Officer who independently reviews the evidence for both organisations prior to any submission. The interim submission also undergoes an external auditor review to provide additional assurance that the evidence supplied is of sufficient quality and meets the standards required. The evidence and return will ultimately be signed off by the Senior Information Risk Owner (SIRO) ahead of the submission in June of each year.

6.2 Annual Penetration Test

The DSPT (and future CAF) mandates that the Trust undertakes a penetration test at least annually to review a number of core areas susceptible to cyber-attack, enabling the Trust to ascertain how controls in place can be further improved to maintain good cyber posture. The most recent test was conducted by Dionach, an NHSE approved tester, in May 2025.

The IT security team manage the remediation control file and work with sections of IT and external providers to ensure remediations are applied. The Digital Senior Managers group are provided with regular progress updates until all of the findings are remediated. Part of the remediation includes considering gaps in our business as usual (BAU) governance to reduce the number of findings that were not already being monitored internally.

Taking learning from recent testing and to ensure that we are, a number of changes to review processes and reporting have and are taking place. These have primarily focused on elevated rights controls, formal reviews and improving toolsets to ensure that a regular review timetable is adhered to. By having the review process evidence and documented exceptions this ensures that what may be assessed by the tester as critical or high risk, can be lowered in level as the risk is known, recorded, has mitigations / controls in place or has been accepted through report sign off.

We are working with a cyber technology partner to assess how we can move from an annual point in time approach to penetration testing to a more regular and automated approach. The toolset we are reviewing along with adding a management wrapper approach would look to ensure that continuous assessment of any gaps is being tested and reported against. The adoption of a management wrapper would then provide a level of independence from the in-house team. The case for investment in a cloud-based testing solution is being written so that either locally or ICS wide we can enhance our detection capabilities.

All remediation changes are logged on the IT service management toolset and are reviewed in line with our Change Advisory Board (CAB) processes. If the changes required are of significant impact a planned response will be created and discussed with the EPRR team for approval and assurance purposes. Where remediation requires financial investment, a business case is created and the request made to highlight the benefits of the investment and risk mitigations.

The standard approach is to focus on the 'Critical and Highs', however where opportunity exists to close off 'Mediums and Lows' these are taken. All findings are recorded in the remediation control file that is manged by the IT security team. A number of remediations have taken place, with continued focus being applied to remediate the issues found. Some of the improvement areas required investment. Capital funding has now been approved therefore further improvement works, in particular around Active Directory is now planned. We are working with procurement to place an order with a technology partner to support this area of improvement.

2025 findings summary:

Code	Category	Ext VA	N3 VA	PAS	File Share	AD Review	Infrastructure	CSS Review	Mobile Review	PC Review	Wifi Review
APP	OWASP	None	None	None	None	None	None	None	None	None	None
ATH	Authentication	None	None	None	None	None	Critical	None	None	None	None
BAK	Backups	None	None	None	None	None	None	None	None	None	None
CNF	Configurations	None	None	None	None	Critical	High	None	None	High	None
CRY	Cryptography	None	None	None	None	None	None	None	None	None	None
LOG	Logs	None	None	None	None	None	None	None	None	None	None
MAL	Malware	None	None	None	None	None	None	None	None	Medium	None
MOB	Mobile Devices	None	None	None	None	None	None	None	High	None	None
NET	Network	High	None	None	None	None	High	None	None	None	Medium
PRC	Insecure Practices	None	None	None	None	None	None	None	None	None	None
PRV	Privileges	None	None	None	Critical	Low	Medium	None	None	Medium	None
PWD	Weak Passwords	None	None	None	None	Critical	None	None	None	None	None
UPD	Security Updates	Medium	None	None	None	None	Critical	Critical	None	High	None

Critical	8
High	10
Medium	20
Low	2

The next penetration test is due to be booked and concluded by Jan 2026, of note tests are now locally funded.

6.3 Annual Phishing Campaign

Phishing emails are more complex today and are harder to spot. The IT team proactively seek information about new campaigns and update our proxy control systems to mitigate these. As an NHSmail service user, we benefit from the 'safer links' service that checks each clickable link to assess any risks associated so that only safe links are allowed to be accessed. An annual phishing exercise using the NHS phishing campaign material is undertaken to assess whether staff require additional awareness training around the threats associated with Phishing attacks. The next test is planned for Q1 2026. Given the increase in phishing attack prevalence, any staff who provide credentials in the exercise will be required to complete face to face awareness training. This is in line with the response approved for wider ICS partners.

