Bundle BSW Group Board 5 November 2026

4.2.3 Safer Staffing Review (Bi-annual)

Item 4.2.3.2 - Appendix A GWH 6 Monthly Safer Staffing Report October 2026
Item 4.2.3.3 - Appendix B RUH Safer Staffing six-month Review
Item 4.2.3.4 - Appendix C - SFT Annual Safer Staffing paper 2026

4.4.4 Equality & Diversity Annual Report

Item 4.4.4.2 - Appendix 1 - EDI Annual Report 2025-26 - Final

5.1 GWH Managing Director's Report - Care Organisation Committee Assurance Reports

5.1.1 - GWH QS Assurance Committee Report Sept-26
5.1.2 - GWH FP&I Assurance Committee Report Sept-26
5.1.3 - GWH People Culture Assurance Report Sept-26

5.2 SFT Managing Director's Report - Care Organisation Committee Assurance Reports

5.2.1 - Quality and Safety Escalation Report to COMC 22 September 2026
5.2.2 -
SFT Finance Performance Committee Highlight Report 23 Sep 2026 UPDATED
5.2.3 - 20261002 - PCC Assurance Report to COMC September 2026 Final

5.3 RUH Managing Director's Report - Care Organisation Committee Assurance Reports

5.3.1 - App 1 - Upward Report to COMC Q&SC September26
5.3.2 - App 2 - FPC Upward Report to COMC Oct 26 v1.2
5.3.3 - App 3 -
RUH People Culture Assurance Report September 2026 Updated Draft2.0

Report title	6 Monthly Safer Staffing	Agenda item	
Meeting	Quality & Safety Committee		
Date of meeting	21/10/2026		
Sponsor	Luisa Goddard- Chief Nursing Officer		
Prepared by	Ana Gardete- Deputy Chief Nursing Officer		
Approval Process: (where has this paper been reviewed and approved)	GWH Quality and Safety Committee (October 26)		

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

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

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

KEY RISKS / BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R9	Improving Staff Satisfaction
R2	Taking Our People With Us

KEY MESSAGES

Nursing Safer Staffing

🔴 ALERT

- **Maintaining planned staffing consistently remains challenging**. Between April and August 2026, 3,833 of 8,954 rostered day and night shifts (42%) were recorded as amber or red, meaning staffing was below planned levels (above the national 1:8 ratio) for either RNs and/or HCSWs. The dataset also includes additional staffing requirements for enhanced care, which contributes to the level of demand recorded. Shortfalls are particularly associated with high operational demand, short-notice absence and escalation.
- **The wider operational context continues to place pressure on the safer staffing position.** Sustained demand can at times exceed available workforce and bed capacity, with pressures in patient flow further reducing operational flexibility. The combined impact of demand, capacity and staffing pressures increases workforce risk and the challenge of consistently maintaining safe, high-

quality care, particularly during periods of escalation. These pressures require continued oversight alongside workforce and quality indicators.

- **The current CHPPD position requires continued scrutiny.** Validation identified that some occupied bed days had not been captured, resulting in previously reported CHPPD being overstated. Following correction, September CHPPD was 8.8. Further work is required to account for different service configurations, for example SAU, where the HealthRoster establishment covers both inpatient and assessment activity while CHPPD reflects inpatient beds only. CHPPD should also be considered alongside operational demand, patient flow, occupancy, acuity and dependency, as these factors influence staffing deployment and interpretation of the metric. Ongoing validation and monitoring will continue as part of the wider assessment of staffing requirements.
- **ED remains an area of staffing risk.** The SNCT model indicated a lower quantitative requirement, particularly overnight, but professional judgement identified factors not fully captured by the tool, including overcrowding, prolonged stays, the department's footprint and the separate Children's Emergency Unit. During the collection period, an average of 17 patients per shift had remained in ED for more than 12 hours.

🟠 ADVISE

- SNCT is one component of the Trust's approach to establishment setting. The February and June collections show variation both between collection periods and between calculated and funded establishments. Small and specialist wards and services where funded establishments cover activity outside the inpatient SNCT scope require particular interpretation. The forthcoming establishment reviews will therefore triangulate SNCT with acuity/dependency, quality and workforce indicators, professional judgement and service requirements.
- All inpatient wards are funded to support a **minimum 1:8 RN-to-patient staffing assumption**. Actual ratios can temporarily exceed this during short-notice absence or operational escalation, which is managed through established escalation arrangements. Establishment reviews will also consider RN/HCSW skill mix, including movement towards 60:40 where clinically appropriate, particularly in surgical services, while recognising the requirements of high-acuity and specialist areas.
- Recruitment and retention provide a comparatively positive workforce position. Overall ward RN vacancies are close to zero. Nursing turnover remains below 8%, below the Trust target, and Band 5 RN leavers have reduced to 3.60 WTE per month. HCSW recruitment also continues to be successful.

🟢 ASSURE

- Planned versus actual staffing fill rates remained above the report's 89% benchmark across the reporting period, although monthly variation remains. RN fill ranged from 90.4% to 94.3%, and HCSW fill from 95.3% to 106.2%. Recent fill rates have fluctuated and are lower than the six-month average.
- Staffing risk is actively overseen through three-times-daily safe staffing meetings, chaired by a Divisional Director of Nursing or deputy, supporting real-time review, escalation, mitigation and redeployment. This is underpinned by the Trust-wide Safer Staffing Policy.
- Monthly Nursing, Midwifery and AHP Workforce Group oversight and reporting to Quality and Safety Committee provide governance of workforce metrics, staffing performance and areas of concern. Annual Chief Nurse-led establishment reviews will further assess funded establishments and skill mix using SNCT, workforce and quality indicators and professional judgement.

Allied Health Professionals

🔴 ALERT

- Workforce pressure remains concentrated in specific professions. Therapies continue to carry the largest vacancy burden, approximately 24–27 WTE and close to 15% during February–June. Imaging remains affected by national supply constraints, particularly sonography, and continues to require

agency staffing to maintain safe service delivery. Smaller AHP services are also vulnerable to the impact of individual vacancies or absences.

- There is currently no single nationally mandated safe-staffing ratio covering the full range of AHP services, and there remain gaps in demand, capacity and quality information. This limits the level of assurance that can be derived from workforce numbers alone.

🟠 ADVISE

- The overall AHP workforce is broadly stable at 387.3 WTE, comprising 75.4% qualified and 24.6% non-qualified staff. Overall turnover has reduced to 11.85 % (17.92% in 2025), including a reduction of more than 40% in voluntary turnover, although turnover remains above the 9% benchmark used in the report.
- AHP workforce planning is increasingly being strengthened through profession-specific capacity and demand modelling, job planning and NHS England-supported optioneering. These need to mature further before the organisation can consistently demonstrate the relationship between establishment, demand, workforce capacity and patient outcomes across all professions.

🟢 ASSURE

- All relevant AHP groups have completed NHS England-supported optioneering and are developing longer-term workforce plans addressing profession-specific recruitment, retention, education, skill mix and workforce transformation. Capacity-and-demand tools are already in place for imaging and podiatric surgery, with further development underway for therapies, SLT and orthoptics; job planning is targeted for completion by April 2027.

RECOMMENDATION

The Committee is asked to:

- Receive the six-monthly Safer Staffing Report.
- Note the areas of ongoing workforce risk and improvement identified.
- Note the arrangements in place to monitor, escalate and mitigate safer staffing risks.
- Note the planned work to further strengthen nursing and AHP workforce assurance.

APPENDICES

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

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 May 2026.

The report covers:

- Safe staffing related to Nursing
- 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.

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

Table 1- NQB: Safe, Sustainable and Productive Staffing

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

The safer staffing position should be considered within the wider operational context, with sustained demand and capacity pressures continuing to affect patient flow, bed availability and workforce deployment. These factors can increase staffing requirements and reduce flexibility to respond to short-notice pressures and are therefore important considerations when assessing workforce sufficiency and associated risk.

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 89% 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.

	Safer Staffing – average fill rate RN (%)	Safer Staffing – average fill rate HCA (%)
April 26	92.9%	106.2%
May 26	93%	103.6%
June 26	94.1%	100.4%
July 26	94.3%	96.4%
Aug 26	90.4%	95.3%
Sept 26	92%	102.1%

Table 2- Trust wide Fill Rates

2.2 Care Hours Per Patient Day (CHPPD)

Trusts are required to report on care hours per patient day. This metric provides a single comparable metric for recording and reporting nursing and care staff deployment. It's a simple calculation which divides the number of actual nursing/midwifery (registered and non-registered) hours available on the ward per day, by the number of patients on the ward at midnight. It represents the average number of hours that are nominally available to each patient that day.

Within Model Hospital, comparisons can be made at both ward and Trust level, however, these should be interpreted with caution as the specific configuration of services within an organisation significantly influences the level of staffing required.

CHPPD required to deliver safe care can vary in response to local factors such as ward layout and the acuity, dependency, and care needs of the patient group. As a result, higher CHPPD levels may be entirely appropriate and reflect assessed patient need. Conversely, lower CHPPD levels may indicate organisational inefficiencies, or alternatively reflect innovative staffing models or redesigned patient pathways. CHPPD, as a tool, is currently being reviewed nationally.

The latest Model Hospital data (July 2026) places the Trust in Quartile 3 for both registered and unregistered nursing and midwifery staffing. Total nursing and midwifery CHPPD is reported at 9.7, compared with a peer median of 9.3. For registered nursing and midwifery staff, the Trust reports CHPPD of 5.3 (Quartile 3), broadly comparable with RUH at 5.4 (Quartile 3). Comparable SFT data is not currently available within Model Hospital.

Following concerns regarding the accuracy of CHPPD reporting, including the impact of ward relocations associated with lifecycle works, a validation exercise was undertaken using Power BI (analytics platform). This identified that some occupied bed days had not been captured within the calculation, resulting in previously reported CHPPD being overstated. Further work is also required to ensure CHPPD accurately reflects different service configurations. For example, SAU's HealthRoster establishment supports both inpatient and assessment activity, whereas the CHPPD calculation captures inpatient beds only. This creates a potential mismatch between the staffing resource included and the patient activity against which it is measured. Validation and monitoring will continue to ensure the data provides an accurate basis for benchmarking and workforce oversight. Following the validation exercise the Trust reported 8.8 CHPPD for September 2026.

CHPPD should also be considered alongside operational demand and capacity, as changes in patient flow, occupancy and service configuration can influence both staffing deployment and the interpretation of the metric.

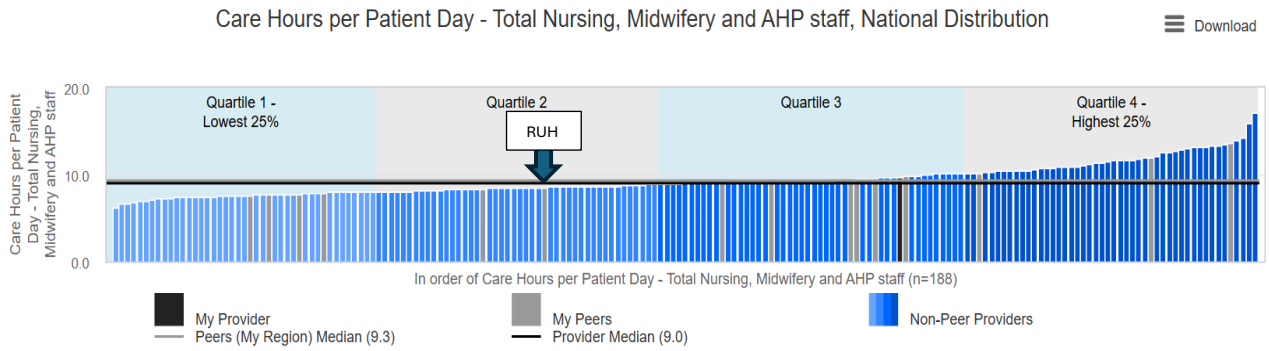


Figure 1- CHPPD for total Nursing and Midwifery staff

In addition, July 2026 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 provides useful national benchmarking of the overall workforce position but does not, in isolation, demonstrate staffing sufficiency at ward level. Triangulation with quality indicators, patient acuity and dependency, workforce deployment and professional judgement remains essential to determine whether establishments continue to meet patient and service requirements safely and effectively.

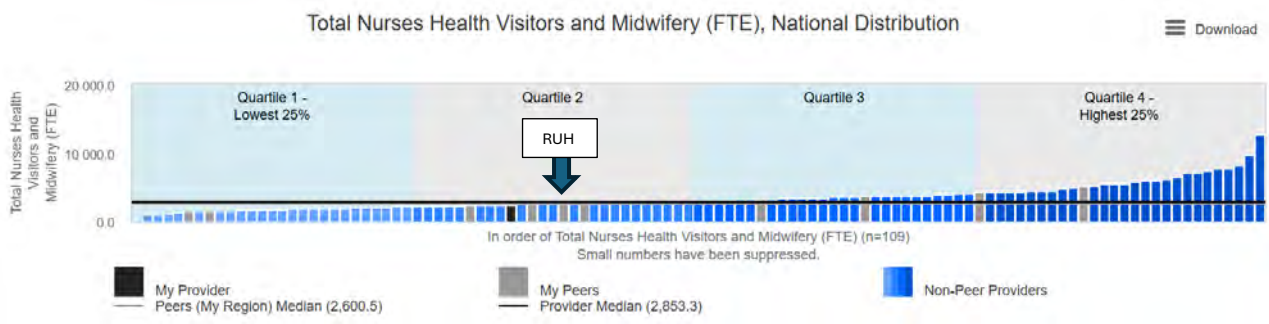


Figure 2- Total Nursing and Midwifery FTE

2.3 Safer Nursing Care Tool

The Safer Nursing Care Tool (SNCT) is the only nationally approved evidence-based tool that enables the evaluation of nurse staffing establishments against patient acuity and dependency. National guidance recommended that it is carried out a minimum of twice per year, for a period of 30 days each time, data capture is limited to ward leaders and deputies and these staff had training provided by NHSE colleagues to ensure good quality of data.

The outcomes from the June data collection are summarised in the table below and compared to February's. Findings have been triangulated with quality outcomes, workforce metrics, and professional judgement, and will inform the next cycle of establishment reviews.

Data collection periods have been aligned with RUH and SFT to enable more consistent benchmarking, with a third round of data collection planned for November 2026.

Ward	Feb RN	Feb HCSW	Feb Total	Trend	June RN	June HCSW	June Total	Funded RN	Funded HCSW	Funded Total	June vs Funded
ACU	10.63	7.09	**17.72**	▲	11.82	7.88	**19.70**	21.51	10.75	**32.26**	-12.56
Falcon	17.34	14.19	**31.53**	▼	15.58	12.75	**28.33**	21.51	16.13	**37.64**	-9.31
Jupiter	38.75	35.77	**74.51**	▼	38.23	35.29	**73.52**	34.95	32.25	**67.20**	+6.32
Kingfisher	38.86	31.79	**70.65**	▼	33.22	27.18	**60.41**	33.26	30.72	**63.98**	-3.57
Linnet	34.38	22.92	**57.30**	▲	36.02	24.01	**60.04**	40.31	29.57	**68.88**	-8.84
Mercury	29.69	27.40	**57.09**	▼	26.81	24.75	**51.56**	34.95	26.88	**61.83**	-10.27
Neptune	33.05	22.04	**55.09**	▲	39.44	26.30	**65.74**	44.02	26.88	**70.90**	-5.16
Saturn	39.02	31.93	**70.94**	▼	38.21	31.26	**69.47**	32.63	31.61	**64.24**	+5.23
Teal	37.89	34.98	**72.87**	▲	39.83	36.77	**76.60**	38.57	32.26	**70.83**	+5.77
Woodpecker	34.69	32.02	**66.71**	▲	37.01	34.16	**71.17**	34.95	32.25	**67.20**	+3.97
Beech	15.06	12.32	**27.37**	▼	14.57	11.92	**26.49**	18.81	18.82	**37.63**	-11.14
Aldbourne	8.87	7.26	**16.13**	▲	11.33	9.27	**20.59**	14.59	12.67	**27.26**	-6.67
Ampney	17.22	14.09	**31.31**	▲	20.08	16.43	**36.51**	17.76	16.13	**33.89**	+2.62
Meldon	33.93	27.76	**61.69**	→	37.23	24.82	**62.06**	36.95	28.47	**65.42**	-3.36
SAU (Inpatient)	21.74	14.50	**36.24**	▼	21.24	14.16	**35.40**	40.10	17.81	**58.22**	-22.82
Trauma	48.86	39.98	**88.84**	▼	42.90	28.60	**71.51**	36.58	32.25	**68.83**	+2.68
Children's Unit*	28.20	9.40	**37.70**	N/A	N/A	N/A	N/A	36.81	12.17	**48.98**	June data unavailable

Table 3- SNCT February and June

A number of factors have been identified during the SNCT data collection periods which help explain the variation between calculated requirements and current funded establishments. Small and specialist areas, including Falcon, ACU and Aldbourne, present particular challenges in applying the SNCT methodology. Due to their size, patient pathways and specialist function, staffing requirements may be influenced by service-specific factors that are not fully reflected within the tool. The variation between the February and June collections at individual ward level further demonstrates the importance of considering SNCT as one component of establishment review rather than as a standalone measure.

There are also known differences between the scope of the SNCT calculation and the funded establishment for some services. For example, the funded establishments for SAU and Beech support both inpatient and assessment activity, whereas the SNCT collection captures inpatient activity only. The resulting variance therefore reflects, in part, differences in the activity and service model captured by the two measures, rather than a direct difference in staffing requirement.

Current ward establishments have been developed to support safe staffing and include a minimum registered nurse staffing assumption of 1:8. SNCT outputs therefore require interpretation alongside the wider clinical and operational context before conclusions are drawn regarding the appropriate establishment for individual areas.

The forthcoming establishment reviews will provide a more comprehensive assessment of workforce requirements, with a particular focus on skill mix and the balance between registered nurses and HCSWs. This will include consideration of greater alignment towards a 60:40 RN/HCSW skill mix, where clinically appropriate, particularly within surgical services, while recognising the requirements of higher-acuity and specialist areas. The objective will be to ensure that establishments reflect patient need, appropriate professional skill mix and the safe delivery of care.

The SNCT findings will therefore be triangulated with professional judgement, patient acuity and dependency, occupancy, quality and safety indicators, service configuration and operational requirements as part of the establishment review process. This approach ensures that the final establishment reflects the totality of each service's requirements rather than the SNCT calculation in isolation.

Emergency Department

The SNCT assessment demonstrated broad alignment between the current staffing shift pattern and the profile indicated by the tool, although the quantitative model suggested a considerably lower staffing requirement, particularly overnight. Professional judgement has therefore been applied in interpreting the results, recognising that the model does not fully reflect the complexity associated with the current operating environment in ED, which has been a theme nationally.

Key considerations include the department’s geographical footprint and separate Children’s Emergency Unit; the ongoing impact of overcrowding and prolonged patient stays; the additional nursing care required for patients remaining in ED for over 12 hours; and nurse-to-patient ratios which can exceed national workforce standards during periods of high demand and constrained flow. During the data collection period, an average of 17 patients per shift had been in ED for more than 12 hours, with some patients remaining for over 24 hours.

Overall, the quantitative SNCT findings do not currently support a reduction in staffing when considered alongside professional judgement and the operational context. Maintaining an

appropriate workforce is required to support safe, high-quality care and minimise the risk of harm. As flow, occupancy and length of stay improve, the SNCT findings should be reassessed to determine whether the model becomes more representative of the underlying workforce requirement.

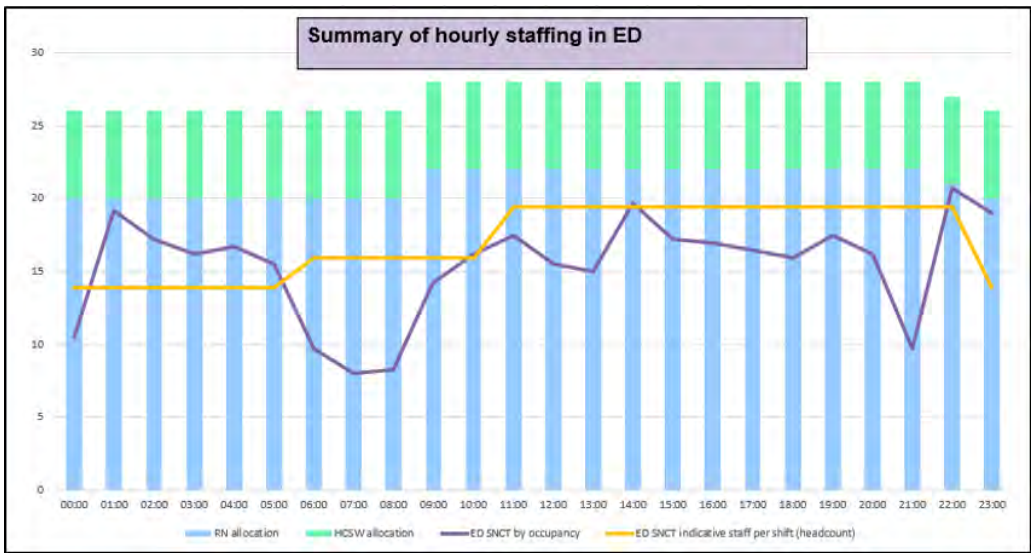


Figure 3 – SNCT hourly staffing in ED

Hour of day	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00
RN allocation	20	20	20	20	20	20	20	20	20	22	22	22	22	22	22	22	22	22	22	22	22	22	21	20
HCSW allocation	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
ED SNCT by occupancy	10	19	17	16	17	15	10	8	8	14	16	17	15	15	20	17	17	16	16	17	16	10	21	19
ED SNCT indicative staff per shift (headcount)	14	14	14	14	14	14	16	16	16	16	16	19	19	19	19	19	19	19	19	19	19	19	19	14

Table 4- Suggested staffing requirement per hour

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.