6.4 Ad hoc assessments undertaken over the last 12 months.

Role Based Accelerator (RBA) Programme (NHSE funded) – Domain Boundary (completed) Server Boundary (active)
GWH bid for and was successful in achieving NHS funding to complete technical remediation on our Active Directory.
As one of the first Trust to adopt this remediation a 3rd party MTi were assigned by NHSE England to work with GWH to implement the "domain boundary" within our Active Directory. The purpose of this was to implement configuration hardening and changes in the way our active directory is setup, introducing additional security layers and boundaries at the admin layers. This work had no effect on service users but has modified for the better the way the digital team interacts with Active Directory to further improve the security of this critical asset.

Following the success of this work GWH have successfully been allocated NHSE technical remediation funding earlier this year to also implement the server boundary configuration and we are working with the MTi team to implement the changes by end of January 2026

Cisco Identity Services Engine (ISE)
GWH operates a Software Defined Network so as part of a review of our Cisco ISE configuration we engaged Block to complete a review of our solution to assess security and configuration optimisations. We have completed the software upgrades needed and will be updating and applying additional configuration to further improve our network security controls.

Cisco WiFi
As part of a review of our Cisco WiFi configuration we engaged Block to complete a review of our solution to assess security and configuration optimisations. We have completed the software upgrades needed and will be updating and applying additional configuration to further improve our network security controls.

Cynerio
All BSW Hospital Group members utilise the Cynerio toolset that provides visibility of a range of networked equipment, primarily medical devices. With the continued need and growth of IoT (Internet of Things) and medical devices being connected to the network

We are currently conducting a proof of concept (POC) in relation to an extra module called PRM, that allows greater visibility or device communications along with remediation information will help both digital and medical equipment colleagues to further improve security in this area.

This module will require additional funding so as part of the POC we are writing a joint BSW Hospital group business case that will also be part of the cyber toolset alignment piece shared below.

Cyber Toolset Alignment
We are in the process of engaging with a partner to independently help the BSW Hospitals Group assess our current cyber tooling so that a roadmap for alignment can be agreed. This alignment will likely require one or more partners to change their current toolset to the agreed toolsets approach. This review will help us to consolidate and standardise how we provide security and assurance to the group as opposed to each individual Trust.

7 Cyber Incident Preparedness

Trust Business Continuity Management (BCM)
The Trust EPRR team lead on the BCM functions of the Trust. The business continuity working group has membership from all divisions, support services and Serco. This group is focused on reviewing, updating and improving the Trust BCM policy, Business Continuity Plans (BCPs) and Business Impact Assessments (BIAs). It is recognised there are gaps around BIAs and BCPs and the EPRR team are working with services to create, update and assess the deeper needs of their areas and services. These reviews and updated plans will include extended loss of service beyond three days. This is a key area of focus for the Trust services.

The iRespond document - 03_000 Incident Response Overview_GWH – is a key document that provides the Trust with a structured response when incidents occur. The iRespond documents are the primary documents used in the event of an outage/issue as they are concise and simple to follow, and they align with the Business Continuity approach when an event is declared. Some key parts of that document are shared below:

1. **Business Continuity Incident Declaration – in comms use that we are 'in Incident Response'.**
   - An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level.

- Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

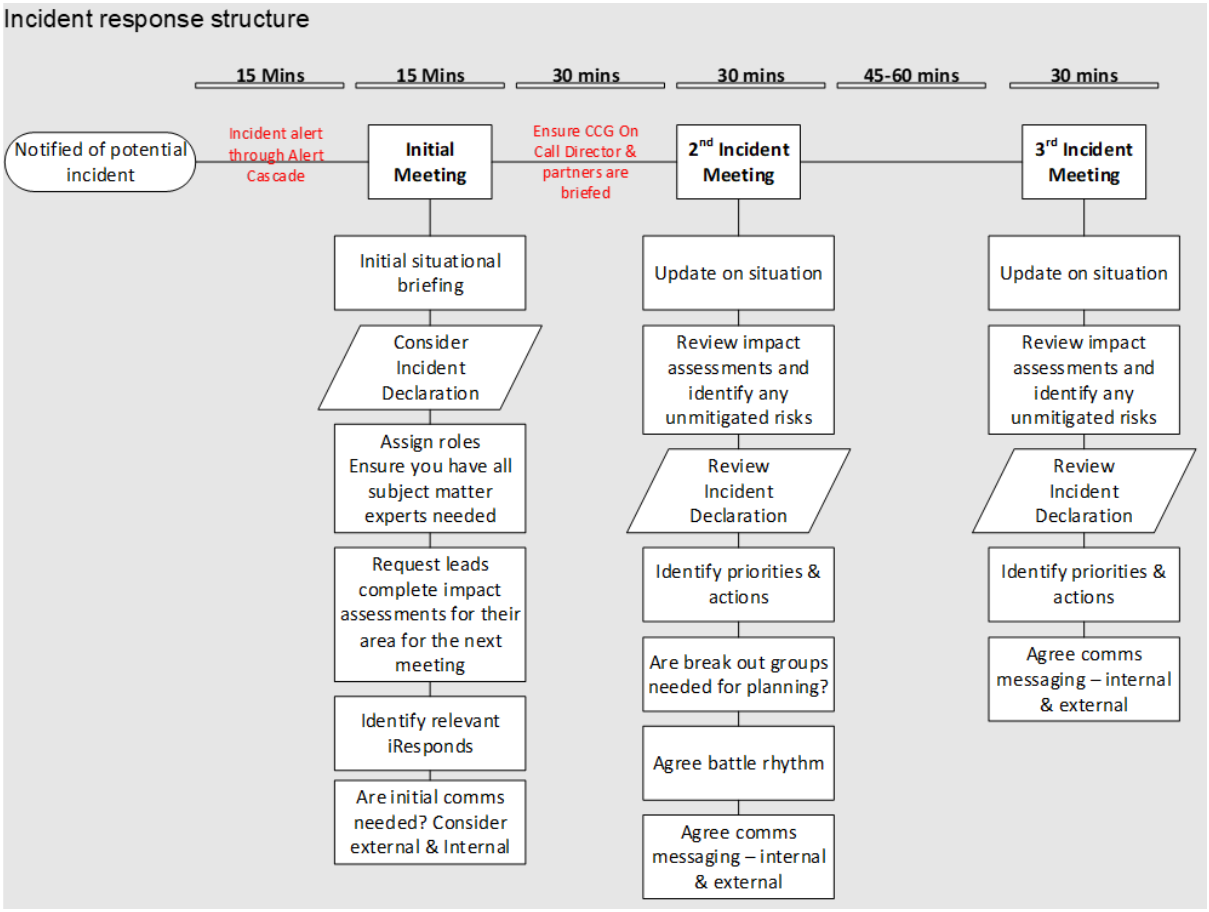
2. Triggers for Critical Incident Declaration

- Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm.
  It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions.
- A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

3. **Triggers for Major Incident Declaration or Major Incident Standby**

- Defined by the Cabinet Office and JESIP as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency.
- For the NHS, any occurrence that presents a serious threat to the health of the community or causes numbers or types of casualties as to require special arrangements to respond.
- May involve a single agency response but more likely to require a multi-agency response.

NHS Alert Levels of Response	
Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans
Level 2	An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support may be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England (Region) to coordinate the NHS response, in collaboration with the ICB, at the tactical level.



IT Continuity

The principal document used is the IT Incident Disaster Recovery Plan (IDRP).

The DR documents (SOP's) to be followed all aim to achieve timely recovery for systems the IT Department is responsible for. They specify the types of disasters that fall within the scope of the DR incident and provide detailed steps for:

- Assessing type of event;
- Assessing impact;
- Notifying and mobilising disaster recovery teams;
- Initiating recovery procedures;
- Recovering affected services and equipment;
- Salvaging and reconstructing the recovery location;
- Restoring systems/network/telephony services and equipment to the recovery location;
- Returning to normal operations.

The purpose of this document is to set out how the IT Department plans to manage an IT disaster or major incident in order to return IT systems, network, telephony services and equipment to normal operation. For security and operational reasons, information regarding the type of equipment, locations and names of third-party suppliers and maintainers have been omitted from this document. Suppliers are referred to as service providers. The Trust has contracts with a number of service providers to maintain and monitor IT systems, network, telephony services and equipment.

Standard Operating Procedures (SOP)

The IT services team create and maintain a suite of SOPs used to monitor, manage and secure the security products used to protect Trust systems and data. It is recognised that whilst we have a range of support documents, standardisation of

format and content levels differ. With closer working with SFT continued and further alignment opportunities are underway to align SO format, content and consistency.

This is a key area of focus for the IT services.

Training / Testing
We are currently meeting the standards set by DSPT submission around testing and evidencing our data and system recoveries. Further work is needed in this aera, and it is recognised there are gaps with the level of training and testing that is currently achievable within the current resources and toolsets available. Teams are often heavily focused on delivering day to day support and the implementation of new projects. This does not currently leave sufficient time for detailed and continuous testing, and this is a key area of focus for IT services.

We are conducting a training gap analysis within IT security and the wider team involved in monitoring, alerting, escalation and remediation. This report will help to shape training needs, documentation and testing requirements that will improve resilience in this area.