All inpatient wards are funded and routinely staffed in line with national standards, supporting delivery of care at a 1:8 nurse-to-patient ratio. Chief Nurse–led establishment reviews provide assurance that funded and deployed staffing supports delivery at this level.

On occasion, particularly during periods of short-notice unplanned absence or operational escalation, actual staffing ratios may temporarily exceed this level; these instances are managed through established escalation and mitigation processes.

A snapshot review covering the period April 2026 to August 2026 shows that, of 8,954 rostered day and night shifts, 3,833 shifts (42%) were recorded as operating at amber or red staffing levels (Figure 4 and Table 5). This indicates that on four in every ten shifts, wards were not staffed to the planned level, either due to shortfalls in registered nurses and/or healthcare support workers. It is recognised that this dataset also includes additional shift requirements associated with enhanced care, which contributes to the overall level of staffing demand reflected in these figures.

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. 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.

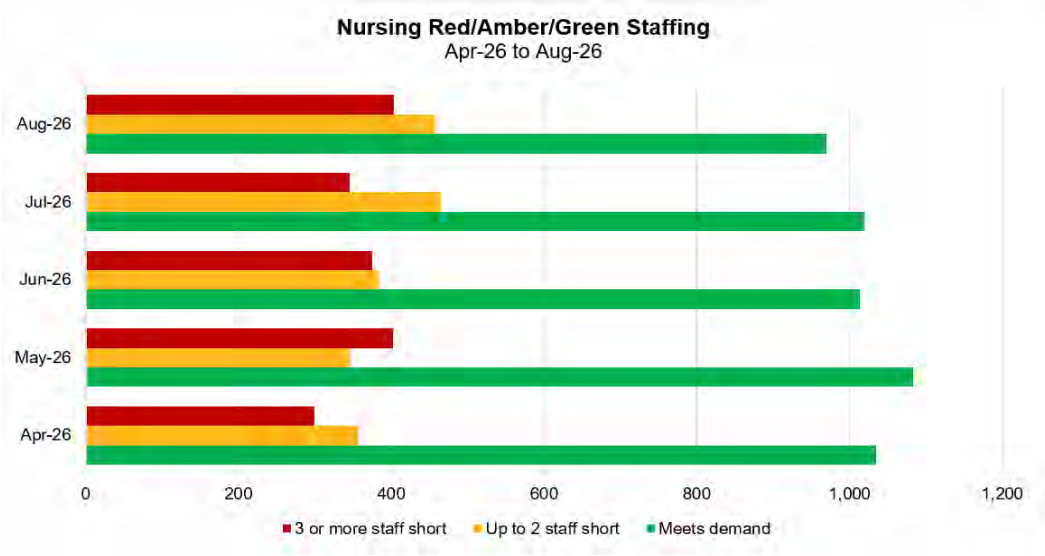


Figure 4- All Nursing shifts (Red, Amber, Green staffing)

Month	Meets demand	Up to 2 staff short	3 or more staff short
Apr-26	1,035	356	299
May-26	1,083	346	402
Jun-26	1,014	383	375

Jul-26	1,019	465	346
Aug-26	970	458	403
Grand Total	5,121	2,008	1,825

Table 5- Breakdown of number of shifts

3.0 Right Skills

3.1 Recruitment and Retention

3.1.1 Vacancies and turnover for Nurses and HCSWs

Achievement in registered nurse recruitment has been largely sustained, with an overall position close to zero vacancies across the wards. This reflects a mixed position, with some areas continuing to hold vacancies while others are currently over-recruited. Nursing turnover remains below 8%, which is lower than the Trust target. It should be noted that reported figures do not currently adjust for staff on maternity leave, which can influence the apparent vacancy position. The average leaver rate for Band 5 registered nurses has reduced to 3.60 WTE per month (previously 3.7 WTE in April 2026, 4.5 WTE in October 2025 and 6.09 WTE in early 2025).

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 educational days alongside registered nurses, which reiterates our organisational commitment to staff. 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	1,877	118	6.29%	92	4.90%
Unregistered Nursing and Midwifery	891	82	9.20%	65	7.30%
Trust Total	5,142	461	8.97%	332	6.46%

Table 6- Turnover

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. The areas currently experiencing the highest vacancy levels are Anaesthetics and the

Emergency Department, and these remain a particular focus for workforce oversight and targeted recruitment activity. 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 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. 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 Trust's Advanced Practice workforce continues to develop, with 73 trainee, advanced and consultant practitioners across the organisation. There are currently 15 active trainees, including one new trainee commencing training. Since the last reporting period, three trainees have completed their programmes, bringing the total number qualifying as Advanced Practitioners during 2026 to 10. This provides a continued pipeline into the qualified workforce and supports longer-term workforce sustainability. However, Allied Health Professionals remain slightly underrepresented within Advanced Practice, and increasing multi-professional participation remains an area for further development.

Good progress has been made against the 2026/27 Advanced Practice strategic objectives, particularly in strengthening governance and establishing clearer and more consistent role structures. The quarterly Advanced Practice Oversight Group has been established and the Trust-wide Advanced Practice Policy published on Eolas. Standardised job descriptions for Trainee, Qualified, Lead and Consultant Practitioner roles are progressing through job evaluation, alongside development of Divisional Advanced Practice Lead, Developing/Trainee Consultant Practitioner and Credentialed Advanced Practitioner roles. Together, these developments aim to provide clearer career progression, improve consistency across services and strengthen succession planning.

Education, capability and supervision remain key priorities. A Trust-wide digital Advanced Practice e-portfolio has been developed to provide a consistent framework for supervision, appraisal, credentialing and assessment against the four pillars of Advanced Practice, with implementation planned during 2026/27. Most Advanced Practitioners have access to clinical supervision; however, sustainable supervisory capacity remains a challenge in some areas, particularly given competing demands on consultant colleagues. Succession planning also requires further development in services where senior Advanced Practitioners are

approaching retirement. Planned job planning activity will support greater visibility of these workforce risks and future requirements.

The next phase of development will increasingly focus on demonstrating the impact and value of Advanced Practice. Work is progressing to establish outcome measures linked to patient outcomes, quality and service performance, alongside increasing Advanced Practitioner-led quality improvement, audit and research. The Advanced Practice community continues to develop through regular professional forums and collaborative learning, with plans for a dedicated research forum and further engagement activity. This builds on the strategic objective to embed evaluation and research as core Advanced Practice functions and link Advanced Practice outcomes with service and quality measures.

Further service development is also being explored. Advanced Practitioners are planned within the Frailty Same Day Emergency Care pathway, with potential expansion being considered in Stroke, Gastroenterology, Haematology and Gynaecology. These developments provide opportunities to align Advanced Practice more closely with service redesign, workforce requirements and areas of increasing clinical demand.

4.0 Right Place and Time

4.1 Safe staffing process

Effective deployment is increasingly important during periods of high operational demand, when available workforce, patient acuity, bed capacity and flow pressures need to be considered together.

The Trust continues to hold safe staffing meetings three times a day, chaired by a Divisional Director of Nursing or deputy. These meetings provide real-time oversight of staffing pressures, enabling timely escalation, mitigation and effective deployment of staff to maintain safe care.

Governance arrangements have been further strengthened through the finalisation and publication of the Trust-wide Safer Staffing Policy on Eolas, providing a consistent framework for the oversight, escalation and management of safer staffing across GWH.

The monthly Nursing, Midwifery and AHP Workforce Group provides oversight of key workforce metrics, including roster performance, vacancies, turnover and recruitment and retention plans. This is complemented by monthly reporting to the Quality and Safety Committee, providing oversight of staffing performance, fill rates and areas of concern.

The annual Chief Nurse-led ward establishment reviews have been scheduled and will provide a further opportunity to assess the appropriateness of funded nursing establishments. This year's reviews will have a particular focus on skill mix, informed by the findings from the Trust's Safer Nursing Care Tool (SNCT) data collections. The reviews will triangulate SNCT findings with workforce and quality indicators, professional judgement and

local service requirements to determine whether establishments and skill mix continue to meet patient acuity, dependency and service needs.

Together, these arrangements provide a clear ward-to-Board line of sight, supporting ongoing assurance that staffing requirements and associated risks are understood, reviewed and appropriately escalated.

5. Allied Health Professionals

5.1 Workforce Overview

Allied Health Professionals (AHPs) are predominantly degree-qualified, professionally autonomous practitioners who provide essential services across assessment, diagnosis, treatment, rehabilitation and discharge. AHPs are the third-largest clinical workforce in health and care nationally and are central to delivering the ambitions of the NHS Long Term Workforce Plan and the *AHPs Deliver* strategy for England. These strategies emphasise workforce growth, retention, education, innovation, integrated care and the development of enhanced and advanced practice roles.

Great Western Hospitals NHS Foundation Trust currently employs 439 AHP staff, equivalent to 387.3 whole-time equivalent staff. Over the past six months, the workforce has remained broadly stable, with a marginal reduction in headcount of 1.1% and a reduction in WTE of 0.3%. GWH hosts nine of the 14 recognised AHP professions:

- Dietitians
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Podiatrists
- Radiographers
- Speech and language therapists

The current workforce comprises 291.9 qualified WTE and 95.4 non-qualified WTE. Qualified staff therefore account for 75.4% of AHP workforce capacity, with non-qualified staff accounting for 24.6%. This represents approximately 3.1 qualified staff for every one non-qualified member of staff.

Non-qualified staffing has grown more quickly than qualified staffing during the past year:

- Qualified headcount increased by 2.4%, from 327 to 335.
- Non-qualified headcount increased by 6.1%, from 98 to 104.

Measure	Qualified	Non-qualified	Ratio
Headcount	335	104	3.22 : 1
FTE	291.91	95.36	3.06 : 1

Table 7- AHP Workforce Skill Mix – Qualified and Non-Qualified Staff

This indicates a gradual broadening of the AHP support workforce. However, the overall skill mix remains stable at approximately 75% qualified and 25% non-qualified staff. Further work is required to ensure that support workforce growth is aligned with competency frameworks, appropriate supervision, career pathways and service need.

Family and Specialist Services represents a significant proportion of the AHP workforce. Imaging, including diagnostic radiography, sonography and mammography, is also a major component of the workforce. Medicine is the only division to have demonstrated workforce growth during the past six months, primarily reflecting ongoing workforce development and investment within imaging.

Some AHPs are employed in roles outside traditional profession-specific services, including leadership, patient safety and urgent treatment centre roles. ESR reporting may therefore include HCPC-registered AHPs employed in non-traditional posts, which should be recognised when interpreting workforce figures. This issue has previously been identified in internal workforce reporting.

5.2 Workforce Diversity

The AHP workforce comprises 439 staff and demonstrates increasing ethnic diversity. White staff remain the largest ethnic group, representing 69% of the workforce, while more than a quarter of staff identify as belonging to an ethnic minority group.

Workforce growth during the past 12 months has been strongest among Black and Asian staff groups, while the White workforce has remained broadly stable. The reduction in the proportion of records categorised as “undefined” suggests improvement in workforce data quality.

Overall, these trends support the Trust’s ambitions for inclusive recruitment and a workforce that is more representative of the communities it serves. However, proportional representation should continue to be reviewed by profession and band because an overall improvement may mask underrepresentation at senior levels or within individual services.

The workforce remains predominantly female. Women represent 76.1% of headcount and 74.2% of WTE. During the past 12 months, male headcount increased by 8.3%, compared with 1.1% growth among female staff.

This suggests a gradual movement towards a more balanced gender profile. Together with increasing ethnic diversity, the data indicates that recent workforce growth has been concentrated among groups that have historically been underrepresented in some AHP professions.

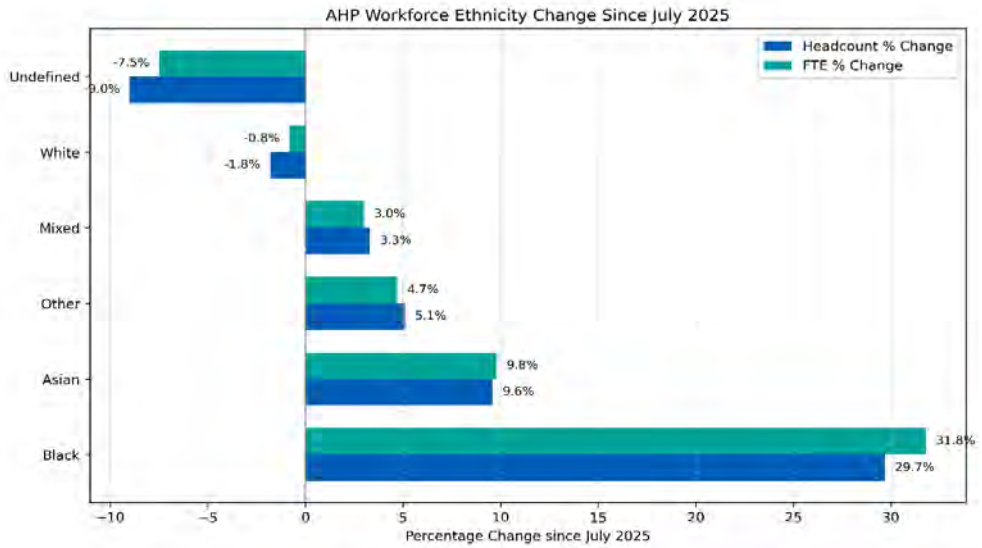


Figure 5- AHP workforce ethnicity

5.3 Workforce Supply

Overall AHP turnover has reduced during the past 12 months, with voluntary turnover falling by more than 40%. This is a positive indication of improved workforce stability. However, turnover remains above the 9% benchmark currently used within this report and should therefore continue to be monitored.

The reduction may reflect a combination of local retention activity and changes in the external AHP labour market. While graduate supply has improved in some professions, the availability of experienced staff remains constrained. It would therefore be premature to assume that reduced turnover reflects a sustained improvement across all professions and bands.

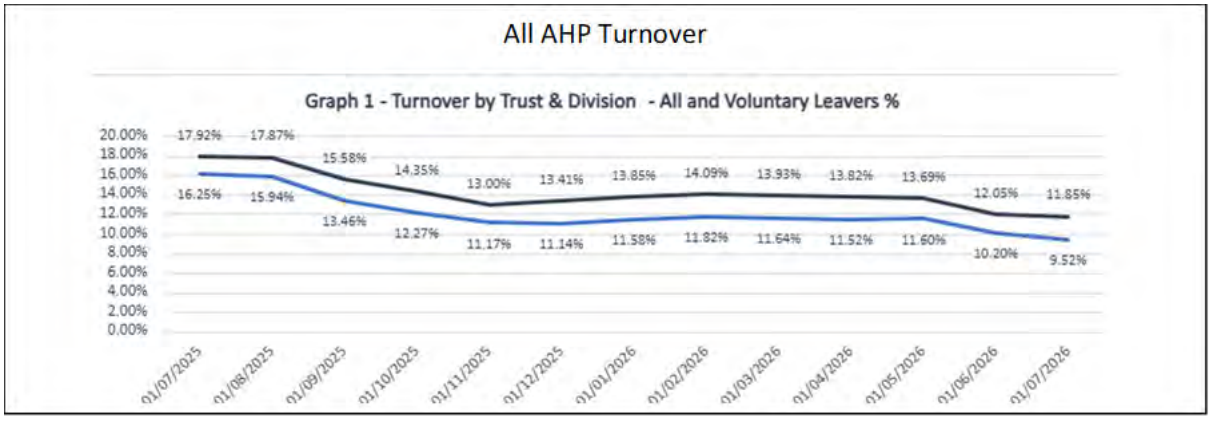


Figure 6- AHP turnover

5.3.1 Therapies

Therapies have demonstrated a significant improvement in retention. Total turnover reduced from 26.4% to 14.3%, while voluntary turnover reduced from 25.7% to 11.7%.

Although turnover remains slightly above the overall AHP average, the gap has narrowed substantially. This suggests that local retention interventions, recruit-to-turnover arrangements and improved external workforce supply may be having a positive impact.

Continued focus is required on senior workforce retention, career progression, workload, professional development and the implications of planned service change. The current position should also be triangulated with vacancy, sickness, staff experience and quality data.

5.3.2 Imaging

Imaging turnover has reduced steadily during the past 12 months and is now below the overall AHP position. Total turnover reduced from 12.7% to 7.9%, while voluntary turnover reduced from 11.6% to 6.9%.

This improvement follows a significant workforce reform programme developed in response to previous staff survey findings. The programme included review of capacity and demand, training requirements, workforce structure and skill mix. Changes to shift patterns were also introduced to reduce fatigue and improve workforce sustainability. Despite this progress, imaging continues to experience national workforce supply constraints, particularly within sonography. GWH, in common with other district general hospitals, remains reliant on agency staff to maintain safe service delivery.

The first two trainee sonographers are expected to qualify during 2026, with additional trainees already in post. The regional network has also funded a trainer post and additional scanning equipment. These investments should improve resilience, although benefits will be realised over several years rather than immediately.

5.3.3 Smaller AHP services

Turnover in dietetics, SLT and podiatry remains broadly stable. However, because these services have comparatively small establishments, the departure or absence of a small number of staff can have a disproportionate operational impact.

Current workforce datasets do not enable ODP and orthoptic turnover to be reported separately because staff are grouped within wider departmental budget codes. Recent workforce planning has improved stability within both services, and no immediate turnover concerns have been identified. Work should nevertheless continue to improve the granularity of ESR and workforce intelligence reporting.

All AHP services have completed NHS England-supported optioneering and are developing longer-term workforce plans. These plans concentrate on profession-specific recruitment, retention, education, skill mix and workforce transformation. The current optioneering report also identifies opportunities for newly qualified recruitment, apprenticeship pathways and support worker development.

5.4 Vacancies

Vacancies and workforce pressures are reviewed through regular AHP leadership meetings and one-to-one sessions. Between February and June 2026, vacancies remained high, fluctuating between 28.8 and 33.5 WTE. Vacancy rates remained within a relatively narrow range of 8.5% to 9.9%, indicating sustained recruitment pressure without significant deterioration during that period.

Workforce pressure is not uniform across all AHP professions.

- Therapies continue to carry the largest vacancy burden, with approximately 24 to 27 WTE vacancies and vacancy rates close to 15% between February and June 2026.
- AHP vacancy rates broadly reflect the therapies position because therapies represent a substantial proportion of the overall AHP workforce.
- Imaging remained comparatively stable, with vacancy rates generally between 5% and 8%, although the increase to 11.1% in July requires further monitoring.
- The extreme podiatry vacancy rate was affected by the removal of podiatric surgery and ESR establishment alignment. The revised position is believed to provide a more accurate representation of acute podiatry staffing.

Therapies have completed optioneering. Although workforce growth appears broadly consistent with predicted demand, the service reports that current capacity does not enable it to deliver the required quality consistently. A defined quality and productivity framework is therefore needed to evaluate workforce sufficiency against demand, patient outcomes, waiting times and unmet need.

Therapies had previously over-recruited to build winter resilience. Financial constraints created reluctance to continue proactive recruitment to anticipated turnover. This risk has been escalated, and further recruitment has been agreed. A significant proportion of current therapy vacancies relates to outpatient services and workforce uncertainty associated with planned service changes involving the local community provider. This remains an organisational risk.

Imaging faces additional risks from national supply constraints and increasing sickness absence. Temporary staffing may continue to be required to maintain safe service delivery. “Grow our own” activity remains focused particularly on sonography and diagnostic radiography. Following optioneering, the service is reviewing opportunities to introduce additional support roles and internal development pathways.

5.5 Workforce Safety and Effectiveness

There is no single nationally mandated safe-staffing ratio covering the full range of AHP services, although there is currently ongoing nationally work in relation to this. This limits direct comparison between workforce numbers, service quality and patient outcomes. To address this gap, AHP teams at GWH have been asked to develop capacity and demand tools. Tools are in place for imaging and podiatric surgery, with development continuing in SLT, therapies and orthoptics.

Job planning is also being implemented across AHP services, with completion targeted for April 2027. The approach will provide greater clarity on:

- Direct clinical care.
- Supporting professional activities.
- Education and supervision.
- Leadership and management.
- Quality improvement and research.
- Service capacity and unmet demand.

Feedback from leavers and career clinics indicates that some AHP staff have limited access to supporting professional activity time. This may constrain development, education, quality improvement, service innovation and wellbeing. Job planning and capacity modelling should therefore be used together. Job planning alone will describe how staff time is allocated, while demand, activity, quality and outcome data will be required to determine whether the establishment is sufficient**.**

5.6 Long Term Workforce Planning

NHS England-supported optioneering was completed in June 2026 for all relevant AHP groups. ODPs were considered through the nursing optioneering work associated with theatre utilisation.

The exercise identified increasing workforce pressures arising from population growth, demand from older people, workforce supply constraints, service configuration and limited education and placement capacity.

5.6.1 Projected workforce gaps by 2035

The modelling indicates potential shortfalls of:

- 25 WTE in sonography and radiography.
- 12 WTE in chiropody and podiatry.
- 5 WTE in dietetics.
- 5 WTE in speech and language therapy.

Occupational therapy and Physiotherapy supply appears sufficient within the current modelling. However, the service reports unmet demand and capacity constraints that may not be visible within the available data sets.