7.1 Business Continuity Plans and Playbooks

Resilient solution design and regular failover testing helps to assure the design and minimises downtime and impact. The Information Technology (IT) Incident Disaster Recovery Plan (ITDRP) documents the procedures to be followed to achieve timely recovery for which the IT Department is responsible. It specifies the types of disasters that fall within the scope of the IDRP and provides detailed steps for:

- Assessing type of event.
- Assessing impact.
- Notifying and mobilising disaster recovery teams.
- Initiating recovery procedures.
- Recovering affected services and equipment.
- Salvaging and reconstructing the recovery location.
- Restoring systems/network/telephony services and equipment to the recovery location.
- Returning to normal operations.

The purpose of the ITDRP is to set out how the IT Department plans to manage an IT disaster or major incident in order to return IT systems, network, telephony services and equipment to normal operation. For security and operational reasons, information regarding the type of equipment, locations and names of third-party suppliers and maintainers have been omitted from this document. Suppliers are referred to as service providers. The Trust has contracts with numerous service providers to maintain and monitor IT systems, network, telephony services and equipment.

Service Categorisation
All services will be classified to their level of importance and impact to the Trust should the service be lost. The following table provides some background information.

Level	Meaning	Significant Impact Occurs In	Service Resilience
1	Critical	Minutes	Services would generally be critical to the efficient running of the Trust. The solution is generally resilient with clustering technologies used and/or failover equipment available to minimise the likelihood service loss.
2	Essential	1 Hour	Services would generally have significant impact if the service was lost. These services will primarily be housed on the Trust's resilient server virtualisation environment, though some services may remain on single servers. Failover equipment would be available but failover would be manual.
3	High Priority	4 Hours	Services would generally have impact on a single department. These services will primarily be housed on the Trust's resilient server virtualisation environment, though some services may remain on single servers. Failover equipment would be available but failover would be manual.
4	Medium Priority	24 Hours	These services would generally be for back office functions where single servers with hardware resilience would be used. The impact of the loss would not affect live services.
5	Low Priority	72 Hours	Services would generally be for Test / Training / Development functions where single servers with hardware resilience are used. The impact of the loss would not affect live services.

High-level BCP are in place to provide an overarching approach to recovery activities. During an event IT will work closely with the EPRR team and Trust Critical / Business continuity incident team, other Trust teams and 3rd parties to restore services. The EPRR team lead and work all areas of the Trust to ensure that Business Impact Assessment, Business Continuity Plans and iReponds are created, reviewed and maintained as these provide simple guides to services in the event of a failure.

The iRespond documents are the primary documents used by the Trust in the event of an outage/issue. These align with the Business Continuity approach when an event is declared.

It is recognised there are gaps around BIA's and BCPs throughout the Trust and the business continuity working group has been established to work on this. The templated process and system are in place to record the BIAs/BCPs with the EPRR team working with services to create update and asses the deeper needs of their areas and services.

Playbooks

These are used to understand resource, equipment, information and process needed to achieve recovery.

A number of playbooks have been developed that focus on server and desktop protections, server shutdown and restoration order. These align to our SOPs as these often include the "what to do if x happens". It is recognised that whilst we have a range of documents, standardisation of format and content levels differ. With closer working with SFT continued and further alignment opportunities are underway to align document format, content and consistency.

7.2 Desktop exercises

The following desktop exercises have been conducted over the last 12 months alongside the "real" events that have provided the opportunity to test Trust resilience and preparedness:

- October 2024 – BSW ICS - Cyber Exercise Propaganda
  The scenario was based on real events that have impacted the NHS.

Additional exercises are planned for 2026 both at a local and ICS level. The output and the action plans from the desktop exercises are shared with the appropriate groups involved and will be monitored through appropriate governance groups, ranging from IT TechOps, IT Digital managers group, Digital Steering Group, ICS Technical Design Authority and ICB Board.

7.3 Policy and Standard Operating Procedures

The Trust has a number of local policies that exist to ensure there is guidance and awareness of what is in place, what staff can and can't do to support. In addition, there are national polices we are required to adhere to that help to support our digital safety and compliance needs.

The following provides a list of the current policies in use within the Trust. Further work is planned to align ICS policies to ensure a consistent and standardised policy approach is adopted.

Policy	How this help Cyber Security
IT Equipment Usage Policy	The purpose of this policy is to provide clarification for employees on the use of computing facilities provided by the Trust, as all employees need to be aware of their responsibilities. Managers must advise employees of the various policies and procedures which apply to the use of computing facilities.
Network Security Policy	This document defines the Network Security Policy for the Trust which applies to all business functions and information contained on the network, the physical environment and relevant people who support the network. It sets out the Trust's policy for the protection of the confidentiality, integrity and availability of the network, and establishes responsibilities for network security.
Internet and Email Usage Policy	The objectives of this policy are to: • Identify proper use of the internet and email in support of the organisation's task. • Ensure employees are aware of proper conduct when using the internet and email; and, • Ensure that all employees are responsible, productive internet and email users and that they are protecting the Trust's public image. This policy covers the use of services in relation to the internet, and NHSmail accounts. The policy similarly establishes employee responsibility in the use of these. In implementing this policy, the Trust aims to maximise the benefits of internet and email access whilst minimising potential risks. This document defines the Internet and Email Usage Policy for the Trust. It aims to ensure the proper use of access to the internet and email by informing employees of what the Trust deems as acceptable and unacceptable use.
Patch Management Policy	In order to minimise risks associated with known operating system and application vulnerabilities, it is important to ensure that ALL systems are updated regularly. In order to be able to effectively achieve this goal, the organisation must know about systems in order to be able to update them and identify unpatched/unmanaged devices.
Information Asset Risk Management Policy	Information risk management is integrated into the Trust's overall corporate risk management process, using the same set of mechanisms for assessing, reporting and monitoring of risk and incidents. The purpose of this policy is to ensure that the Trust has adequate safeguards and controls in place to protect its employees and its patients from risks to information security where the likelihood of occurrence and the consequences are significant. This policy will ensure that a consistent risk management framework is in place which will identify, consider and address risks to information security and develop key approval, review and control processes.
Data Protection Policy	This policy aims to ensure that Trust information systems and information stores are properly assessed for security, that confidentiality, integrity and availability are maintained, that employees are aware of their responsibilities, roles and accountability, and that there are procedures in place to detect and resolve information security breaches. Key issues addressed by this policy are:

	• Confidentiality – ensuring information is accessible only to authorised employees/users. • Integrity – safeguarding the accuracy and completeness of information and processing methods. • Availability – information and associated assets are available to authorised users when required. • Risk Assessment – assessing threats to, impacts on, and vulnerabilities of, information and information processing facilities and the likelihood of their occurrence. • Risk Management – process for identifying, controlling and minimising/eliminating information security risks that may affect IT systems or other information assets.

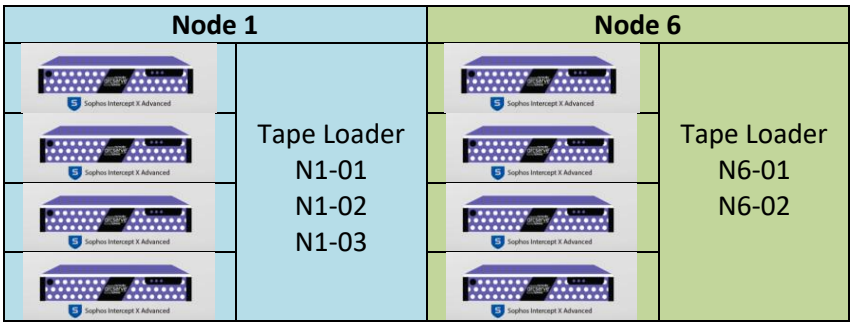
7.4 Rolling Backup and Recovery Testing

As described in the Information Technology (IT) Backup Strategy, within GWH we use Arcserve UDP appliance backup solutions with Sophos security for further backup data protection.

The system adopts a nodal based backup approach utilising both disks and Tape Loader s to backup data and application software. The default approach is that each media server will back up a number of servers using a two-stage backup process: We have eight active appliances providing both on-site and off-site media backups.

- Stage 1 - Disk to Disk Backups
- Stage 2 - Disk to Tape Loader Backups
- Stage 3 - Disk to Disk Replication (Node to Node)

Eight Arcserve appliances and five tape loaders protect the data using disk-based backups, data deduplication, data replication between node rooms and appliances long with encryption. All data backed up to disks is also pushed out to tape loader. The following summarises the architecture used:



Tape Loader Encryption
All backup tape loaders stored to be stored off-site are encrypted using the in-built Arcserve tools that provide AES 256 Bit encryption. The system requires a “key & pass phrase” to operate and means that you can only recover data from encrypted Tape Loader s if the Tape loader is known to the media server or you have the “key and pass phrase” to decrypt the Tape Loader.

Backup Checking
GWH, IT check the Arcserve console Monday to Friday to ensure that backups have completed successfully. Any unsuccessful backups are escalated to the IT technical specialist and / or IT technical operations manager to assess impact, issue assessment and resolution. Where practical the failed backup would then be rerun.