These projections should be described as planning estimates rather than confirmed future vacancies. They depend on assumptions about demand, service models, productivity, retention, education supply and population change.

5.6.2 Principal strategic risks

1. **Workforce sustainability:** recruitment pipelines alone are unlikely to meet future demand without improved retention and career development.
2. **Training and placement capacity:** workforce expansion may not be deliverable without sufficient educators, supervisors, placements and infrastructure.
3. **Infrastructure:** imaging workforce growth will not increase service capacity unless equipment and physical capacity grow alongside staffing.
4. **Retention:** career bottlenecks, sickness absence, temporary staffing dependency and external competition continue to affect stability.
5. **Data quality:** incomplete workforce, activity, demand and outcome data reduces confidence in long-term projections.
6. **Quality assurance:** limited capacity and demand modelling in acute therapies makes it difficult to determine whether staffing growth is sufficient to meet quality and demand.

5.6.3 Proposed Action Plan

Priority action	Intended outcome and measure	Lead	Target date	Assurance route
Develop a therapy quality, demand and capacity dashboard	Monthly reporting of demand, activity, waiting times, outcomes, unmet need, vacancies and productivity	Therapies Lead with Operational Analytics	May 2027	Divisional performance review
Agree service-level recruitment-to-turnover arrangements	Reduced vacancy lag and improved winter resilience, subject to affordability and quality impact assessment	Divisional Directors, Finance, HR and AHP Leads	December 2026	Workforce and finance governance
Establish an imaging workforce and temporary staffing trajectory	Quarterly reduction plan linked to trainee completion, sickness, vacancies and safe staffing requirements	Imaging Lead and Medicine Division	December 2027	Temporary Staffing Group
Complete job planning across all AHP services	100% of applicable staff with agreed job plans, including defined SPA allocation	AHP Leadership Team and Service Leads	April 2027	AHP Workforce Group
Complete capacity and demand tools for SLT and orthoptics	Profession-specific demand, capacity and risk assessment available for workforce planning	SLT and Orthoptic Leads	March 2027	AHP governance

Review sickness hotspots using validated data	Service-level improvement plans for areas above target, with occupational health and staff experience triangulation	Service Leads and HR Business Partners	Initial review by December 2026	Divisional people review
Protect mandatory training compliance	Maintain overall compliance above 90% and all categories above the Trust's 85% threshold	Service Leads	Monthly	Divisional governance
Produce profession-specific optioneering delivery plans	Agreed annual pipeline assumptions for graduates, apprentices, support workers, enhanced and advanced practice	AHP Workforce and Education Lead	January 2027	Strategic People and Culture Committee
Expand placement and educator capacity	Annual placement plan linked to educator capacity, equipment, supervision and workforce shortages	AHP Education Lead	March 2027	Education governance
Develop enhanced and advanced practice pathways	Governance-approved pathways in priority services, with role need, supervision, funding and succession arrangements	AHP Workforce Group and Clinical Leads	April 2027	Advanced Practice Governance
Improve workforce data granularity	Separate reporting for ODPs, orthoptics and small AHP professional groups where technically possible	Workforce Intelligence	March 2027	Workforce governance
Review seven-day and weekend workforce models	Costed options addressing service requirements, substantive establishment, bank reliance and quality impact	Therapies and Imaging Leads with Finance	February 2027	Divisional business planning
Monitor workforce equality by profession and band	Annual analysis of recruitment, progression, turnover and senior representation by protected characteristic	AHP Workforce Lead and EDI Team	March 2027	EDI and workforce governance
Report progress against projected 2035 gaps	Annual refresh of optioneering assumptions, workforce supply, attrition and training outputs	Associate Director of AHPs	Annual review from June 2027	Strategic People and Culture Committee

The focus on job planning, capacity and demand, career pathways, apprenticeships and targeted reduction of temporary staffing is consistent with the Trust's previous workforce action planning and the current optioneering work.

5.7 Review of Previous Actions

Previous action	Revised status
Implement imaging shift-pattern changes to reduce bank reliance	**Completed.** Benefits should continue to be monitored through bank expenditure, sickness, turnover and staff experience.
Embed recruit-to-turnover arrangements across therapies	**Partially completed.** Implemented for Band 5 roles, but continuation is affected by financial constraints. Further executive agreement is required for future recruitment cycles and Band 6 expansion.
Complete job planning for all AHP teams	**In progress.** Delayed because of issues with the regional form. A local process has been developed, with completion targeted for April 2027.
Expand apprenticeship routes and targeted workforce campaigns	**Delayed/at risk.** Progress has been affected by the vacancy in the AHP workforce and education leadership role. Profession-specific plans should be agreed through optioneering delivery.
Develop senior career progression opportunities	**In progress.** Enhanced and advanced roles should be prioritised according to service need, governance requirements, supervision capacity and workforce risk.

6. Conclusion

The six-month review provides reasonable assurance that established safer staffing governance arrangements are in place, with regular oversight from ward to Board and processes to identify, escalate and mitigate staffing pressures. The nursing workforce position has strengthened through sustained recruitment and improved retention, with RN vacancies close to zero overall and turnover remaining below the Trust target. Fill rates have remained above the expected benchmark throughout the reporting period.

However, the report also demonstrates that staffing pressures remain and assurance is not absolute. A significant proportion of shifts have operated below planned staffing levels, particularly during periods of increased demand, absence and operational escalation. These pressures continue to be actively managed through three-times-daily safer staffing oversight and escalation. The wider operational context remains challenging, with sustained demand at times exceeding available workforce and bed capacity. The interaction between demand, patient flow, capacity and staffing places additional pressure on the workforce and reduces operational resilience, particularly during periods of ongoing escalation. This increases the

risk to the consistent delivery of safe, high-quality care and reinforces the importance of maintaining close oversight of staffing alongside operational and quality indicators.

The February and June SNCT collections provide an updated evidence base for the forthcoming nursing establishment reviews. These reviews will consider establishment and skill mix through triangulation of SNCT findings with patient acuity and dependency, workforce and quality indicators, local service requirements and professional judgement. Current ward establishments support a minimum RN staffing assumption of 1:8, with the reviews also providing an opportunity to ensure the balance of registered and support staff remains appropriate to the needs of individual clinical areas.

CHPPD remains an area requiring continued improvement in data quality and interpretation. The validation work undertaken has corrected previously overstated reporting, with September CHPPD now reported at 8.8. Further work is required to address differences in service configuration and ensure the measure provides a reliable basis for ongoing benchmarking and workforce oversight.

For AHPs, the overall workforce remains broadly stable and retention has improved, but this position provides partial rather than full assurance. Persistent vacancies within therapies, specialist workforce constraints within imaging and limitations in capacity, demand and quality intelligence remain important areas for continued focus. Job planning, workforce optioneering and development of profession-specific capacity and demand approaches will strengthen the evidence available to assess workforce requirements and service capacity.

Royal United Hospitals Bath
NHS Foundation Trust

Safer Staffing Six-Month Review

Executive Summary

The purpose of this paper is to provide assurance to the Board of Directors by assessing nursing staffing levels and the associated challenges for nursing. This assessment covers the six-month period from April 2026 – September 2026 specifically reviewing nursing workforce levels within inpatient areas, including the Intensive Care Unit (ICU), Theatres, and the Emergency Department (ED).

Key headlines include:

- Nursing turnover remains low which contributes to safe staffing.
- Inpatient fill rate for both RN and HCSW have remained below the 90% fill rate particularly on day shifts.
- Nursing workforce sickness absence levels remain significantly above the 3% funded headroom, which is placing pressure on nursing fill rates and requires close monitoring.
- The Emergency Department and acute medical assessment areas continue to experience nursing vacancy; however, this is supported with a recruitment trajectory aiming to achieve full establishment by March 2027.
- Substantive recruitment to the Enhanced Care Team and Mental Health Lead Nurse has delivered notable benefits, including a significant reduction in bank and Registered Mental Health agency spend alongside, improved personalised care and support.
- The nursing safe staffing data in this report provides assurance to the Quality and Safety Committee that no specific safety themes linked to nursing staffing were identified between April and September 2026. However, maintaining consistently safe, high-quality care remains challenging in the context of current operational and workforce pressures, particularly, but not exclusively, within urgent and emergency care. Sustained demand can exceed available workforce and bed capacity, while patient flow pressures further limit operational flexibility. Together, these pressures increase workforce risk and make maintaining standards of care more difficult, especially during escalation. Continued oversight of workforce and quality indicators is therefore required.

1. Purpose of Paper

1.1. The purpose of this paper is to provide assurance to the Board of Directors by assessing nursing staffing levels and presenting an overview of the workforce and associated challenges at the Royal United Hospitals Bath. This assessment covers the six-month period from April 2026 to September 2026.

1.2. This is evaluated against compliance with the Developing Workforce Safeguards (NHSI, 2018). The DWS NHSE assessment took place in May 2026 (Appendix 1) shows full compliance with

eleven and partially compliant with one out of the twelve recommendations. This is due to be reassessed with NHSE in November 2026. Compliance is also evaluated against the National Quality Board (NQB 2016). The NQB self-assessment reported an improvement in compliance from 33 (June 2026) to 35 (Sept 2026) out of the thirty-seven recommendations.

1.3. This review builds on the standards set by the NQB and guidance from the National Institute for Health and Care Excellence (NICE, 2014).

1.4. This paper specifically reviews nursing workforce data from the mid-year reviews. The inpatient areas include Intensive Care Unit (ICU) and the Emergency Department (ED), during the period of April 2026 to September 2026.

1.5. The workforce requirements for safe Maternity services and the Neonatal Unit (NNU) have been reviewed separately, and the paper was reported to the Board of Directors in June 2026.

2. Nursing Staffing Overview

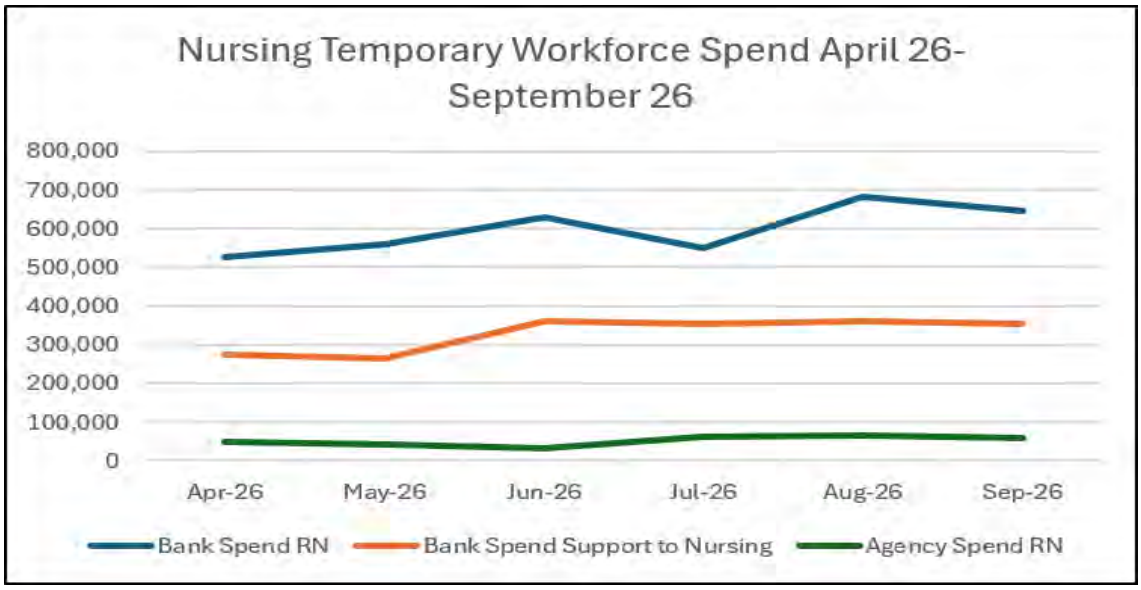
2.1. The planned skill mix review for Registered Nurses (RNs) and Health Care Support Workers (HCSWs) was completed in April 2026 and incorporated into the bi-annual establishment review. This work enabled roster templates to be realigned with the safe-staffing establishments agreed through the September 2025 safe-staffing review**,** strengthening roster efficiency and supporting the deployment of staff with the appropriate skills in the right place at the right time. The current annual establishment reviews are ongoing through October – November 2026 and will be reported in the next safer staffing paper in six months' time.

2.2. The Nursing workforce turnover rate remains consistently low, having successfully retained the nursing workforce and reduced vacancies. The requirement to open additional capacity due to operational pressure and high numbers of vacancies within the Emergency Department has seen the high-cost temporary staffing increase throughout the period of this report to ensure safe staffing levels were maintained (Graph 1).

2.3. The Emergency Department (ED) continues to make sustained progress in reducing its registered nurse (RN) vacancies in line with the planned recruitment trajectory and the implementation of an enhanced induction programme. Vacancies have reduced significantly from 22 WTE in April 2026 to 10 WTE in September 2026**,** demonstrating the impact of targeted recruitment and improved onboarding. An active ED recruitment plan remains in place, with dedicated support to ensure the remaining vacancies are filled, and the department moves toward a fully established nursing workforce.

2.4. The Nursing teams continue to prioritise efficient resource utilisation, balancing clinical risk, maintaining safe staffing levels, and ensuring financial sustainability. Agency Nurse expenditure has continued to increase during this period. There has been an increasing bank and agency spend from April 2026 due to meeting the demands of sustained increased sickness absence, operational pressures and escalation capacity whilst ensuring agreed safe staffing levels within our escalation and inpatient areas.

2.5. Graph 1 illustrates the increase in agency and bank nurse spend from April 2026.



Graph 1: Bank & Agency Nursing Spend April – September 2026.

2.6 The significant demand for Enhanced Care and Support has been addressed through the establishment of the specialist Enhanced Care Team, which includes a Lead Mental Health Nurse and a Lead Learning Disability & Autism Nurse, alongside additional Registered Mental Health Nurses (RMNs) and Mental Health Clinical Support Workers (MHCSWs)**.** The team is now well established, enabling a shift from reliance on bank and agency staffing to a predominantly highly trained substantive workforce, improving both continuity and quality of personalised care.

2.7 Further development of the Enhanced Care workstream is planned over the next 12 months, building on the success of the now established team. This work will align with the national and regional NHSE Enhanced Therapeutic Observations of Care (ETOC) programme, supporting the continued development of enhanced care practice across all Nursing, Midwifery and Allied Health Professional (AHP) teams**.**

2.8 All inpatient rosters have been reviewed against the agreed safe staffing establishments as part of the mid-year establishment review. This has strengthened effective rostering, with accurate roster templates which has enabled appropriate temporary staffing requests and accurate reporting in terms of fill rate and care hours per patient per day. Each Division has now embedded prospective and retrospective E-roster reviews. The Trust has been recognised within the top 10% of Trusts nationally for effective E-rostering, achieving level 4 attainment against NHSE E-rostering meaningful use standards.

2.9 Headroom is the percentage financial uplift applied when calculating inpatient establishments from band 2 HCSW to the band 6 Junior Sister/ Charge Nurse post. The Shelford Group recommends 22%, however the headroom at the RUH is 20%. (15.5% annual leave, 1.5% study leave and 3% sickness). 20% has been applied to all nursing inpatient establishments other than the Emergency Department (ED), ICU and the paediatric inpatient ward. The ED review includes 27% as recommended by the Royal College of Emergency Medicine, Intensive Care includes 24% as recommended within the Guidelines for Provision of Intensive Care Services (GPICS) and similarly the paediatric ward including the Paediatric Assessment Unit includes a headroom of 25% as per the Royal College of Nursing recommendation. This enables staff to undertake

considerable levels of training and clinical supervision to ensure they possess the right knowledge and skills to deliver care. Further work is planned during September and October 2026 with NHSE to review unavailability headroom, opportunities and workforce planning to meet current demand.

Between April and September 2026, a total of 11 escalations were reported from the RUH nursing and midwifery workforce through the Freedom to Speak Up (FTSU) process.

The main themes raised via FTSU, in descending order of prevalence, was staff well-being, inappropriate attitudes and behaviours, bullying and harassment, and patient safety. Key concerns centred on inappropriate and discriminatory behaviours, patient safety risks and pressures linked to service demand. These issues are being actively addressed within Divisions.

3 Nursing Staff Planned Versus Actual (Inpatient areas)

3.1 The Trust submits monthly staffing returns to the Department of Health via the NHS national staffing return system (Unify2). This submission outlines the Trust's overall position, comparing actual hours worked with expected hours across all inpatient areas. It includes percentage fill rates for RNs and HCSWs for both day and night shifts, as well as the overall Trust-wide fill rate. Additionally, the return includes data on Care Hours per Patient Day (CHpPD).

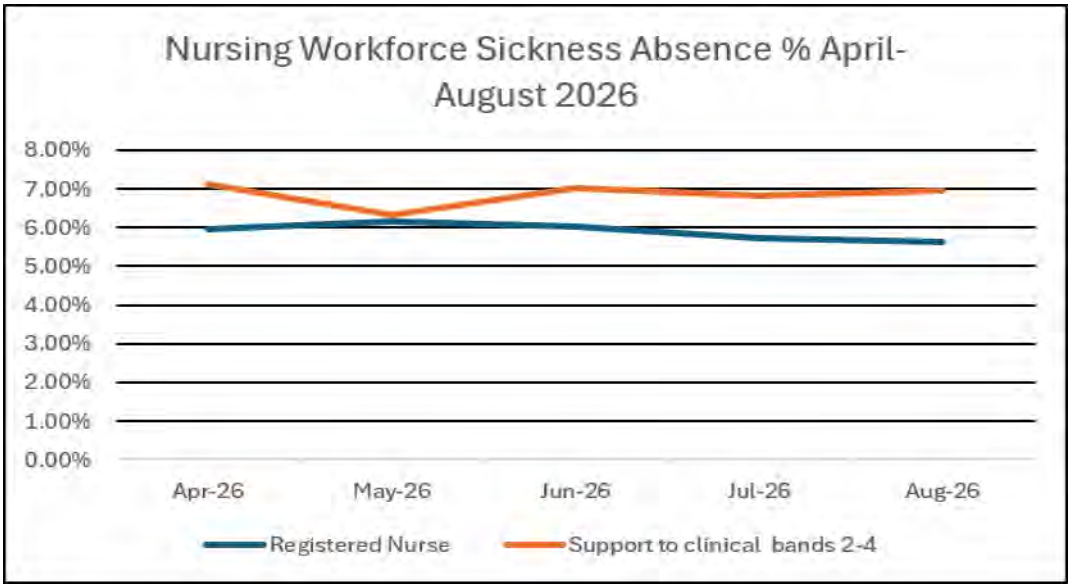
3.2 Inpatient fill rates for RNs and HCSWs have continued to decrease overall during the reporting period. It is anticipated that these rates will increase from November 2026, reflecting improvements in recruitment across nursing teams. Nonetheless, some fluctuations remain due to changes in operational activity and increased levels of sickness absence.

3.3 Table 1 demonstrates consistently night-time fill rates of greater than 91% for both RNs and HCSWs. The majority of HCSW night fill rates have exceeded 98%. Day shift fill rates have shown more variability with RN fill rates fluctuating between 78-86%, and HCSW fill rates ranging from 82-90%. The reduction in daytime fill rates correlate with the increased vacancy and sickness absence levels across the nursing workforce during this period, which has had a direct impact on overall fill rates.

Total Average	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sept-26
Total monthly actual staff Day hours- RN	83%	86%	83%	81%	78%	83%
Total monthly actual staff day hours- HCSW	90%	88%	87%	86%	82%	82%
Total monthly actual staff night hours- RN	93%	94%	93%	93%	91%	91%
Total monthly actual staff night hours -HCSW	98%	101%	99%	99%	98%	98%

Table 1: RN and HCSW fill rates April – September 2026

3.4 Increased sickness absence levels across the nursing workforce have impacted significantly on shift fill rates. The sickness rates for RN and HCSW remains significantly above the 3% funded headroom as reflected in Graph 2, this in turn impacts the fill rates across most wards. Sickness absence is being actively managed across the clinical divisions. Supporting attendance is a priority for line managers as per the Trust guidelines with a focus on staff health and wellbeing.



Graph 2: Nursing workforce sickness rates April - August 2026

3.5 Any variations or risks related to safe staffing is operationalised by a minimum of twice-daily staffing meetings, seven days a week, to review clinical acuity, patient dependency, staffing levels and skill mix. This supports a dynamic, risk-based approach to staff deployment, led by a Senior Nurse. Oversight of out-of-hours staffing is provided by Clinical Site Managers and Senior Patient Flow Leads.

3.6 CHpPD as recommended in the Carter Review (2015), is reported via the Model Health System dashboard. This provides a standardised method for NHS Trusts to benchmark their staffing levels and productivity.

3.7 Each month, the total hours worked during day and night shifts by RNs, Midwives, and HCSWs are calculated. Alongside this, the number of patients occupying beds at midnight is recorded daily, then added across the month and divided by the number of days to obtain a daily average for the month. The total hours worked are then divided by this daily average to calculate the CHpPD figure.