We are working with technology partners to further assess improvement to our data protection systems, processes and security. This is area where additional investment will be required, and a budgetary capital bid has been submitted. Working with ICS partners there may be opportunities to further align technology choices in the future.

Restoration
As described in the Information Technology (IT) Recovery Testing Strategy, we adopt an annual test plan to perform system and data recovery. These tests are recorded and provides evidence for DSPT/CAF that our backup and restoration system are functioning, with the type of tests undertaken shared below.

- Disk / Tape Loader file restorations - evidence that data is readable from backup media.
- Full System & Partial Data Recovery - some systems take days to recover so partial recoveries are used.
- Full System & Full Data recovery - provides the service recovery scenario.

All recovery testing and sign offs are undertaken by the local IT team.

Whilst we are meeting the minimum standards for recovery testing, we will be conducting a review on this area, as part of the training gap analysis work, of the restoration levels that can achieved within the current toolset, resources available and acceptance of downtime by the Trust. This summary report will detail the additional investment in terms of time, product and resources required to improve restoration capabilities required by the Trust. **Governance**
The primary method of reporting our backup and restoration activities in as follows:

Backup
This is currently reported at an operational level, where issues are reported to the IT infrastructure specialist and IT infrastructure manager. They will assess failures, work with the technology partner of product support issues including hardware, software and root cause analysis for failures.

We are reviewing how the backup success and failure report will be shared on a monthly basis with the IT TechOps group. This report will also share issues and capacity planning with a wider audience and allow for improved forecasting to aid investment planning.

Restoration
In terms of planned restorations, this is currently reported as part of the DSPT submission.

We are making improvements to the planned restoration activities so that evidence and assurance data is shared on a bi-monthly basis with the IT TechOps group to ensure the wider group has increased awareness.

8 Our People (Digital Staff)

Within the Trust, the IT Security and Configuration team is responsible for cyber security controls including configuration management, infrastructure solution and security design. Overseen by the Head of IT Security and Configuration, the team consists of 2 WTE:

- IT Technical Specialist - Device Configuration, Patching and Security
- IT Technical Architect - Infrastructure Configuration

Configuration management and control is at the heart of safe and secure systems, so this team work closely with all IT services and technology partners to ensure resilient system design, security requirements, improvement and compliance standards are being adopted. The team also work closely with Information Governance (IG) and Emergency, Preparedness, Resilience and Response (EPRR) colleagues, with active participation on Regional Cyber groups, ICS Technical Design and Cyber authority groups. The Head of IT Security and Configuration works closely with EPRR colleagues on cyber desktop exercises, business impact assessments, planned downtime responses and iResponds.

With 'prevention' being better than cure and with the increase of successful attacks being reported and impact occurring, additional focus is required to ensure we are continually improving our 'prevention' approach. Only through investment in people, training, protection systems, processes and recovery capabilities can we look to reduce risks and impact associated with cyber.

As the BSW Hospitals group model matures, there will be opportunities to align the cyber teams more closely as part of the toolset alignment and digital teams review process.

Communication

At a local level, IT services are closely linked with our EPRR and Estates colleagues who meet fortnightly to review and agree the joint forward schedule of change for planned activity. This advanced awareness to take place ensuring that IT are not planning a major system upgrade at the same time estates are looking to complete major changes to oxygen systems. This approach has also improved the 'planned response' documents that detail changes, impact and downtime ensuring these impact assessments are known, communicated and authorised.

From an IT perspective we proactively use the IT / Resilience teams channel ensuring direct and immediate alerting is in place for IT issues of concern or will cause impact to operational services. This communication route to two-way and allows EPRR direct and immediate alerting access into IT for any or operational services having significant issues that need rapid IT response.

This communication route is also used for 'awareness and standby' purposes and ensures that information shared with EPRR / IT through other routes is available. This approach has been in place for a number of years and is embedded into the business-as-usual operations of our services.

IT Services Training

The IT security team meets with our security providers regularly to ensure we are aware of developments related to our security products and to ensure we are enhancing and optimising the product use. With shared security products across the three Acute Trusts within the ICS key staff will share knowledge with each other on how we are using, enhancing the products we use.

GWH are active members of the:

- ITHealth assurance dashboard and Cynerio user groups.
- South-west Regional Cyber security group
- BSW ICS Technical Design Authority (TDA) and Cyber subgroup
- Cyber Associates Network (CAN)

The majority of the skills we have are based around experience, exposure and usage of toolsets. Working with our partners and peers in the ICIS and through the use of NHSE training materials we look to keep our awareness and skills up to date.