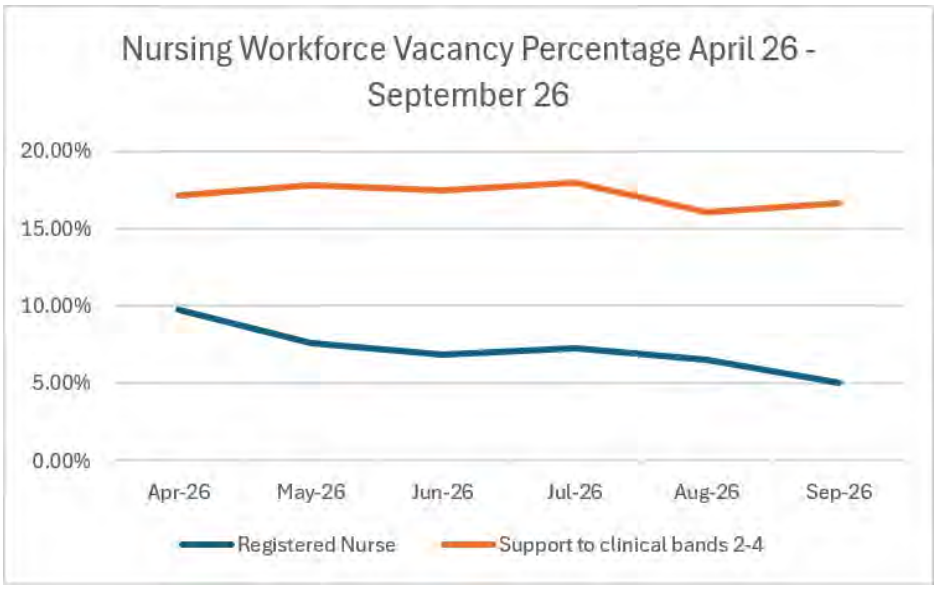
3.8 The Nursing workforce CHpPD is broadly in line with both the provider median and that of Trusts of a comparable size (Graph 3). The Trust is positioned in Quartile 2 with a CHpPD median of 8.6, which aligns with the peer median of 8.6.



Graph 3: CHpPD Total for Nursing and Midwifery Staff – National Distribution benchmarked against peer hospitals. (July 2026 latest Model Health System data)

4 Vacancy and Turnover

4.1 The sustained improvements in recruitment and retention have resulted in reduced levels of vacancies and turnover within these staff groups. Ongoing recruitment for HCSW and RN continues to be successful but requires close monitoring and regular engagement events with potential candidates. Graph 4 illustrates the low percentage of vacancies across RNs.



Graph 4: Vacancy Percentage Registered Nursing and Support to Clinical Band 2-4 April – September 2026

4.2 The above data has been validated with the live Divisional recruitment trackers. The hot spot within this current time period were vacancies for RNs within the Emergency and acute medicine areas (29 WTE). Active recruitment into these posts is ongoing, with the aim of reaching full establishment

by March 2027. The Trust have 38 Newly Qualified Nurses joining us between November 2026 and January 2027 which will continue to reduce our vacancy position.

4.3 As of September 2026, there were 35 WTE HCSW vacancies, a significant improvement from the 55 WTE vacancies in April 2026. Graph 4 reflects this reduction. A divisional targeted HCSW recruitment campaign was undertaken between May and June 2026, contributing to the improved position. Additional Trust wide recruitment campaigns are planned for November 2026.

4.4 In addition, focused work on HCSW retention and development has commenced through the HCSW RISE project (Recruit, Induct, Support and Educate). This programme aims to strengthen early employment experience, build professional identity, and establish clear long-term development pathways for the HCSW workforce.

4.5 There continues to be low levels of turnover, and rates remain relatively stable within the nursing workforce (Graph 5).



Graph 5: Registered Nursing/ Support to Clinical Turnover Percentage, April – September 2026

5 Nursing Staffing Incidents (including rostering red flags)

5.1 The 151 (132 same period 2025) incidents (Datix) across the time-period were reviewed by the appropriate line managers or senior nurses. The significant themes when reporting was lack of suitably trained staff, and low staffing levels due to sickness.

5.2 The Nurse in Charge raises a red flag within the staffing roster if, in their professional assessment, nursing staffing levels are insufficient to meet patient care needs. This action notifies the Matron, and the red flag must then be addressed or mitigated to close the escalation. Red flag reporting, as outlined in national safe staffing guidance, provides a consistent framework for reporting shortages in RN time or when patient acuity or dependency exceeds the agreed establishment levels.



Graph 6: Number of Nursing in-patient roster red flags, April – September 2026.

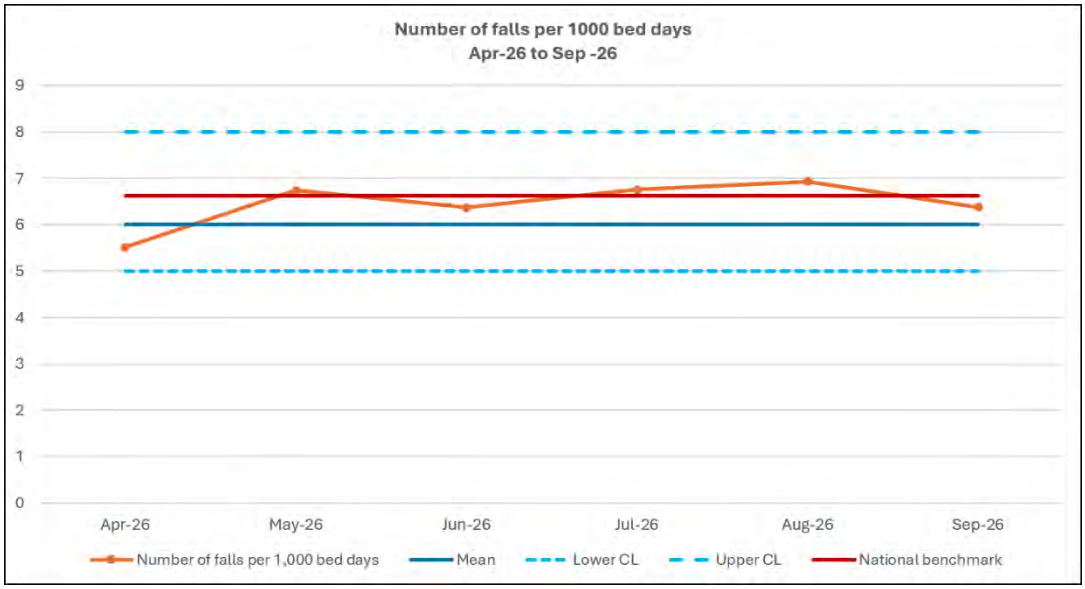
5.3 Red flag reporting has increased since July (Graph 6), rising by 45% compared with the same period in 2025.

The most common reason for red flag reporting was a 25% shortfall in RNs, followed by missed comfort rounds. Red flags continue to be monitored in real time and addressed through professional judgement at twice-daily safer staffing meetings led by a Senior Nurse. Monthly oversight is provided by the Nursing, Allied Health Professionals and Midwifery Workforce Group (NAMWG), chaired by the Chief Nursing Officer.

Over the past six months, education and promotion of the red flag system, supported by the revised Safe Staffing Standard Operating Procedure published in November 2025, have improved reporting accuracy.

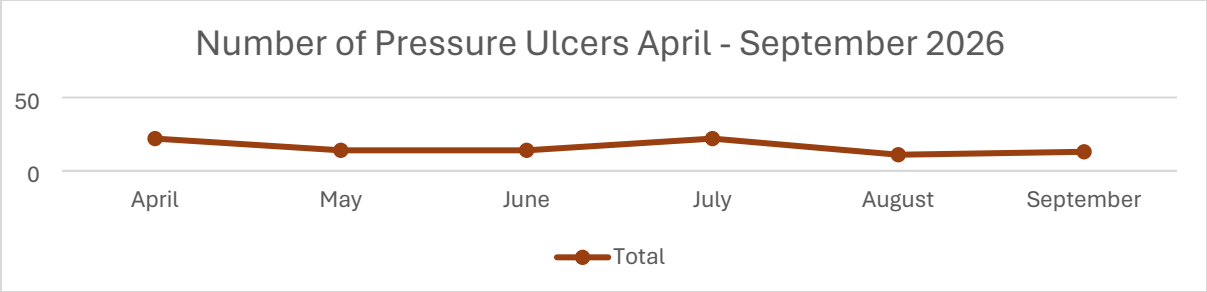
6 Performance against key quality metrics

The inpatient falls rate remained stable and was at or below the national benchmark for most of the reporting period (Graph 7). The Trust recorded 9% fewer falls than in the previous six months. The main contributing factors continue to be delirium and dementia, reflecting the complexity and vulnerability of these patients.



Graph 7: Number of falls per 1,000 bed days, April – September 2026

6.1 There were 96 pressure ulcers reported from April – September 2026 (Graph 8). Intensive Care Unit had the highest incidence at 24 cases. All pressure ulcers were investigated and identified learning was met with appropriate ongoing action plans. The key themes related to the incidents were multi-factorial with gaps in knowledge and increasing patient frailty, rather than safe staffing levels in isolation, as observed in the Intensive Care Unit, where staffing was aligned to the Guidelines for the Provision of Intensive Care Services (GPICS) staffing recommendations.



Graph 8: Number of pressure ulcers April - September 2026

7 Nursing Workforce Risks above 12 - Significant

7.1 There was one approved risk on the risk register for Nursing. The highest risk relates to nursing vacancies within the Medical division, which has an action plan with a focus on a recruitment trajectory to be realised by January 2027.

Risk ID	Division	Description	Residual Risk Score	Action Plan RAG
3329	Medicine	Nurse staffing shortages as a result of acute sickness and unfilled vacancy	12	Amber

Table 2: Risk register entries with a risk score > 12 relating to nursing.

8 Annual Staffing Review (ASR)

8.1 The next ASRs are being undertaken through September to November 2026 to inform the 2027/28 workforce plans. The key outcomes of this review will be included in the annual report on safe staffing to the Quality and Safety Committee in April 2027 and before submission to BSW Hospitals Group Board. A focused piece of work is underway to review timings of reports, establishment review and Safer Nursing Care Tool collections to align this across the three Trusts within the BSW group.

9 Conclusion

9.1 The nursing safe staffing data in this report provides assurance to the Quality and Safety Committee that no specific safety themes linked to nursing staffing were identified between April and September 2026. However, sustained demand can exceed available workforce and bed capacity, while patient flow pressures further limit operational flexibility. Together, these pressures increase workforce risk and make it more challenging to consistently maintain safe, high-quality care, particularly during escalation. Continued oversight of workforce and quality indicators is therefore required.

9.2 Increased sickness absence rates within the nursing workforce requires renewed focus to support the reduction in sickness absence and the associated nursing day and night shift fill rates.

9.3 The nursing workforce requires continued focus on recruitment into outstanding vacancies, supported by targeted retention, health and wellbeing initiatives. Ongoing monitoring will be essential to understand the impact of this work on nursing fill rates, population (patient and staff) safety and experience, with early identification of any emerging risks.

9.4 The establishment review has identified no further investment requirements during this review period in nursing establishments for Inpatient Wards, Paediatrics and the Emergency Department.

9.5 During the period of the report there continues to be ongoing improvement in supporting our patients requiring enhanced care, highlighting the substantial work being undertaken by our enhanced care team. Further work is planned to further develop the enhanced care workstream linked to the national and regional NHSE Enhanced Therapeutic Observations of Care (ETOC) programme over the next 12 months for all our nursing, midwifery and AHP teams.

9.6 There is no current correlation between quality metrics and safe-staffing levels during this reporting period. However, this will continue to be monitored closely, with particular attention to the triangulation of increased sickness absence levels and lower-than-planned nursing fill rates, given their potential to impact quality outcomes over time.

Appendix 1 NHSE Developing Workforce Safeguards Recommendations NHSE Compliance Report (July2025)

Royal United Hospitals Bath NHS FT (RUH Bath)

Below is the heat map for RUH Bath with details for their initial submission and how their compliance has been updated post initial meeting and following the six-month review.

Safer Staffing Topic	Compliance	Compliance After Initial Meeting	Compliance After 6 monthly Review Meeting	Comments
1.NQB guidance	Partial Compliance	Compliant	Compliant	
2.Triangulation	Compliant	Compliant	Compliant	
3.Evidence based tools utilisation	Compliant	Compliant	Compliant	The Trust are using SNCT
4. No tool manipulation	Compliant	Compliant	Compliant	
5. Monthly Actual Vs Planned staff reporting	Compliant	Compliant	Compliant	
6. Annual statement	Partial Compliance	Compliant	Compliant	
7. Workforce plan	Partial Compliance	Partial Compliance	Partial Compliance	The Trust are currently updating their workforce plan, will send once completed.
8. Bi-annual establishment reviews	Partial Compliance	Compliant	Compliant	
9. Quality dashboards	Compliant	Compliant	Compliant	
10. Quality Impact Assessments	Compliant	Compliant	Compliant	
11. Risk management & escalation	Partial Compliance	Compliant	Compliant	
12. Board awareness	Compliant	Compliant	Compliant	

The outcome of the 6-month review meeting shows that the Trust have become compliant in 11 domains.

Annual Nursing Safer Staffing Review

1. Purpose

1.1 This paper presents the outcomes of the 2026 annual review of nursing staffing establishments across inpatient wards, the Emergency Department and Intensive Care at Salisbury NHS Foundation Trust. Theatres, outpatient services and AHP roles are outside the scope of this review. Maternity, neonatal and newborn staffing is subject to separate assurance led by the Director of Midwifery.

1.2 The review provides ward-to-Board assurance that staffing decisions are evidence based, professionally led and financially responsible. It fulfils Expectations 1 and 2 of the National Quality Board requirements[1,2] and demonstrates ongoing compliance with Developing Workforce Safeguards[3], the Care Quality Commission quality statement on safe and effective staffing and Regulation 18, the Royal College of Nursing Workforce Standards 2021[4], NICE guidance[5] and relevant setting-specific requirements. Collectively, these frameworks support assurance that the right staff, with the right skills, are deployed in the right place and at the right time, with the Board fully sighted on staffing requirements.

1.3 The review triangulates validated Safer Nursing Care Tool outputs, Care Hours per Patient Day, planned and actual fill rates, nurse-to-patient ratios, quality and safety outcomes, workforce and finance indicators, e-rostering intelligence, benchmarking and professional judgement. The final paper will set out material changes since the previous review, residual risks, mitigations, financial implications and recommendations requiring approval.

1.4 The previous full establishment review was presented to the Board in November 2025. Its recommendations, summarised below, were deferred pending the NHS England South West review and subsequently approved through the budget-setting process following the March 2026 biannual safer staffing review. As implementation and recruitment were not complete, benefits realisation could not yet be assessed and will remain subject to ongoing monitoring.

WARD	BANDING and WTE	ROLE/SHIFT
Longford	B3 / 4.29 wte	To enable them to provide increased therapy – currently under providing hours of therapy (need 15 and getting 2/3) – currently 4 rehab assistants in post and within HCA establishment.
Emergency Dept	B5 / 1.3 wte	Need to increase speciality skills to recognise and respond to the ever-changing complexity of the paediatrics within a remote space in ED.
Emergency Dept	B3 / 2.73 wte	Occupancy and attendance within the department have increased over the past two years, changes have been made to the ED footprint to accommodate these additional patients, but the workforce is challenged overnight as the HCA numbers drop by 2

		compared to the day shift. This results in a delay in transferring patients for CT scans, completing routine observations, and skin checks.
Emergency Dept	B3 / 1.42 wte	The paediatric area is staffed by 1 RN. There has been an increase in paediatric admissions later in the day, resulting in an unmanageable workload for one staff member. This role is key in supporting timely initial assessment, treatment and transferring patients to the ward if needed, ensuring patients move out of ED within the four-hour target.
Redlynch	B6 / uplift B5 to B6	Support junior skill mix, especially on nights, low compared to most wards B6 wte.
Laverstock	B6 / uplift B5 to B6	Increase of Level 2 patients, specialist skills and ensure B6 on 24/7.
Odstock	B6 / uplift B5 to B6	To ensure B6 able to be rostered on each shift with specialist skills.

2.0 Background

2.1 National Guidance

In 2013 as part of the response to the Francis Enquiry[6] the National Quality Board (NQB) published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place, at the right time'. This guidance was refreshed and broadened to include all staff groups and re-issued in July 2016 to include the need to focus on safe, sustainable and productive staffing. The guidance ensures that safe staffing levels are determined on patient needs, acuity and risks and can be monitored from 'ward to board'. This triangulated approach to reviewing staffing establishments provides evidence for CQC assessment. The expectations outlined in this guide are offered below.

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

In October 2018, NHSI published 'Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing'. The document moves forward from the NQB Guidance as described above, and from April 2019, NHSI assessed Trusts compliance with the triangulated approach to deciding staffing requirements described in the NQB guidance – the Trust is compliant with this through the staffing review process. The Trust is also required to include a specific workforce statement in its annual governance statement.

In January 2018 the NQB published an additional resource 'An improvement resource for the deployment of nursing associates in secondary care'.[7] The Trust remains compliant with the recommendations; the placement of Nursing Associates has not resulted in a substantial change to the RN establishment (a full EQIA would need to be undertaken if this approach changed).

CQC Quality Statement

The CQC assessment framework's quality statement relating to staffing is:

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

2.2 **BSW Hospitals Group – Safe Staffing**

Given the focus on safe staffing and associated expenditure, an external review was commissioned to provide additional assurance across the BSW Hospitals Group. The review was undertaken at Salisbury in June 2026 by the NHS England South West Workforce, Training and Education Directorate, with support from SFT Finance and Organisational Development and People colleagues. It assessed opportunities to reduce staff unavailability across inpatient areas and, where appropriate, convert recurrent temporary staffing into substantive posts.

2.3 **External safer staffing assurance**

The NHS England South West review provides external assurance that the Trust was compliant in 11 of 12 safer staffing domains at the six-month review (appendix 4). The only area of partial compliance was the online visibility of monthly actual-versus-planned staffing reports. The Informatics Team is addressing this, with completion monitored through safer staffing governance.

3.0 Right Staff

3.1 Ward staffing review methodology

3.1.1 Salisbury NHS Foundation Trust has an established, systematic and evidence-based approach to reviewing ward staffing establishments. A full review is undertaken annually, supported by a six-month update, using triangulated evidence to inform any proposed changes. Recommendations are submitted to the Board for approval and, where agreed, implemented through the budget-setting process. This provides assurance that staffing establishments are safe, effective, sustainable and capable of supporting high-quality care.

3.1.2 The approach taken for the full skill mix review utilises the following methodologies and full detail of each ward review is in Appendix 1:

- Shelford Safer Nursing Care Tool data.
- Care Hours per Patient Day.
- Ratios.
- Professional judgement.
- Peer group validation.
- Benchmarking and review of national guidance.
- Review of e-rostering data.
- Review of ward nurse sensitive indicator data.
- Review of HR indicators and finance metrics.

3.1.3 The 2026 establishment review was undertaken with each clinical area during Quarter 2, drawing on data from June 2025 to June 2026. The review was led by the Safe Staffing Matron and Deputy Chief Nurse, with participation from ward leaders and divisional nursing leadership and input from Finance, Workforce and relevant subject-matter experts. Recommendations were informed by triangulated evidence, including patient acuity and dependency, quality outcomes, workforce availability, roster performance, financial and operational data, and professional judgement.

3.1.4 Safer Nursing Care Tool (SNCT)

In 2023, the Deputy Chief Nursing Officer and Safe Staffing Matron implemented the Shelford Safer Nursing Care Tool (SNCT)[8], the nationally endorsed evidence-based tool for assessing adult inpatient nursing establishments against patient acuity and dependency. In line with national guidance, data is collected for at least 30 days twice yearly. Data entry is restricted to ward leaders and their deputies, who receive refresher training before each collection period to promote data quality and consistency.

Appendix 1 presents the data collection results, with Appendix 3 setting out the proposed establishment increases. These proposals are underpinned by a triangulated assessment of SNCT findings, quality and workforce indicators, and professional judgement, providing a robust evidence base for the recommendations

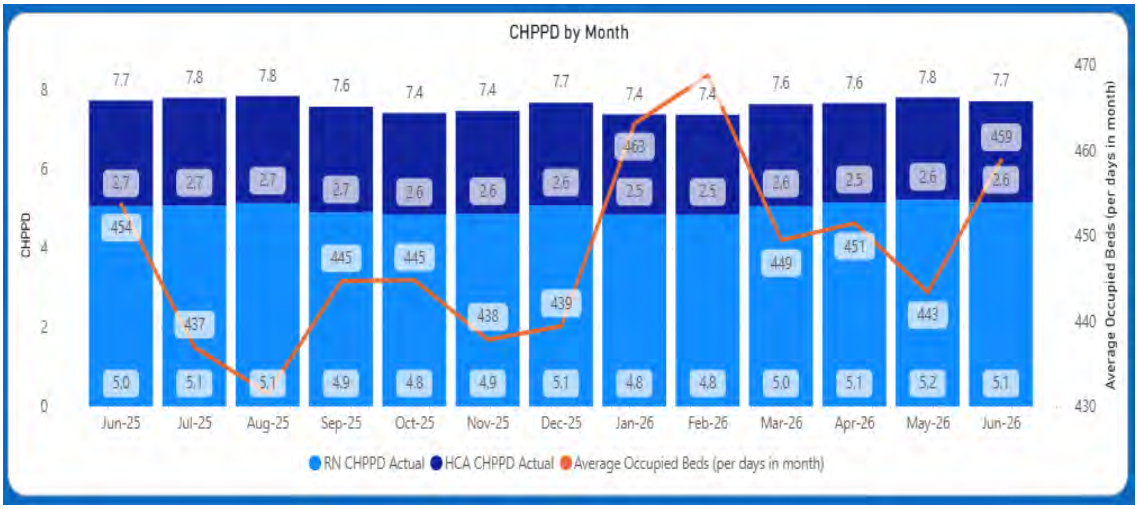
3.1.5 Care Hours per Patient Day (CHPPD)

Trusts are required to report Care Hours per Patient Day (CHPPD), a nationally comparable measure of nursing and care staff deployment. CHPPD is calculated by dividing the total actual hours worked by registered nursing and supporting workforce staff by the number of patients on the ward at midnight, providing an average of the care hours available per patient each day.

Model Health System enables comparison at Trust level; however, CHPPD should not be interpreted in isolation. Appropriate staffing levels vary according to service configuration, ward layout, patient acuity and dependency, care needs, staffing models and clinical pathways. Higher CHPPD may therefore reflect greater patient need, while lower CHPPD may reflect service design, productivity, deployment models or organisational inefficiencies. CHPPD provides an additional lens through which staffing can be benchmarked, challenged

and triangulated with acuity, dependency, quality outcomes, workforce indicators and professional judgement.

Average CHPPD fell from 7.8 to 7.6, reflecting increased escalation-bed occupancy and staff unavailability during June 25 – June 26 reporting period.

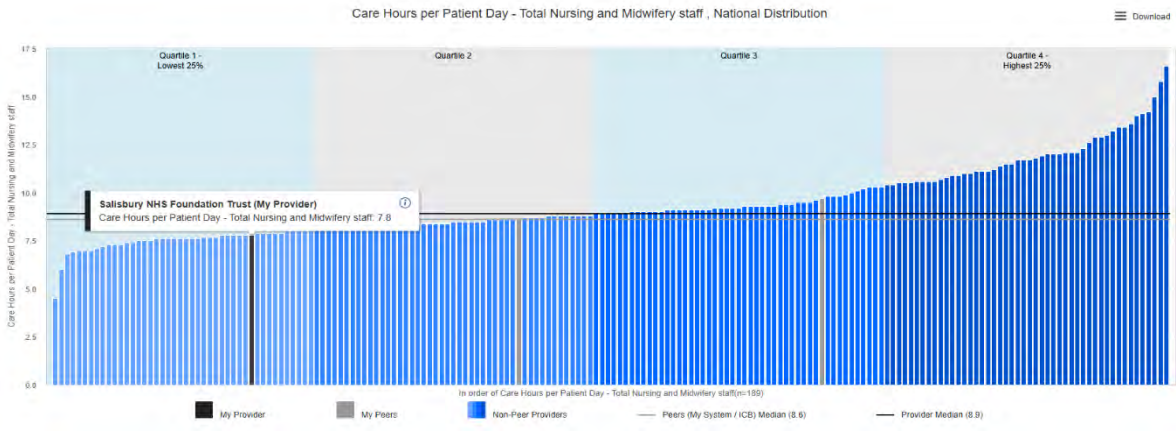


Consistent with national guidance, ward-level CHPPD is assessed against each ward's performance over time. The chart above presents aggregate actual CHPPD for all inpatient areas, including maternity and NICU.

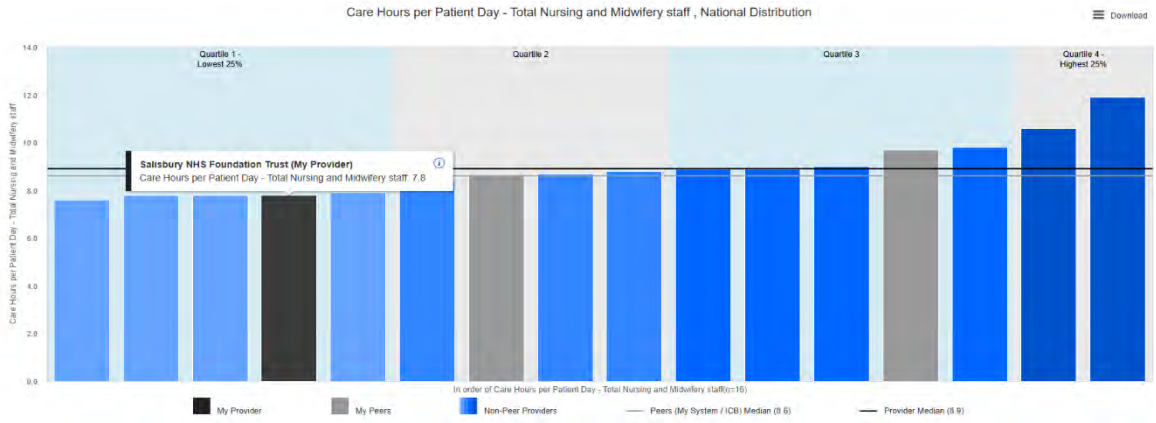
CHPPD Benchmarking

The charts below compares SFT's May 2026 CHPPD with acute providers nationally and BSW partner trusts. SFT reported 7.8 CHPPD and remained in national Quartile 1, unchanged from the previous year, compared with 8.6 at RUH (Quartile 2) and 9.7 at GWH (Quartile 3). As CHPPD reflects service configuration, patient acuity and staffing models, the findings are considered alongside quality outcomes, workforce indicators and professional judgement when assessing staffing safety. Work is progressing across BSW to establish a consistent approach to the units and roles included within staffing figures, strengthening the accuracy and comparability of reporting across the Group.

National comparison

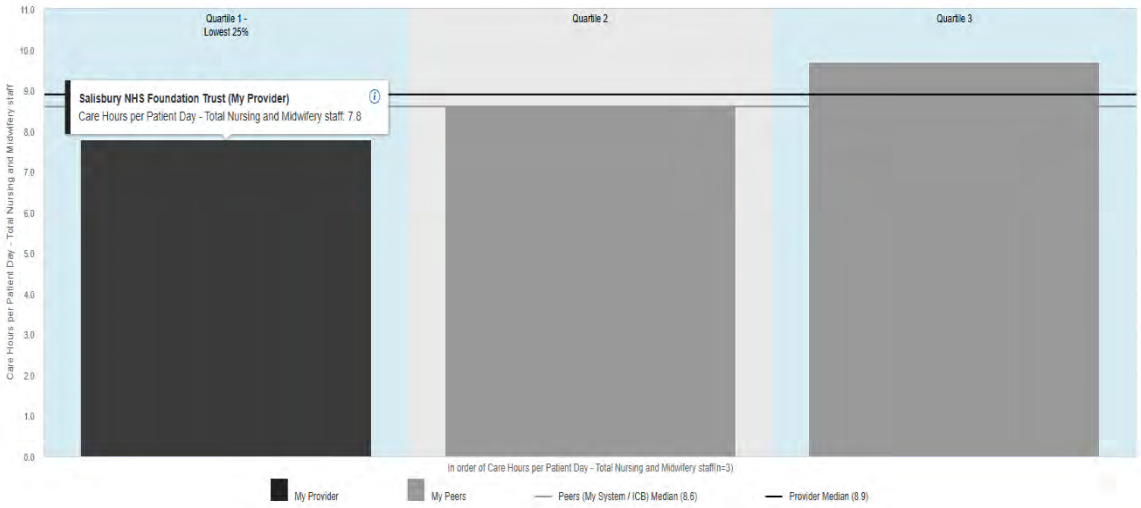


South West comparison



RUH in grey 8.6 & GWH at 9.7

ICB level comparison



3.1.6 Nurse to patient ratios by registered and total nursing

NICE guidance identifies registered nurse staffing below one RN to eight patients on day shifts as a threshold requiring review and escalation. Although no universal ratio is mandated, extensive evidence associates lower registered nurse staffing levels with increased mortality, avoidable harm and poorer patient experience.

Appendix 2 summarises current RN:Patient ratios which, within current establishments, range from 1:4 to 1:8 on day shifts and 1:4 to 1:9 at night depending on specialty and overall staffing model.

These ratios do include the nurse in charge (shift co-ordinator), as recommended by the RCN; Workforce Standards 2021[4] and noted within BSW Group safe staffing work, the intent is for ratios not to include this role. In some areas where there has been active implementation of the Band 4 role, these ratios can vary on specific shifts, although the underlying establishment ratio is not altered. These ratios are set against establishment and can regularly increase when wards are not fully staffed (vacancy/sickness etc).

Ward leaders are funded to achieve 80% of their hours as supervisory time. However, during periods of operational escalation, high sickness absence and reduced temporary staffing fill, ward leaders may be required to work clinically, reducing protected supervisory time and their capacity to deliver essential non-clinical leadership responsibilities

3.1.7 Fill rates – nursing staff planned vs actual (in-patient beds)

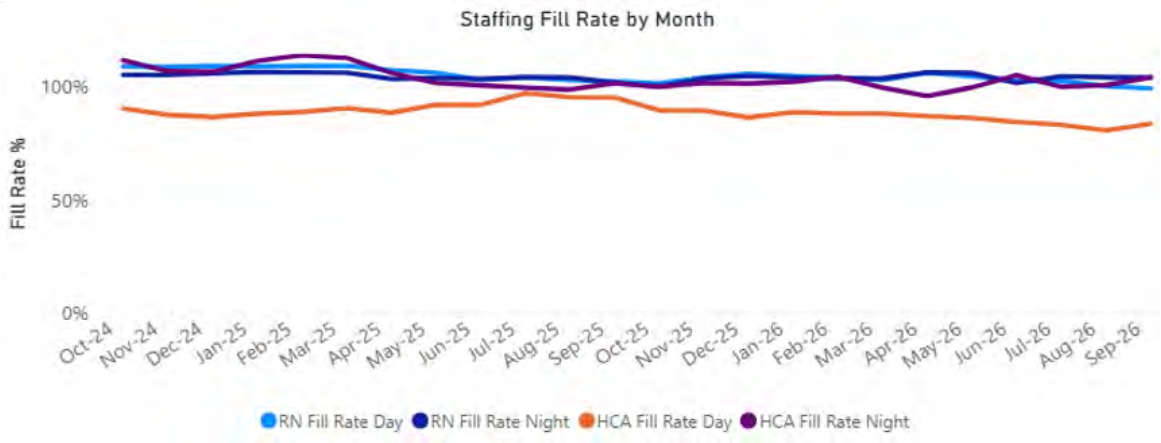
As part of the monthly Care Hours per Patient Day submission, the Trust reports actual hours worked against planned hours across all inpatient areas. Fill rates are reported separately for registered nurses (RNs) and healthcare assistants (HCAs) on day and night shifts.

The chart shows that RN fill rates were broadly stable at or above 100% over the reporting period, with both day and night fill close to planned levels by September 2026. HCA night fill was generally around or above 100%, although it fell below plan in some months during 2026. HCA day fill remained below 100% throughout and declined during the latter part of the period, reaching its lowest point in August 2026 before a partial recovery in September. This pattern is consistent with sustained HCA vacancies and the deployment of additional HCA hours at night to meet enhanced-care requirements.

The June 2026 workforce availability review with NHSE found that staffing pressure was driven predominantly by staff unavailability and increasing service complexity, rather than widespread over-establishment. Most wards recorded unavailability of approximately 28%-35%, above the traditional 24% headroom assumption. The principal drivers were sickness absence, parental leave, training and study leave, and inactive days. The review concluded that reducing avoidable sickness representing the most significant controllable opportunity.

The review identified scope to convert recurrent bank and agency deployment into substantive capacity where this supports core overnight cover, escalation activity or enhanced therapeutic observation and care. Targeted management action will focus on reducing sickness in AMU, Laverstock HCSWs, Redlynch, Tisbury HCSWs, Amesbury, Chilmark and Downton/Britford, and reviewing inactive days in Farley, Imber, Whiteparish HCSWs and Redlynch HCSWs.

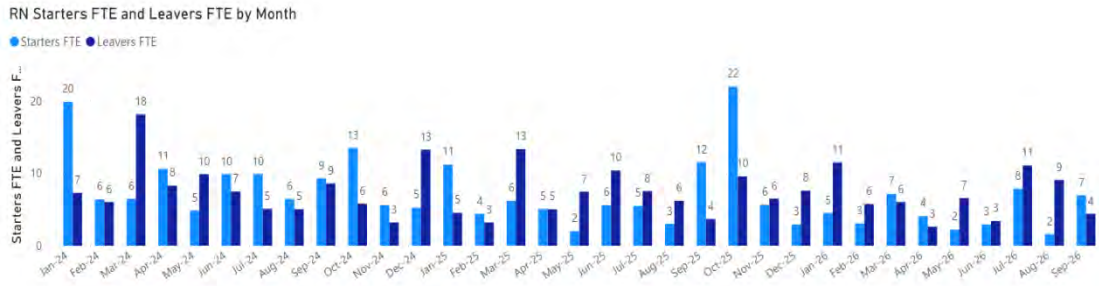
The monthly trend is shown below:

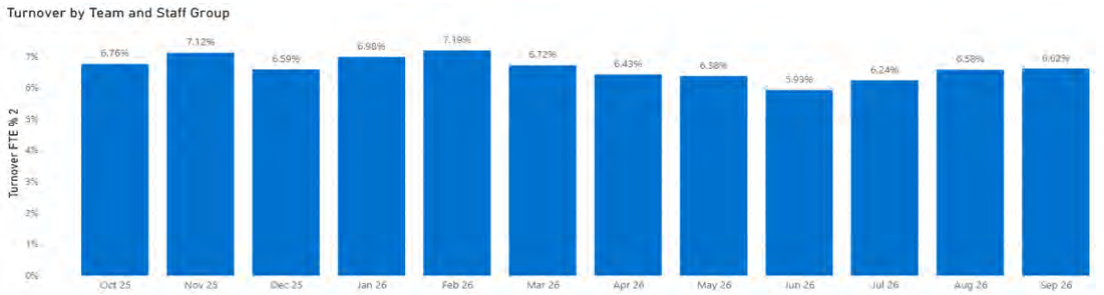


4.0 Right Skills

4.1 Recruitment and retention

4.1.1 Registered Nurses



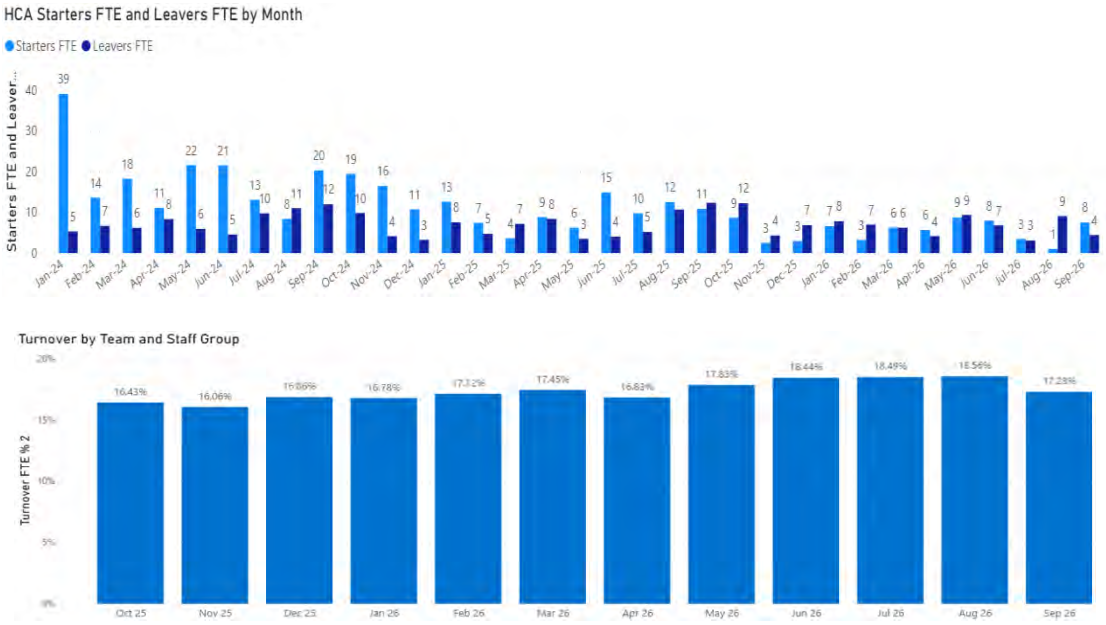


RN recruitment has maintained a near-zero ward vacancy position, with turnover remaining below 10% and within the Trust target throughout the year, at 6.62% in September 2026. Workforce movement nevertheless remains a sustainability risk, with an average of 6.5 WTE RNs reported as leaving each month. Sixteen offers have been made to newly qualified nurses commencing in Autumn 2026, supporting the shift towards domestic supply. Further mitigation will focus on retention and active pipeline management, including early engagement with student nurses, apprenticeship and internal progression routes, and targeted recruitment where required.

NHSE medium-term modelling identifies a projected adult nursing supply requirement of 55.16 WTE by March 2027 after forecast turnover; delivery will be monitored through established workforce governance.

Apprenticeship routes are a key component of the Trust's nursing workforce pipeline, widening access to the profession and supporting retention and internal progression. Twelve Nursing Associates qualified during 2026: five in March and seven in September. A further five are expected to qualify in March 2027 and six in September 2027. In addition, five Nursing Associates undertaking a recognition of prior learning pathway are due to qualify in December 2026, with a further six expected in December 2027. Five Registered Nurse Degree Apprentices who commenced training in 2025 are progressing towards qualification in 2029. Collectively, these pathways provide a planned pipeline of 34 nursing professionals, subject to successful programme completion, and strengthen the Trust's longer-term domestic workforce supply.

4.1.2 Health Care Assistants



HCA turnover remains above the Trust target, increasing to 18.56% in August 2026 before improving to 17.28% in September. Monthly starter and leaver activity remains variable, creating an ongoing requirement for recruitment, induction and workforce development. Mitigations include a two-week induction programme, completion of the Care Certificate, and a 12-month preceptorship programme. Turnover and the impact of these interventions remain under active review.

4.1.3 Retention Initiatives

Clinical Practice Educators

The central Practice Education Team continues to provide ward-based support for newly qualified nurses and preceptees. Work is progressing towards achievement of the national Preceptorship Quality Mark, alongside multidisciplinary and BSW Group collaboration to align programmes across Salisbury, Bath and Swindon. Care Certificate and HCA preceptorship compliance remains above 90%, with SFT practice shared across the Group. The team is also developing Enhanced Therapeutic Observation and Care training pathways for nursing and HCA staff and supporting the Trust's largest cohort of T Level students, apprenticeship career pathways, and HCA development and recognition initiatives. Collectively, this work supports workforce competence, retention and the future workforce pipeline.

Professional Nurse Advocates and Professional Advocates

The Professional Nurse Advocate and Professional Advocate workforce has increased to 31 qualified practitioners (29 PNAs and two PAs), with five colleagues awaiting results and a further five due to commence training. Although service pressures have affected training uptake, progress continues towards the Trust target of 68 PNAs/PAs. From September 2026, training will be delivered in partnership with Coventry University and will include face-to-face learning at South Newton Hospital.

Demand for the service continues to grow, with more than 700 staff supported during the past year. Support has included staff wellbeing and resilience, bereavement, clinical incidents, challenging patient behaviours, performance management, work-related and personal stress, career development and quality improvement. Feedback remains consistently positive, with staff reporting that PNA/PA support has helped them remain at work, providing assurance of the service's contribution to staff experience, retention and organisational resilience.

Targeted team support has been provided to Breamore, Pembroke and the Eye Clinic, alongside continued involvement in a Spinal Unit quality improvement initiative focused on managing challenging patient behaviours. The service also contributes to BSW Group collaboration with RUH and GWH, South West PNA strategy and guidance, and planning for the Group PNA/PA/PMA conference to be hosted by SFT in April 2027. The Spinal Unit improvement work received national recognition through presentation at the Just Culture, Being Fair conference in February 2026 and generated interest from other trusts.

5.0 Right Place and Time

5.1 Safe staffing process

5.1.1 Daily staffing meetings and Safecare

Daily SafeCare acuity and dependency assessments, supported by recorded professional judgement and embedded through Leader Standard Work, provide a consistent evidence base for staffing decisions. Staffing capacity and demand are reviewed through three operational staffing meetings each day, with red flags, unfilled shifts and staffing shortfalls formally recorded and escalated to divisional matrons for mitigation and senior oversight.

These arrangements are supplemented by weekly staffing reviews with Deputy Directors of Nursing, led by the Deputy Chief Nursing Officer and Safe Staffing Matron. These reviews provide senior scrutiny of staffing risks, escalation requirements, mitigating actions and temporary staffing use.

Ongoing Safer Nursing Care Tool training and strengthened SafeCare processes support the accuracy and reliability of staffing assessments, providing assurance that staffing risks are identified promptly, mitigated proportionately and monitored through established governance arrangements.

5.1.2 Temporary Staff

Reducing reliance on temporary staffing must be balanced with the requirement to maintain safe staffing, care quality and patient safety. Griffiths et al. (2024)[9] identified a statistically significant increase in mortality risk associated with exposure to low nurse staffing levels and higher proportions of temporary staff. Although using temporary staff to address staffing shortfalls reduced the risk associated with low staffing, the risk remained elevated compared with staffing provided by the substantive workforce. The presence of senior staff did not mitigate the adverse effects associated with low nurse staffing.