As part of NHSE cyber security training funding the BSW Hospitals Group leads met to agree and prioritise our bid and all partners received places to attend industry recognised cyber training. Those who have / are attending will be taking the exam aligned to their course to further enhance recognised training accreditations. As a group we are ready to make another application when the process is released during Q1 2026.

9 Risks

A recent review of cyber risks has been undertaken for the Trust. There is now one Board Assurance Framework (BAF) risk, SR10, covering the inherent risk associated with cyber security. This is currently (as of July 2024) score at 20.

BAF 4 : Use of Resources - Digital Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care		
Aggregated Assurance Rating	**PARTIAL ASSURANCE**	Likelihood risk score LIKELY
SR10	**There is a risk of a shutdown of the IT network due to a cyber-attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.**	

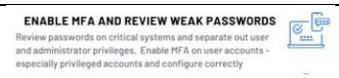
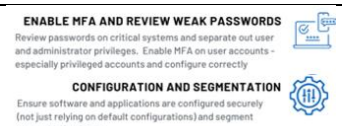
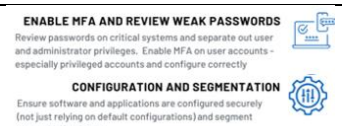
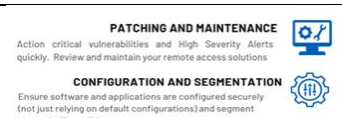
Below this BAF risk there are range of more detailed risks recording on the Trust's risk management software Datix IQ. These risks detail both the potential risk, the controls/assurance in place for each and the actions to mitigate any gaps in controls/assurance. These risks have been aligned to the ICS risk register so there is consistency both in risk description and alignment wherever possible in mitigating actions to support the "defend as one" ethos:

Risk Category	Cyber Risk Name	Executive Risk Owner	Risk Manager	Likelihood	Impact	Latest Risk Score	Target Risk Score	Risk Treatment	Description of risk incluidng event, cause and consequences
Cyber Risk	Data loss via internal abuse including 3rd parties in building	Chief Digital Officer	Head of IT Security and Configuration	3	4	12	8	Mitigate	Cyber Security - Data loss via internal abuse including 3rd parties in building
Cyber Risk	Ransomware breaching a ICS network	Chief Digital Officer	Head of IT Security and Configuration	3	5	15	8	Mitigate	There is a risk of a ransomware that prevents access to all medical and patient systems, including diagnostics and integrated care records, leading to poor health outcomes, significant financial penalties and reputational damage. Attacker could also disclose information.
Cyber Risk	Phishing breaching a ICS network	Chief Digital Officer	Head of IT Security and Configuration	2	5	10	8	Mitigate	There is a risk that a phishing attack could lead to the compromise of key systems causing a loss of data and a denial of key systems which may have a negative impact on patient outcomes while the attack is remediated. Use of a NHS mail account to create fraud e.g. finance
Cyber Risk	Websites breach / Denial Of Service (DOS)	Chief Digital Officer	Head of IT Security and Configuration	3	4	12	8	Mitigate	Cyber Security - Websites breach / Denial Of Service (DOS)
Cyber Risk	Cyber Attack on supply chain	Chief Digital Officer	Head of IT Security and Configuration	4	5	20	10	Mitigate	There is a risk of a cyber-attack on the supply chain/procured partner that causes disruption (e.g. recent 111 Adastra incident). NB Impact will vary a lot depending on the user case and whether it is our direct supply chain or an indirect consequence of a cyber-attack on a partner's supply chain.
Cyber Risk	Other Cyber Attack- non specific	Chief Digital Officer	Head of IT Security and Configuration	2	3	6	6	Mitigate	Cyber Security - Other Cyber Attack- non specific