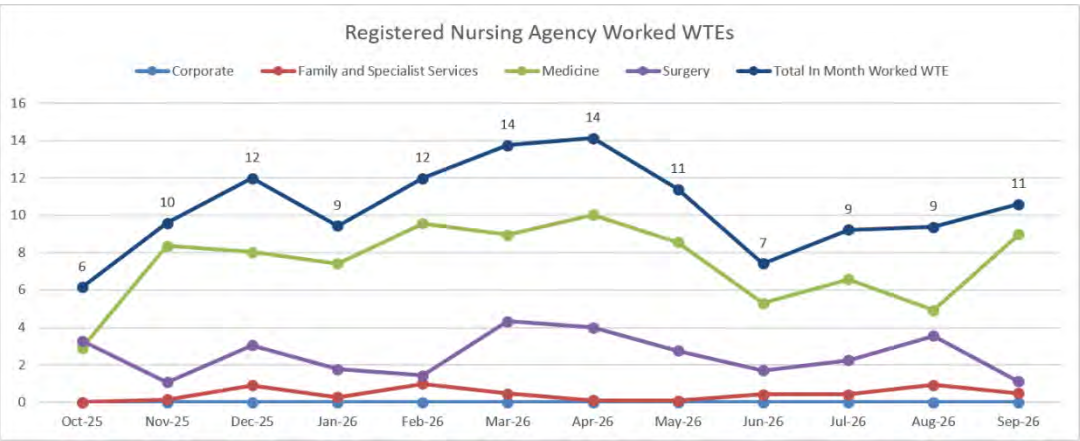
Agency usage has continued to reduce during the current financial year, supported by targeted action to eliminate off-framework provision. Remaining agency usage is predominantly concentrated within Theatres, ICU, Sarum and ED, together with agency RMN provision.

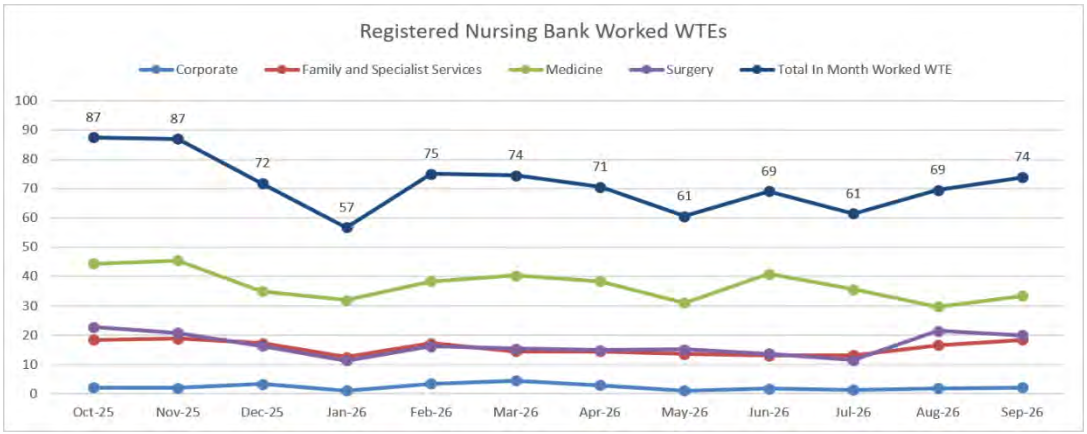
Progress in reducing bank usage has been less consistent. As illustrated in the graphs, registered nurse and support worker bank usage has varied month by month, reflecting fluctuations in operational and escalation demand. Registered nurse bank usage reduced from 87 worked WTE in October 2025 to 74 WTE in September 2026, while support worker bank usage reduced from 81 to 77 WTE over the same period.

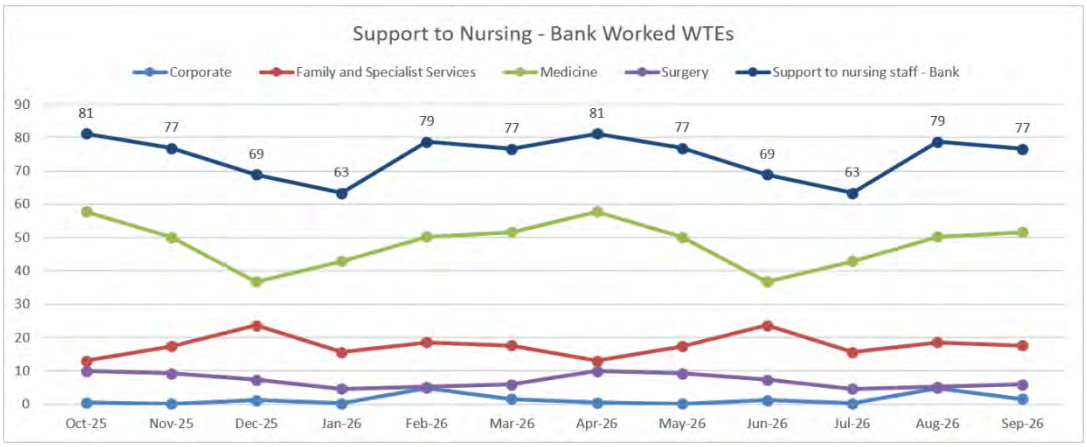
Bank demand continues to be driven primarily by escalation capacity, ward-based sickness absence and healthcare assistant vacancies. Despite the improved registered nurse vacancy position, healthcare assistant vacancies and comparatively lower CHPPD in some areas limit the ability of wards to absorb staffing gaps safely without temporary cover. Worked WTE does not represent the full level of temporary staffing requested, as not all shifts released to bank and agency were filled. At M05, across all staff groups, SFT requested 8,640 temporary staffing shifts, of which 5,480 were filled through bank and 498 through agency provision. Worked WTE should therefore be considered alongside shifts requested, fill rates, unfilled duties and the mitigations implemented to maintain safe staffing.

Fill rates were also adversely affected during the transition to Bank Partners, the new temporary staffing provider across the BSW Hospitals Group. The reduction in worked temporary staffing should therefore be interpreted with caution, as it reflects both changes in operational demand and reduced temporary staff availability during the transition period.
In addition to the daily and weekly oversight arrangements described in section 5.1.1, a two-stage escalation and approval process has been introduced for bank requests. This strengthens scrutiny and supports the authorisation of temporary staffing in response to evidenced clinical need. Compliance with agency framework and price-cap requirements continues to be monitored through established workforce governance arrangements.

Collectively, these controls support the safe and proportionate use of temporary staffing while enabling further reductions in expenditure without compromising safe staffing, care quality or patient outcomes.

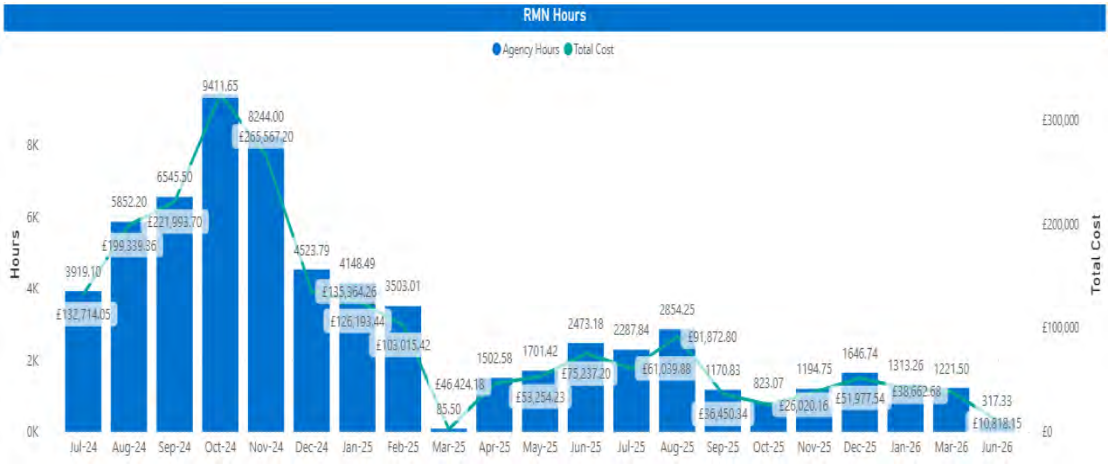






5.1.3 Impact of Mental Health

Demand for specialist mental health support remains a material workforce and financial pressure across adult and paediatric services. The chart demonstrates an overall reduction in agency RMN use during the June 2025 to June 2026 reporting period, although demand remained variable. Agency use increased from 2,473 hours (£75,237) in June 2025 to a peak of 2,854 hours (£91,873) in August 2025, before reducing substantially from September 2025. Following further monthly variation, use fell to 317 hours and £10,818 by June 2026, the lowest level in the period. This improvement reflects strengthened multidisciplinary review, de-escalation training and operational oversight, while maintaining safe, proportionate and least-restrictive care. A Trust-wide ETOC (Enhanced Therapeutic Observations and Care) working group, comprising key clinical, operational, safeguarding, security and mental health stakeholders, provides coordinated oversight of the NHS England collaborative programme. The group is updating the standard operating procedure, strengthening authorisation, escalation and review controls for RMN and security deployment, and delivering staff education with support from the Mental Health Liaison Team. Activity, expenditure, quality and safety indicators are monitored through established governance routes, with exceptions escalated for senior review. These controls provide assurance that RMN and security resources are used only where clinically justified and that reductions in restrictive practice and expenditure are achieved without compromising patient or staff safety. Residual reliance on agency RMNs for clinically complex cases remains under active oversight.



5.1.4 Additional Duties

Additional duties are deployed above the funded ward establishment where assessed patient need exceeds rostered capacity, primarily to support enhanced therapeutic observation and care or specialist mental health requirements. Deployment is informed by SafeCare acuity and dependency data and reviewed through three-times-daily staffing oversight.

Year-to-date expenditure on additional duties, including RMN, RN and HCA provision, is £265,000. If the current run rate is sustained, full-year expenditure is forecast at £636,000, remaining below each of the previous three financial years, as shown below.

	Additional Duty Costings (Costings based on Hourly rates from TSS, top of bands which align with previous years estimated costs)
2026-2027	£265k at end of month 5 (Aug), predicted £636k by end of the year (£265k/5 x 12 = £636k)
2025-2026	£742k
2024-2025	£1.4m
2023-2024	£1.8m
2022-2023	£1.7m
2021-2022	£70,961
2020-2021	£376,242
2019-2020	£622,193

5.1.5 Allowance for additional headroom requirements and supervisory ward leader

Funded ward establishments include 24% headroom, with a further 3% centrally funded provision for maternity leave. The Emergency Department has 27% headroom. The external NHSE workforce availability review identified average reported staff unavailability of approximately 32%, with most clinical areas reporting between 28% and 35%. This reflects sickness absence, parental leave, annual leave, training and study leave, and inactive time. The Trust's reported maternity leave average of 5.86% exceeds the 3% funded provision; however, this requires confirmation against the validated Electronic Staff Record dataset before final submission.

The Trust funds ward sisters and charge nurses to undertake 80% supervisory and 20% clinical duties. The review confirms that this provision has been broadly maintained, supporting

clinical leadership, workforce management, quality improvement and oversight of safe care. During periods of operational and staffing pressures, some supervisory time has been redirected to clinical cover to mitigate identified gaps.

5.2 Demographic and service demand outlook

Population modelling indicates continued growth and ageing across BSW. Over the next decade the BSW population is projected to grow by approximately 8%, with the population aged over 65 increasing by around 30%, and the over-80 population increasing disproportionately. For Salisbury, the logic model projects total service demand growth of 2.18% by 2026 and 12.31% by 2035 on a more-of-the-same basis. Demand growth is expected to be greatest in services used by older people, including elderly medicine, renal medicine, stroke, respiratory, cardiology, emergency medicine and palliative care, with implications for acuity, bed use, length of stay, enhanced care and discharge support.

The demand projection is a planning scenario rather than a staffing determinant and must be triangulated with actual activity, pathway redesign, productivity, acuity and dependency, quality outcomes and professional judgement. However, it supports prioritising resilient models for frailty, emergency and acute medicine, enhanced care, older people's services and specialist rehabilitation.

6.0 Establishment review outcome - Specific Divisional Themes

The divisional rationale for the proposed establishment increases is summarised below, with individual ward recommendations detailed in Appendix 3. Full implementation would require recurrent investment of £2,632,108, partially offset by reductions in additional duties and temporary staffing expenditure.

6.1 Medicine Division

Medicine Division proposals respond to sustained acuity, ETOC, frailty, escalation capacity and patient flow pressures. Targeted staffing uplifts address specific shift and skill-mix gaps, informed by patient safety data showing increased falls during evening periods in identified areas. The recommendations also recognise that patient acuity and workload now remain high throughout the day, making traditional late-shift staffing reductions less aligned to current demand. Divisional priorities are listed in order below.

Emergency Department: Workforce and operational review identified nursing capacity gaps in the Ambulatory Chairs area, Rapid Assessment, Triage and Treatment area and escalation beds. Additional registered nurse capacity is proposed for Ambulatory Chairs and RATT, together with substantive 24/7 RN cover for the escalation area. This would support timely assessment, monitoring and treatment, improve patient flow and ambulance handovers, strengthen safety and reduce reliance on temporary staffing. It should be noted that the Urgent Treatment Centre (UTC) is scheduled to open in autumn 2026. This may alter patient flow, activity levels and workforce requirements across the Emergency Department, and staffing recommendations will be reviewed and adjusted accordingly as the new service model is embedded

Acute Medical Unit: The current establishment does not support continuous operation of the assessment area, which closes to new admissions from 00:30. Since August 2025, overnight use has required bank or agency RN cover on 145 nights. Additional substantive registered nurse capacity from 00:00 to 07:30 is proposed to enable 24/7 assessment, improve flow, reduce Emergency Department pressure and reliance on temporary staffing, and support national access standards without additional medical staffing.

Acute Frailty Unit: The 23-bed unit cares for frail older people with complex medical, cognitive and discharge-planning needs. Increasing acuity, enhanced observation, Deprivation of Liberty Safeguards and discharge-to-assess activity are contributing to overnight falls, skin damage, delayed care and governance pressure. An additional RN on the 11.5-hour day are proposed to strengthen patient safety, oversight, personal care and flow.

Redlynch Ward: Acuity and safety data indicate that overnight registered nurse staffing does not reflect sustained clinical need. Reduced completion of observations overnight has coincided with increased falls. The proposed skill-mix change adds registered nurse capacity at night and reduces one HCA, improving monitoring, timely escalation and alignment with patient need while limiting the net establishment impact.

Farley Ward: This 30-bed acute stroke and rehabilitation ward has consistently high dependency and substantial feeding and personal-care needs. Escalation beds, redeployment, moisture-associated skin damage and a slight rise in falls have increased pressure. A Band 3 HCA twilight shift, seven days a week, is proposed to improve mealtime support, personal care and falls prevention during peak demand.

Spire Ward: The 30–32-bed ward supports older people with dementia, delirium, enhanced-care needs and high falls risk. Late shifts currently have fewer HCAs than early shifts despite comparable workload and dependency. An additional HCA on late shifts is proposed to support mealtime and evening care and strengthen falls prevention, in response to increased falls reported during the evening period, whilst also reduce pressure transferred to night staff.

Tisbury Ward: Review of the 22-bed cardiac ward identified insufficient Band 6 capacity to provide consistent senior clinical leadership across 24/7 services, with Band 5 nurses frequently leading shifts. An uplift from Band 5 to Band 6 is proposed to strengthen governance, supervision, decision-making and operational oversight for this high-acuity patient group.

Hospice Inpatient Unit: Increased acuity, complex admissions, out-of-hours activity and end-of-life care demands can leave limited RN capacity for inpatient care, medicines, discharge planning, bereavement support and the specialist advice line. An additional RN on late shifts, providing three registered nurses on days including weekends, is proposed to improve resilience and timely care for patients and families.

Laverstock Ward: Following morning ward rounds, increasing numbers of respiratory patients require afternoon escorts to X-ray, CT and other diagnostics. Extended escorts reduce ward capacity for observations, mealtime support and direct care. An additional Band 3 HCA on the

late shift is proposed to maintain safe ward cover, reduce investigation delays and support patient flow.

Imber Ward: Imber's older patient cohort includes patients with dementia and delirium, with increased enhanced-care needs and peak evening pressures associated with sundowning, confusion and falls risk. Falls data demonstrates a higher incidence of falls during evening periods, aligning with times of greatest patient need. Following the change from four RNs and two HCAs at night to three RNs and three HCAs, a cost-neutral HCA twilight shift is proposed, funded through the RN reduction, to better align staffing with peak demand, support patient observation and reduce falls risk while maintaining the overall staffing budget.

6.2 Surgical Division

Surgical Division proposals focus on weekend same-day emergency care demand and senior clinical leadership in elective surgery and critical care, as listed below in divisional priority order.

Chilmark Ward: A Band 5 to Band 6 uplift is proposed to provide consistent 24/7 senior clinical leadership for the busy 24-bed elective orthopaedic ward, strengthening clinical decision-making, staff supervision, operational oversight and governance across all shifts.

Surgical SDEC, Britford: Weekend activity has more than doubled since 2024 owing to increased same-day emergency care demand, additional specialty pathways and greater use of ambulatory care to avoid admission. One additional weekend RN is proposed, increasing weekend provision to two RNs in line with weekdays, to maintain safe care, reduce delays and support flow and admission avoidance.

Intensive Care Unit: Critical care activity and acuity have increased, with more Level 3 patients and Level 2 patients requiring one-to-one nursing. The current model of eight RNs per shift limits flexibility and has increased reliance on bank, agency and off-framework staffing. Development time is frequently redirected to clinical cover, contributing to a more junior skill mix and reducing capacity for training, appraisal, governance and sickness management. Mitigations include a flexible staffing SOP and accelerated secondment programme. The service remains under divisional intensive support, including review of the staffing template; any proposed change will be considered through the Clinical Operational Leadership Team.

6.3 Family and Specialist Services

Longford Ward: The 39-bed spinal rehabilitation ward remains under divisional intensive support, with its workforce requirements subject to further review. The Northwick Park Dependency Tool, while not a NICE-endorsed establishment-setting tool, has provided an additional assessment of the rehabilitation needs of the patient cohort and indicates a requirement for increased registered nurse capacity. Workforce modelling has also identified opportunities to optimise skill mix and recruitment. A further Northwick Park assessment will be undertaken alongside the Safer Nursing Care Tool in November 2026 to strengthen triangulation. The final staffing proposal, including shift distribution and WTE, will be confirmed following completion of these assessments, the intensive support review and

divisional validation, ensuring that any recommendation is evidence based, affordable and subject to appropriate governance.

7.0 Conclusion

The 2026 establishment review provides assurance that the Trust applies a systematic, evidence-based and professionally led approach to determining nursing establishments. Requirements were assessed by triangulating the Safer Nursing Care Tool, Care Hours per Patient Day, nurse-to-patient ratios, planned and actual staffing, quality and safety outcomes, workforce and financial indicators, operational context and professional judgement. NHS England South West found the Trust compliant in 11 of 12 safer staffing domains. Remedial action on the remaining area of partial compliance—the online accessibility of monthly actual-versus-planned staffing reports—is progressing through safer staffing governance.

The NHS England South West workforce review found that pressures arise primarily from workforce unavailability, increasing acuity and complexity, enhanced therapeutic observation and care, escalation activity and patient flow, rather than widespread over-establishment. Unavailability averages approximately 32%, with most areas reporting 28%–35%, compared with 24% funded headroom. Priorities are to reduce avoidable sickness, improve retention, address inactive time and appropriately reflect maternity, training and study leave in workforce planning.

The Trust has maintained a low registered nurse vacancy position. However, healthcare assistant vacancies and turnover, forecast registered nurse supply requirements, variable temporary staffing fill rates and reliance on bank, agency and specialist mental health provision remain sustainability risks. Agency use, including off-framework provision, has reduced, although bank reductions have been less consistent. Worked temporary staffing must be considered alongside requested shifts and fill rates, as not all released shifts were filled and availability was affected during the transition to the new provider.

Risks are actively managed through daily SafeCare assessment, three operational staffing meetings each day and weekly reviews with Deputy Directors of Nursing, led by the Deputy Chief Nursing Officer and Safe Staffing Matron. These arrangements support timely identification, escalation and mitigation, including proportionate temporary staffing deployment. A two-stage approval process provides further scrutiny of bank requests against evidenced clinical need.

Expenditure on additional RMN, RN and healthcare assistant duties has reduced compared with previous years. Enhanced therapeutic observation and care and specialist mental health requirements nevertheless remain material workforce and financial pressures. Multidisciplinary review, strengthened authorisation and escalation, staff education and governance monitoring will continue to support expenditure reductions without compromising patient or staff safety.

Care Hours per Patient Day has reduced and remains in the lower national quartile. As it does not determine staffing safety in isolation, it will continue to be triangulated with acuity and dependency, planned and actual staffing, nurse-to-patient ratios, quality outcomes,

workforce indicators and professional judgement. Ward leaders achieved the funded 80% supervisory provision for most of the year, supporting clinical leadership, workforce management, quality improvement and oversight of safe care. However, increasing operational and staffing pressures are making this more difficult to sustain, as ward leaders are often the first to be redeployed into direct care to mitigate staffing gaps.

Divisional reviews support targeted establishment and skill-mix changes rather than a uniform uplift. Proposals strengthen registered nurse capacity, senior clinical leadership, evening and overnight support, enhanced care, diagnostic escorts, weekend same-day emergency care and resilience across emergency, acute, frailty, older people's, critical care, palliative care and specialist rehabilitation services. Final positions for Intensive Care, Chilmark and Longford remain subject to further review, assessment and validation.

The Board can take assurance that established processes identify, escalate and mitigate staffing risks and that proposals are informed by a comprehensive, triangulated review. Assurance remains conditional on completing outstanding divisional reviews, validating final WTE and banding, confirming recurrent costs and affordability, and completing quality and equality impact assessments where required. Ongoing assurance will be provided through daily staffing oversight, weekly senior nursing review, monthly workforce and quality reporting, safer staffing governance and biannual establishment review.

8.0 Recommendations

- Note the findings of the 2026 nursing establishment review and performance against safer staffing metrics.

- Note progress against National Quality Board staffing expectations and the actions addressing the one remaining area of partial compliance.

- Receive assurance that safe staffing and nursing establishments have been assessed through triangulation of staffing, workforce, quality, financial and operational evidence, supported by professional judgement.

- Support continued action to improve retention and reduce temporary staffing reliance, including RMN bank recruitment and HCA development for enhanced therapeutic observation and care.

- Approve in principle the Appendix 3 establishment changes, subject to divisional validation, confirmation of final WTE and banding, recurrent affordability and required impact assessments; noting that reduced temporary staffing and additional duties may partially offset the investment.

- Note that ongoing assurance will be reported through the Safer Staffing Steering Group and Quality and Safety Committee, with the annual review presented to the Public Board in line with National Quality Board expectations.

References

1. National Quality Board. How to ensure the right people, with the right skills, are in the right place and the right time: A guide to nursing, midwifery and care staffing capacity and capability. NQB. 2013.

2. National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: London: NQB. 2016.

3. NHS improvement. *Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing*. NHSi. 2018

4. Royal College of Nursing. Nursing Workforce Standards: Supporting a safe and effective workforce: RCN 2021

5. National Institute for Health and Care Excellence (NICE). *Safe staffing for nursing in adult inpatient wards in acute hospitals*. London: NICE 2014. Available from https://www.nice.org.uk/guidance/sg1/resources

6. Francis R. Independent Inquiry: Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office, 2013.

7. National Quality Board. Safe, sustainable and productive staffing. An improvement resource for the deployment of nursing associates in secondary care. NQB. 2018.

8. The Shelford Group. Safer Nursing Care Tool; Implementation Resource Pack 2014.

9. Griffiths, Saville, Ball et al *Nursing Team Composition and Mortality Following Acute Hospital Admission 2024* Available from Nursing Team Composition and Mortality Following Acute Hospital Admission | Health Policy | JAMA Network Open | JAMA Network

Appendix 1

Links to data from all establishment reviews.

Division	Ward	Sharepoint Link
FASS	Longford	Longford SSR Dashboard (2026).xlsx
FASS	Sarum	Sarum SSR Dashboard (2026).xlsx
Medicine	AMU	AMU SSR Dashboard 2026.xlsx
Medicine	Breamore	Breamore SSR Dashboard (2026).xlsx
Medicine	ED	Emergency Dept SSR Dashboard (2026).xlsx
Medicine	Farley	Farley SSR dashboard 2026.xlsx
Medicine	Hospice	Hospice SSR Dashboard (2026).xlsx
Medicine	Imber	Imber SSR Dashboard (2026).xlsx
Medicine	Pembroke	Pembroke- SSR Dashboard 2026.xlsx
Medicine	Redlynch	Redlynch SSR Dashboard (2026) (1).xlsx
Medicine	Spire	Spire SSR Dashboard (2026).xlsx
Medicine	Tisbury	Tisbury SSR dashboard 2026.xlsx
Medicine	Whiteparish	Whiteparish SSR Dashboard 2026.xlsx
Medicine	Durrington AFU	AFU SSR Dashboard (2026).xlsx
Medicine	Laverstock	Laverstock SSR Dashboard (2026).xlsx
Surgery	Amesbury	Amesbury SSR Dashboard (2026) (1).xlsx
Surgery	Britford	Britford SSR Dashboard 2026.xlsx
Surgery	Chilmark	Chilmark SSR Dashboard 2026.xlsx
Surgery	Downton	Downton SSR Dashboard 2026.xlsx
Surgery	ICU	ICU SSR Dashboard 2026.xlsx
Surgery	Odstock	Odstock SSR Dashboard 2026.xlsx

Appendix 2

RN : Patient ratios

Ward	Division	RN Ratio (Core Early / Late / Night – excluding other roles)			Additional information
		Early	Late	Night	
Longford	FASS	1:5.5	1:6.5	1:7.8	
Sarum	FASS	1:4	1:4	1:4	
AFU	Medicine	1:5.7	1:5.7	1:5.7	
AMU	Medicine	1:4.4	1:4.4	1:4.4	
Farley	Medicine	1:5.5	1:5.5	1:6.5	
Hospice	Medicine	1:3.33 (1:5 at weekend)	1:5	1:5	
Imber	Medicine	1:4.8	1:4.8	1:8	
Laverstock	Medicine	1:4.8	1:4.8	1:6	
Pembroke	Medicine	1:5 until 10am then 1:3.33	1:3.33	1:5	
Pitton	Medicine	1:5.5	1:5.25	1:7	
Redlynch	Medicine	1:5.4	1:5.5	1:9	
Spire	Medicine	1:6	1:6	1:7.5	
Tisbury	Medicine	1:3.6	1:3.6	1:5.5	
Whiteparish	Medicine	1:5.5	1:5.5	1:7.3	
Amesbury	Surgery	1:6.4	1:6.4	1:8	
Britford	Surgery	1:5	1:5	1:75	Currently at 15 beds - SAU+SDEC not included in ratio
Chilmark	Surgery	1:6	1:6	1:8	
Downton	Surgery	1:4.5	1:6	1:6	
ICU	Surgery	Nationally Mandated	Nationally Mandated	Nationally Mandated	
Odstock	Surgery	1:4.25	1:5.66	1:5.6	

Appendix 3

2026/27 Skill-Mix Recommendations

Area	Recommendation	Rationale and anticipated benefit	WTE	Recurrent cost	Costing basis / further assurance
Spire	Add Band 3 HCA late shift.	Strengthens late-shift capacity for mealtime and evening care, enhanced therapeutic observation and care, and falls prevention.	2.78	£119,793	Seven days per week, including 24% headroom; Band 3. Confirm recurrent affordability and measurable reduction in additional duties.
Redlynch	Add one Band 5 RN at night, offset by reducing Band 3 provision.	Improves overnight registered nurse cover, monitoring and timely escalation, aligned to sustained acuity and falls risk.	2.66	£39,790	Net cost differential between Band 3 and Band 5 shift-working rates; Band 3 reduces from 17.71 to 15.05 WTE and Band 5 increases to 18.89 WTE. Confirm quality and safety impact.
Imber	Add a Band 3 HCA twilight shift.	Provides targeted support for sundowning, extended lengths of stay and enhanced therapeutic observation and care during peak evening demand.	2.78	£119,793	Seven days per week, including 24% headroom; Band 3. Confirm final shift times and consider how this could be made cost neutral.
Emergency Department	Increase Band 5 RNs across Ambulatory Chairs, RATT and escalation capacity.	Support the ambulatory chair area, strengthen the RATT function and provide escalation capacity, enabling a timely response to activity demands, improving patient assessment and flow, and reducing reliance on temporary staffing and associated expenditure. The opening of the UTC in autumn 2026 may alter Emergency Department demand and workforce requirements, and staffing recommendations will be reviewed accordingly.	22.76	£1,321,207	Four RNs providing 24/7 cover, costed at the Band 5 shift-working midpoint with 27% ED headroom. Validate deployment against the ED dashboard and quantify the temporary staffing offset.

Laverstock	Add a Band 3 HCA late shift.	Provides capacity for diagnostic escorts while maintaining safe ward cover, observations, mealtime support and patient flow.	2.78	£119,793	Seven days per week, including 24% headroom; Band 3.
Farley	Add a Band 3 HCA late or twilight shift.	Supports feeding, personal care and falls prevention during peak demand for a high-dependency stroke and rehabilitation cohort.	2.78	£119,793	Seven days per week, including 24% headroom; Band 3. Confirm the preferred shift pattern.
Tisbury	Uplift 5.44 WTE from Band 5 to Band 6.	Provides consistent senior clinical leadership, supervision and decision-making across the 24/7 service.	5.44	£25,673	Cost represents the midpoint shift-working differential; Band 5 reduces from 22.32 to 16.88 WTE.
Britford / SAU	Increase Band 5 RN provision at weekends.	Reflects increased weekend same-day emergency care demand, supports admission avoidance and maintains safe patient flow.	1.55	£89,977	Weekend 24-hour provision, including 24% headroom. Confirm final shift pattern.
Chilmark	Uplift 5.44 WTE from Band 5 to Band 6.	Provides consistent senior clinical leadership, supervision and decision-making across the 24/7 service.	5.44	£25,673	Cost represents the midpoint shift-working differential; Band 5 reduces from 15.90 to 10.46 WTE. Final divisional confirmation and affordability assessment are required.
AMU	Establish an additional substantive Band 5 RN night post.	Formalises recurrent overnight cover currently generally provided through temporary staffing, enabling 24/7 assessment and supporting flow.	1.85	£107,392	Seven days per week, including 24% headroom. Confirm recurrent affordability and quantify the bank and agency offset.
AFU	Additional Band 5 RN on the long day.	Responds to increased acuity, enhanced-care requirements, extended lengths of stay and approximately 10% growth in patient activity, strengthening safety and oversight.	2.66	£154,412	2.66 WTE Band 5 for seven days per week with 24% headroom. Validate the activity baseline and financial impact.
Longford	Increase Band 5 RN provision.	Dependency assessment indicates additional registered nurse capacity is required for the specialist rehabilitation cohort.	5.32	£308,823	Seven days per week, including 24% headroom; Band 5. Confirm dependency-tool

					output, shift distribution and divisional approval.
Hospice	Add a Band 5 RN on the late shift or convert an early shift to a mid-shift.	Aligns registered nurse availability with periods of greatest service demand and strengthens resilience for complex inpatient and out-of-hours care.	1.39	£80,689	Seven days per week, including 24% headroom; Band 5. Confirm the preferred option and whether a shift conversion could reduce or remove the recurrent cost.
Total quantified investment			**60.19 WTE**	**£2,632,108**	

Appendix 4

Salisbury NHS Foundation Trust Safer Staffing End of Year Report 2025/26

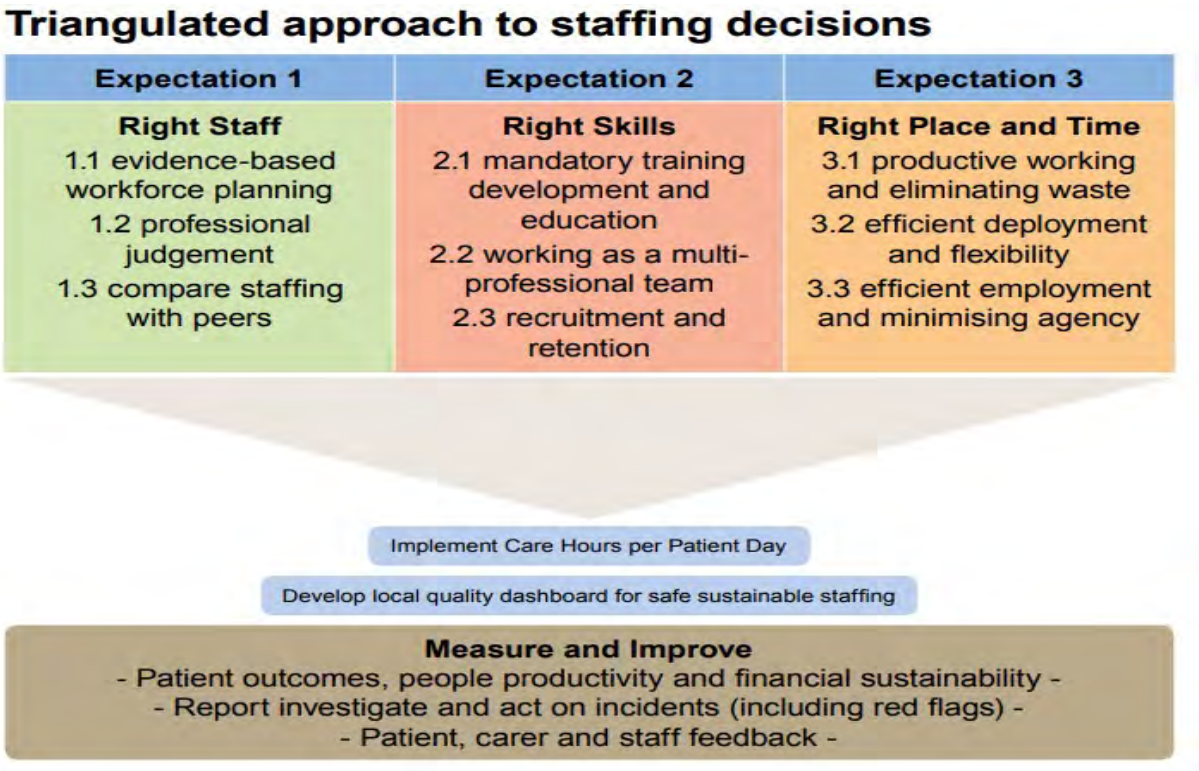


Background

The National Quality Board (NQB) (2016) and Developing Workforce Safeguards (2018) set out mandatory requirements of Trust Boards to ensure that staffing levels are based on patients' needs, acuity, and risks, which are monitored from 'ward to board' and will enable NHS provider boards to ensure that the right staff with the right skills are in the right place at the right time.

- Trust Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard including Care Hours Per Patient Day (CHPPD). Trusts should report on this to their board every month and the results are published on the Trusts' internet page.
- An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.
- As stated in Care Quality Commission's (CQC) well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
- Given day-to-day operational challenges, we expect Trusts to carry out business-as usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance, and staff experience must be clearly described in these risk assessments.
- Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

As part of the establishment review, the Chief Nursing Officer must confirm in a statement to the Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable, using the triangulated approach to staffing decisions as detailed below.



In order to provide quality assurance that these requirements were being met, the Chief Nursing Officer for NHS England established the Faculty for Safer Staffing. Each region has been tasked with undertaking a gap analysis of the NHS Provider organisations in their region, to ensure that they are meeting these requirements.

The South West (SW) Safer Staffing Team have used the gap analysis to generate a baseline heat map of safer staffing assurance across the region, covering 21 organisations. This includes acute, mental health, learning disabilities and community services. NHSE SW Safer Staffing Advisor rated the safer staffing gap analysis responses as per NQB guidance. They then reported the safer staffing gap analysis results to National Safer Staffing Team via a heat map showing compliance, partial compliance and non-compliance.
Following the heat map report submission, the NHSE National Safer Staffing Team have requested a deeper dive to identify the evidence that was not presented or could not be found. The Regional Safer Staffing Team is in the process of undertaking meetings with all 21 providers across the South West and updating the gap analysis records as they gain evidence that the requirements are being met. They are also providing support to these organisations and will be working towards ensuring that all organisations are providing safe and effective staffing for high quality patient care.

The NHSE South West Safer Staffing Team meet regularly with the National Safer Staffing Team to discuss the assurance of safe staffing across the South West region. The reports from the SW Safe Staffing Team will also feed into the South West Quality Group.

Salisbury NHS Foundation Trust (SaFT)

Below is the heat map for SaFT with details for their initial submission and how their compliance has been updated post initial meeting and following the six-month review.

Safer Staffing Topic	Compliance	Compliance After Initial Meeting	Compliance After 6 monthly Review Meeting	Comments
1.NQB guidance	**Compliant**	**Compliant**	**Compliant**	
2.Triangulation	**Partial Compliance**	**Compliant**	**Compliant**	
3.Evidence based tools utilisation	**Compliant**	**Compliant**	**Compliant**	The Trust are using SNCT
4. No tool manipulation	**Compliant**	**Compliant**	**Compliant**	
5. Monthly Actual Vs Planned staff reporting	**Partial Compliance**	**Partial Compliance**	**Partial Compliance**	No evidence seen of monthly reports, unable to find online
6. Annual statement	**Partial Compliance**	**Compliant**	**Compliant**	
7. Workforce plan	**Partial Compliance**	**Partial Compliance**	**Compliant**	
8. Bi-annual establishment reviews	**Partial Compliance**	**Compliant**	**Compliant**	
9. Quality dashboards	**Partial Compliance**	**Partial Compliance**	**Compliant**	
10. Quality Impact Assessments	**Compliant**	**Compliant**	**Compliant**	
11. Risk management & escalation	**Partial Compliance**	**Compliant**	**Compliant**	
12. Board awareness	**Compliant**	**Compliant**	**Compliant**	

The outcome of the 6-month review meeting shows that the Trust have become compliant in 11 domains.

Further actions and issues noted from the meeting are: The Trust will be reviewing the visibility of monthly reports online and will send NHSE SW a copy of these.

BSW HOSPITALS GROUP

Equality, Diversity and Inclusion (EDI) report

April 2025 – March 2026



Accessibility statement

If you require this document in an alternative language or format, please email sft.bswedi@nhs.net.

If you have any comments, suggestions or feedback about this document, please contact the BSW Hospitals Group EDI Lead, using the above email address.

Legal statement

This document sets out how we have met the legal duties set out in the Equality Act 2010 – the Public Sector Equality Duty and the Health & Social Care Act 2022 and our obligations set out in the NHS Standard Contract 25/26 Service Condition 13 (SC13) – Equity of Access, Equality and Non-Discrimination.

The report outlines the work undertaken to meet our commitment to improve equity in experience and support the wellbeing of our staff.

Lead Author

BSW Hospitals Group EDI Lead.



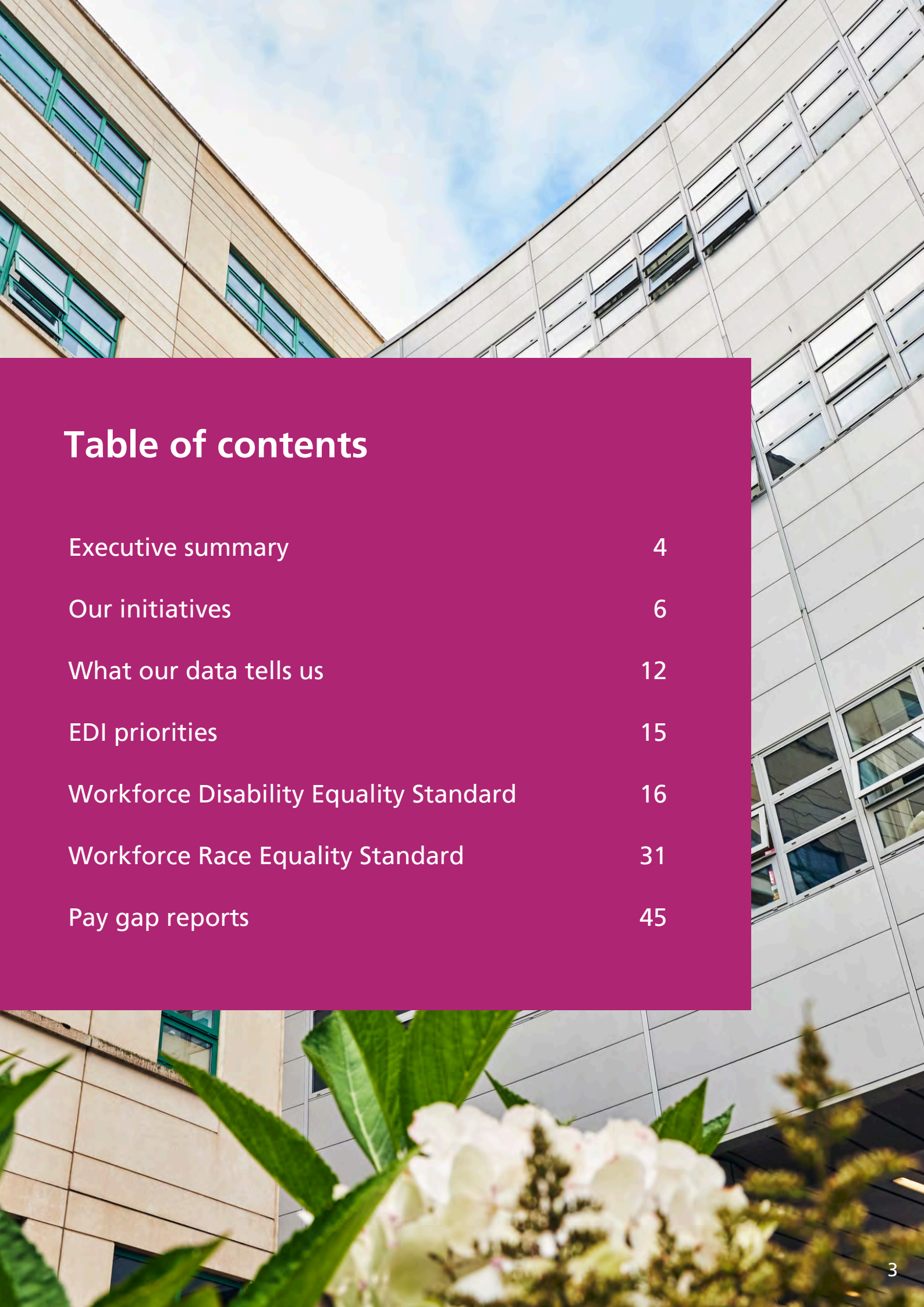


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Executive Summary

Cara Charles-Barks, Chief Executive



Our annual Equality, Diversity and Inclusion report has been produced in partnership with our three local care organisations – Great Western Hospitals NHS Foundation Trust (GWH), Royal United Hospitals Bath NHS Foundation Trust (RUH) and Salisbury NHS Foundation Trust (SFT), which together employ almost 17,000 members of staff who serve the communities of Bath and North East Somerset, Swindon and Wiltshire.

In May 2026, our three Trusts formally agreed to work together as BSW Hospitals Group, building on more than a decade of increasingly close collaboration. We chose to strengthen our partnership because many of the challenges we face, widening health inequalities, rising demand, workforce pressures and long-term financial sustainability, cannot be solved by any single organisation alone. By acting as one Group, while remaining sovereign Trusts, we can plan more effectively, share learning, reduce duplication and deliver more consistent, equitable care for the people and communities we collectively serve.