Cyber Risk	Out-dated Systems	Chief Digital Officer	Head of IT Security and Configuration	3	5	15	8	Mitigate	There is a risk that out-dated and unsupported software including databases will be susceptible to vulnerabilities that could be exploited by malicious actors, as well as malware targeting older systems. This could lead to loss of applications, loss of data and negative patient outcomes. Server 2012 going end of life in Oct 2023 will further increase this risk if all organisations fail to mitigate. Orgs could also face NIS notices and possible fines
Non-Cyber, Non Malicious	Out-dated Hardware Failure (Not power or cooling)	Chief Digital Officer	Head of IT Security and Configuration	3	3	9	6	Mitigate	There is a risk that physical hardware including server and network infrastructure will fail more often as it ages, increasing system outages and creating negative patient outcomes
Non-Cyber, Non Malicious	Physical Security	Chief Digital Officer	Head of IT Security and Configuration	3	4	12	6	Mitigate	There is risk that physical security controls that secure computers and data, are no longer fit for purpose due to age, maintenance or mis-configuration.
Non-Cyber, Non Malicious	Environmental & Power	Chief Digital Officer	Head of IT Security and Configuration	3	4	12	8	Mitigate	There is a risk that environmental control & Power systems are not sufficiently defended in order to prevent tampering by a malicious software or actor or from failure. This could lead to multiple systems over-heating and failing causing mass loss of data and key systems.
Cyber Risk	Artificial Inteligence	Chief Digital Officer	Head of IT Security and Configuration	2	3	6	6	Mitigate	There is a a risk that poor use of AI deploying incorrect code or being used to create complex cyber-attacks. NB Still trying to understand risk
Cyber Risk	Lack of ICS Cyber lead	Chief Digital Officer	Head of IT Security and Configuration	3	5	15	8	Mitigate	The ICS Cyber Lead has not yet been approved by the ICB and this post is now vacant after the current contractor has come to end of contract, without this post the ICS will be unable to actively manage the system wide risk and coordinate across the ICS to improve cyber security. This could lead to the ICB/ICS being unable to fulfil its obligations under NHS resulting in loss of reputation, fines and most importantly disruption to patient care.
Cyber Risk	Medical Equipment	Chief Digital Officer	Head of IT Security and Configuration	3	4	12	6	Mitigate	There is a risk that medical equipment, including diagnostics machines, are being introduced to the organisation is inherently insecure and susceptible to cyber-attack, due to out-dated software and poor configuration by the vendors, which could lead to system-wide compromise of key systems causing loss of patient treatment options and reputational damage. Update Path due to CE mark may not be in place
Cyber Risk	Staff Awareness and Training	Chief Digital Officer	Head of IT Security and Configuration	3	4	12	6	Mitigate	There is a risk that should the Trust not provide sufficient awareness and training on cyber risk and business continuity plans, then there is an increased potential of staff either causing a cyber incident unintentionally or not being prepared in the event of an attack.

10 Improvement plans for the next 12 months

The following table shares current focus and how this links in with the three acute trust and/or the ICS. Both local and national funding routes are used to strengthen our cyber protections.

Strong Password (Locally funded) Additional and updated client deployment to assist with enrolment of remaining staff into of SpecOps by end of March 2026 to ensure remaining staff with weak passwords are required to meet new guidelines. GWH, SFT and RUH are all using the same solution and work closely to align configuration.	
Multi Factor Authentication (Locally funded - Pending**)** Enhance existing and bring on-line new services. This key protection toolset ensures additional control is in place for approved access.	
Windows 11 – complete device replacement and specialist devices under ESU Secure by design desktop configuration. Improved automation capabilities to meet today's modern workforce. GWH and SFT are working closely to align configuration.	
Microsoft InTune (Toolset centrally funded – Implementation Locally funded) Implement MAM and Device Management. MAM enables secure application delivery for secure BYOD (bring your own device). GWH and SFT are working closely to align configuration.	
Privileged Access Management (Locally funded) Extend the use oof exiting toolsets to add additional controls for system admins. Active Directory security review will be part of this security improvement. GWH, SFT and RUH are all using the same solution and work closely to align configuration.	

Data Backup Cyber protection improvements (Locally funded) We are working with technology partners to further assess improvement to our data protection systems, processes and security. Working with ICS partners there may be opportunities to further align technology choices. GWH also in discussion with technology partners to support this area with investment required.	
Medical Equipment / Internet of Things (IoT) Management (Locally funded) Increase monitoring to ensure that patient benefits are available securely. GWH, SFT and RUH are all using the same solution and work closely to align configuration.	
Policy Updating / ICS Alignment The ICS technical design authority group are looking to harmonise and align policies, recognising local variation need. This ensures consistent standards across exist for al partner organisations and service users. GWH and SFT are working closely to align policies. ICS review following Softcat CiS8 survey for further alignment planned.	
Education – Digital Team Continuous staff awareness for Digital Team focusing on Business Continuity Plans, playbooks and service recovery. GWH and SFT are working closely to align in this area. GWH also in discussion with technology partners to support this area with investment required.	
Education – Service User Improved and continuous staff awareness to help service users understand. what they can do to help reduce risk as part of a rolling education plan. NHS England education material will be used as the primary source for this.	

Overall the aim is to undertake improvements to increase our posture over the next 12 months, while aligning tools, knowledge and configuration to enable easier pathway for BSW Group alignment for both and IT and Cyber perspective keeping a keen eye toward the Oracle EPR works. The picture below shares how this will improve