This report reflects that shared commitment. It brings together our collective progress, challenges and priorities, demonstrating how working as a Group enables us to accelerate improvement, strengthen accountability and create a more inclusive culture for all our staff and volunteers.

Our initiatives are mapped against the NHS England EDI Improvement Plan and supports our collective Equality, Diversity and Inclusion objectives:

GWH

- Inclusive and compassionate leadership
- Represented and supported workforce
- Delivering transformative care
- Giving everyone a voice

RUH

- Better health outcomes
- Improved patient access and experience
- A represented and supported workforce
- Inclusive leadership

SFT

- To reduce occurrences of discrimination, prejudice, abuse and harassment
- To promote and design-in diversity at all levels, advocating the benefits of this both internally and to our wider community
- To create safe, inclusive, diverse teams and working environments in which people feel they belong, are valued and can thrive.

This year we have strengthened how we work together across the Group. Our EDI teams have co-created and co-delivered training and engagement and in 2026-27 these teams will combine to reduce duplication, share expertise and build capability and capacity across the Group.

We have expanded our Pay Gap reporting – publishing an Ethnicity Pay Gap report for the second year running at GWH and RUH and the Disability Pay Gap for the first time in all three organisations, this goes beyond legal compliance and demonstrates our commitment to transparency and equity for all staff across the Group.

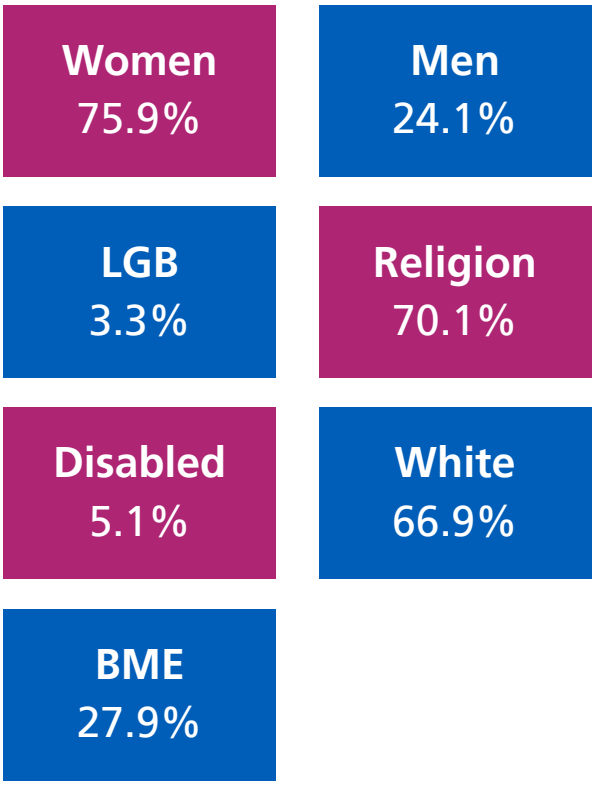
Our Group data tells a mixed story. The workforce has a broadly similar age profile, with the largest proportion of staff aged between 31 and 45 years (42.6% of the workforce). Around 30% of staff are aged 50 and over. Although we are diverse, diversity thins sharply with seniority for our disabled staff and staff from an Ethnic Minority background.

Women are under-represented in senior roles, especially in our medical and dental fields which is driving our Gender Pay Gap – we are clear that the pay gap does not mean unequal pay for equal work, the gap reflects the distribution of different groups across grades, professions and seniority.

Overall, staff experience is slowly improving – discrimination reported by our Ethnic Minority staff fell significantly at GWH, and harassment, bullying and abuse fell at RUH; however, the performance has remained relatively static at SFT.

Our data indicates that disabled staff continue to report a poorer experience of work than their non-disabled colleagues and this is demonstrated by the limited improvements highlighted in our WDES report. Our priority for the year ahead is to understand and address the workforce factors that drive these disparities.

BSW Hospitals Group Workforce



The above data is supported by the following local care organisation data:

	GWH	RUH	SFT
Women	4,404 80%	4,800 74%	4,087 73.7%
Men	1,086 20%	1,680 26%	1,459 26.3%
LGB	142 2.5%	276 4.3%	165 3%
Religion / Belief	4,019 70.5%	3,819 59%	4,626 83.4%
Disabled	316 5.5%	347 5.4%	203 4.4%
White	3,374 59.1%	4,775 73.1%	3,150 67.7%
BME	1,738 30.5%	1,619 25%	1,355 29.1%

Cara Charles-Barks
Chief Executive, BSW Hospitals Group

Our initiatives 2025-26

Our 2025-2026 programme of work has been mapped against the NHS England EDI Improvement Plan High Impact Actions (HIA) (1-6 below). This has enabled us to have a consistent approach to improving performance across all NHS organisations.

These initiatives have supported our improvement across several mandatory and statutory Standards including the Workforce Race Equality Standard, Workforce Disability Equality Standard, and Pay Gap reporting included in the appendix of this report.

High Impact Actions

1 **Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.**

GWH	RUH	SFT	Group
EDI objectives set during the appraisal process for Board members. Increase the diversity of board membership – see metric 9. The Board attended a workshop with staff network chairs to review WRES and WDES data and inform the actions for 25/26.	EDI objectives set during the appraisal process for Board members. EDI effectiveness is embedded into the Board Self Assessment Tool.	SMART EDI objectives have been agreed for some Board executive members; further work is required. The Board has taken part in several EDI development sessions over the past 12 months. The Board worked with external partners to improve its awareness and to strengthen executive sponsorship roles for staff networks.	Each organisation engages with its staff to understand their lived experience including drop-in sessions and Go & Sees (visits). The care organisations are currently forming a Group Board and will consider any actions for 2026/27.

2 Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

GWH	RUH	SFT	Group
Increase the number of Inclusion Recruitment Champions (staff who sit on interview panels for senior roles). Deliver programmes to support recruitment from groups who are economically or otherwise disadvantaged. Examples include – Project Search for young people with learning disabilities; Dare 2 programmes for young people who want to learn about the varied professions.	Train and deploy Independent Inclusion Advisors (RCN Cultural Ambassadors) who work with Recruitment to remove bias from processes. Deliver Project Search, which provides year-long work experience for young people with learning disabilities.	Recruitment and selection processes have been reviewed and strengthened to improve fairness and inclusion. Best practice, including diverse interview panels have been rolled out to managers. 'Licence to Manage' workshops are building manager skills in inclusive leadership and staff development. Talent Management and Succession Planning was piloted for critical Executive and Director roles.	The Group People Plan will include a talent management workstream, this will be rolled out in 2026-27; this is aimed at addressing systemic barriers to progression.

3 Develop and implement an improvement plan to eliminate pay gaps.

GWH	RUH	SFT	Group
Promoted and delivered leadership development programmes. Staff accessed external programmes like Edward Jenner; Florence Nightingale and apprenticeships.	Promote and deliver internal leadership development programmes; staff access university-led apprenticeships leading to MBAs.	SFT has implemented all relevant Mend the Gap review recommendations and is currently evaluating this programme of work. Good practice will be shared across the Group.	All care organisations offer apprenticeship opportunities, including apprenticeships leading to MBAs.

GWH	RUH	SFT	Group
Delivered Expectations of Line Managers training, which helps line managers to support and develop their teams. Delivered a mentoring programme – this programme was adapted to Speed Mentoring which improved engagement; staff can access internal coaches.	Staff can access qualified coaches, including team coaching. The coaching service is evaluated and feedback is very positive. Delivered Root to Success Leadership programme, targeting Ethnic Minority nurses, midwives and AHPs. The programme supports progression into senior roles.	Preparatory work is also progressing to support future reporting on race and disability pay gaps.	The Group will streamline our Pay Gap (Gender, Ethnicity, Disability) processes, to enable additional analysis to take place in the 2027-28 reporting period. The Group will also review its current initiatives in 2026-27, and map them against the 'Mend the Gap' Report to identify opportunities to close the Gender Pay Gap.

4 Develop and implement an improvement plan to address health inequalities within the workforce.

GWH	RUH	SFT	Group
In preparation of piloting the use of Cultural Ambassadors to improve the experience of staff involved in formal and informal HR processes – the Conduct Management policy was updated in March 2026 to embed the role. GWH launched a guide to making reasonable adjustments, following engagement with staff; the Differently Abled Network chair	Health and wellbeing is monitored through the Equality Delivery System Review (a self-assessment, which measures equity of experience), actions are ongoing that support staff with specific health conditions. RUH reviewed their Employee Assistant Programme to enable this to be more responsive to demographic factors in health	The 'Supporting Disabled People at Work' Policy has been updated and Health Passports have been launched. A Reasonable Adjustments Policy, centralised budget and consistent approach are in place to support equitable access. Both the Men's Health Strategy and Women's Health Strategy have been launched.	All care organisations offer occupational health and wellbeing services, and staff have access to 24/7 support and resources to manage their heath, wellbeing and finances. Staff can also access mental health first aiders and other champion roles to help maintain their physical and mental health. All three care organisations have

GWH	RUH	SFT	Group
played a significant role in the initial design. Our action to improve data dashboards to support tackling workforce health inequalities will be carried forward to 26-27.	and wellbeing. EDI delivered a Health Inequalities Inclusion Week with local partner organisations to explore Health Inequalities in the Bath and North East Somerset area and the approaches to countering them. The Health Inequalities team also recently delivered a Health Inequalities week of events.	SFT partnered with Avon and Wiltshire Partnership (AWP) to deliver five bespoke Know-Vember men's health webinars.	achieved accreditation under the Disability Confident scheme – GWH and SFT have level 3 Disability Confident Leader status and RUH Level 2 Disability Confident Employer status. The Health Inequalities Leads across the group are currently developing plans to jointly address health inequalities for our patients and workforce.

5 Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.

GWH	RUH	SFT	Group
The Trust delivered the Supporting Information from Employers (SIFE) Programme, the six-month structured programme supports internationally recruited Healthcare Support Workers to progress towards becoming registered nurses (RN). Three internationally recruited nurses attended the	RUH has a comprehensive onboarding programme for its recruits; all staff receive appraisals which enable them to highlight training and development needs. All staff have access to CPD funding to support their learning and development.	Successful cultural celebration events have been held, including Bhangra, South Asian and Filipino heritage events, with over 200–250 staff attending. A dedicated Internationally Educated Nurses (IEN) development day was held in year. SFT has achieved the Pastoral Care Award for Internationally Educated Nurses.	The Group's support package for internationally recruited staff has been extremely successful, the focus of our efforts has now moved to staff retention – supporting our internationally recruited staff to thrive and progress in their careers. All care organisations have staff networks including Disability, Race, Women, Men and LGBTQ+ groups.

GWH	RUH	SFT	Group
Braver Than Before programme, designed to develop courageous, compassionate and connected leaders in the NHS. In addition, international staff can access a full suite of leadership and development programmes and development is discussed during the appraisal process and Scope for Growth conversations and these staff have access to a Legacy Mentor.		An IEN and line manager handbook has been created to support cultural transition and inclusive team cultures. Cultural awareness and cultural intelligence sessions are available, supported by Legacy Mentors who provide pastoral support to IENs.	The Group will merge its EDI teams in 2026-27 and this will support the sharing of good practice, resources and expertise.

6 Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

GWH	RUH	SFT	Group
GWH has increased the number of EDI Champions in year, these staff have been trained to respond to unprofessional behaviours. Delivered 'Addressing Unprofessional Behaviours' workshop, this workshop was co-designed with staff. Advice and Guidance sessions are widely promoted to staff,	RUH increased the number of Inclusion Champions this year. Improved reporting safety by adopting Report+Support (a tool used to report experiences). The People Hub has been developed to provide equitable support and guidance towards conflict resolution.	Piloted a Behaviours Charter in Theatres, with roll-out across other teams. Refreshed the Freedom to Speak Up policy and strategy. Established a strong FTSU Ambassador network, made up of colleagues from diverse backgrounds, members are supported through regular networking	Addressing Unprofessional Behaviours workshops, developed by GWH, is now being delivered virtually across the group. The care organisations launched its 'Let's Talk Inclusion' survey in March 2026 to enable staff to inform the EDI actions for the coming year across the Group.

GWH	RUH	SFT	Group
these sessions are facilitated by an EDI practitioner. The Trust relaunched the Never OK campaign, which puts a spotlight on the personal impact of abuse, while reminding staff of the importance of reporting incidents. This has included training, ward visits and a 7-point action plan to support staff to report incidents.	Established a FTSU Champion network, made up of colleagues passionate about creating a speaking up culture, supported through regular networking sessions. Leadership programmes and Inclusion Champion training include bias awareness, civility, compassion etc. The Violence Prevention and Reduction policy was implemented.	sessions. New leadership programmes include sessions on cultural intelligence, civility, conflict, behaviours, speaking up and team dynamics. Comprehensive conflict resolution training is in place. SFT developed an Improving Together A3 (a continuous improvement tool) to identify actions to address bullying and harassment and discrimination.	



What our data tells us

Pay gap

	Mean			Median		
	GWH	RUH	SFT	GWH	RUH	SFT
Gender	27%	15%	17.4%	17.3%	-3.9%	0.8%
Ethnicity	6.4%	8.2%	3.9%	2.9%	0.4%	4.4%
Disability	17.9%	19.6%	13.3%	11.8%	18.8%	15.4%

The above table summarises the mean and median pay gaps for each care organisation. A positive gap favours men, White staff or non-disabled staff; a negative gap favours the comparator group.

Gender: Women make up around three-quarters of our workforce but remain under-represented in the highest paid roles, particularly medical and dental career pathways and are more likely to work less than full time. The mean gender pay gap increased slightly at all three organisations this year. Five-year progress is slow, at the current rate it would take over 14 years to reach parity at RUH and closer to 30 years at GWH and SFT.

Ethnicity: The mean pay gap favours White staff at all three organisations, driven by greater White representation in the upper pay quartile. The median pay gap is slightly in favour of White staff at GWH, very close to parity at RUH and in favour of Ethnic Minority staff at SFT. Ethnic Minority staff are concentrated in the middle two quartiles.

Disability: The mean and median gaps favour non-disabled staff across the Group, caution is noted as there is a high level of staff with a declaration status of 'unknown' and Disabled staff are under-represented in senior roles. Disabled staff are concentrated in the lower pay quartiles.

What we'll do to address the disparities:

- Undertake a Gender Pay Gap Deep Dive to identify the drivers of the gap, including movement between bands and adoption of the Mend the Gap recommendations, and set short and medium-term goals that increase the rate of progress (December 2026).
- Engage with the BSW Hospitals Group Joint Women's Staff Network so staff feedback shapes our actions (December 2026).
- Standardise pay gap reporting across the Group through combined datasets to support improved analysis (September 2027).
- Address the disability and ethnicity pay gaps through the WDES and WRES action plans, led by a multiprofessional working group (March 2027). This workstream is informed by NHS England's recommendations based on the Lord Mann review – to address systemic racism and discrimination.

Workforce Race Equality Standard

29.1% of our staff are from an ethnic minority background, broadly in line with the national NHS picture. Representation rose at GWH (30.3% to 33.7%) and RUH (23.6% to 25.0%) and held steady at SFT (29.1%).

However, diversity thins sharply with seniority. Ethnic minority staff make up 35.0% of Bands 5-7, yet only 6.8% of posts at Band 8a and above – just one of our 18 very senior managers and 10.8% of board members. Non-clinical teams (14.3% Ethnic Minority) are much less diverse than clinical teams (34.5%), but more representative of the local populations.

Staff experience is improving in places, discrimination fell significantly at GWH (-5.2%) and harassment, bullying and abuse from patients (-3.0%) and colleagues (-2.9%) fell at RUH. However, RUH's discrimination rate (17.6%) remains the Group's highest and is above the national average and SFT's shortlisting-to-appointment ratio has significantly worsened (6.04, whereas parity is equal to 1).

The equality gap still persists across the Group. Ethnic minority staff are around 5-10 percentage points less likely than White staff to believe their organisation provides equal opportunities for career progression.

What we'll do to address the disparities:

- Implement the Lord Mann Review recommendations, including publishing a Group Antiracism Statement, strengthening mandatory training and providing tailored training for boards and people services (by March 2027).
- Evaluate shortlisting-to-appointment data, with a priority deep dive at SFT, and act on disparities (by March 2027).
- Monitor take-up of leadership and development opportunities by demographic group and triangulate with progression into senior roles (Q4 2026).
- Run the 'Data & You' campaign to improve ethnicity declaration rates, targeting GWH unknown status below 5% (March 2027).
- Publish Ethnicity Pay Gap reports by 31 March 2027 and act on the Let's Talk Inclusion survey findings (from Q3 2026).



Workforce Disability Equality Standard

Declaration rates are improving but still understates reality. 5.1% of staff have a disability recorded, this has improved at GWH and RUH, but this rate is far below the roughly one-in-four staff who report a disability or long-term health condition in our NHS Staff Survey results.

More than one in ten staff at GWH (13.4%) and RUH (11.7%) have no status recorded, compared with under 2% at SFT.

Disability representation falls with seniority. 6.8% of staff in Bands 1-4 have a disability recorded, falling to 3.8% at Band 8a and above and 2.3% of medical and dental staff.

Experience has improved in places, harassment, bullying and abuse from colleagues fell significantly at GWH (-4.4%) and RUH (-5.4%) and fewer staff entered formal capability processes at GWH and SFT.

However, some metrics have significantly declined at SFT. More disabled staff feel pressured to come to work when unwell (+6.0%), fewer felt their work was valued (-3.6%) and fewer reported harassment, bullying and abuse when they experienced it (-3.8%).

Disabled staff across the Group remain less likely to feel they have equal opportunities or that their organisation values their work.

What we'll do to address the disparities:

- Run the 'Data & You' campaign to improve disability declaration rates, targeting unknown status below 8% at all organisations (March 2027).
- Roll out Business Disability Forum resources across the Group and support managers to provide timely, consistent reasonable adjustments, using tools such as the NHS Health Passport (Q3 2026).
- Engage with disabled staff and networks to identify improvements to equal opportunities and reasonable adjustments (Q2 2026).
- Establish a Group benchmark for completed appraisals by protected characteristic and monitor access to leadership development (Q2-Q4 2026).
- Encourage speaking up, promote reporting routes and continue annual monitoring of the formal capability process (ongoing).

An action plan is included at the end of each report in the Appendix.

EDI Priorities for 2026-27

Our three reports, our data and the voice of our staff points us towards a common set of Group EDI priorities for the year ahead.

One Group, One Team: We will combine our EDI teams to share expertise, reduce duplication of service, achieve savings and deliver a consistent offer across the three care organisations, supported by the new Group strategy, People Plan and its talent management and organisation design workstream.

Understand and close our pay gaps: We will deliver a Gender Pay Gap deep dive, including adopting the appropriate Mend the Gap report recommendations and setting short- and medium-term goals to accelerate progress.

Safe to Learn. Safe to Work initiatives: We will address discrimination, harassment, bulling and abuse from whatever source and implement the Lord Mann Review recommendations, including adopting a Group Antiracism Statement.

Trustworthy data: We will build a culture where staff feel safe and see the benefit of sharing information about their protected characteristics.

Fair recruitment and progression: We will make recruitment and promotion demonstrably fair from shortlisting to appointment and build stronger routes for under-represented staff into Band 8a+ and board-level roles – we acknowledge it will take time to see transformation in this area, due to an overall reduction in our staffing levels and resultant fewer vacancies, developing and promoting internal talent is key to future plans.

Listen and act: We will continue to engage with our staff and our staff networks to shape our plans and act on the 'Let's talk Inclusion' survey findings and improve timely access to reasonable adjustments.

We hope that you have found this report informative. Please refer to the full reports in the appendix for a more in-depth insight into our data and corresponding action plans.

We invite our stakeholders to take part in our 'Improving Together' journey. Building a culture where everyone feels valued, respected and included requires a collective effort.

We know the best solutions come from listening to and working alongside our staff, patients, communities and partners. By sharing your experiences, feedback and ideas, you can help us drive meaningful improvements across our hospitals.

To get involved in our EDI work, please email sft.bswedi@nhs.net.

BSW HOSPITALS GROUP

Workforce Disability Equality Standard (WDES) Report

April 2025 – March 2026



BSW Hospitals Group Workforce

The following data shows our Group workforce at a glance.

- Staff with a disability recorded: 867 (5.1%)
- Staff recorded as non-disabled: 14,339 (84.7%)
- Disability status not recorded: 1,723 (10.2%)

NHS comparator: 6.7% of NHS Trust staff had a disability recorded on Electronic Staff Record (ESR) in March 2025.

16,929

BSW Hospitals Group staff

Workforce profile

Across the three local care organisations, 867 staff (5.1%) have a disability recorded on ESR. Rates are broadly similar at GWH and RUH and slightly lower at SFT.

Staff with a disability recorded on ESR, 2025-26 (%)



Our ESR records indicate that disabled staff across the Group are under-represented (5.1), when compared to the national comparator (6.7%), however, when we compare this data with our NHS Staff Survey results, more staff have stated they have a disability or long-term health condition (GWH 22.0%, RUH 24.5%, SFT 22.1%), signalling that our staff records do not reflect reality and we must continue to encourage staff to share this information.

Based on our electronic staff records, the disabled staff group is under-represented when compared to the local populations (Bath & North East Somerset 16.2%, Swindon 16.9%, Wiltshire 16.4% - Census 2021).

Disabled staff (including staff with long-term health conditions) are more likely to be employed in non-clinical roles (7.2%), compared to clinical roles (4.9%) and are significantly under-represented in medical and dental roles (2.3%).

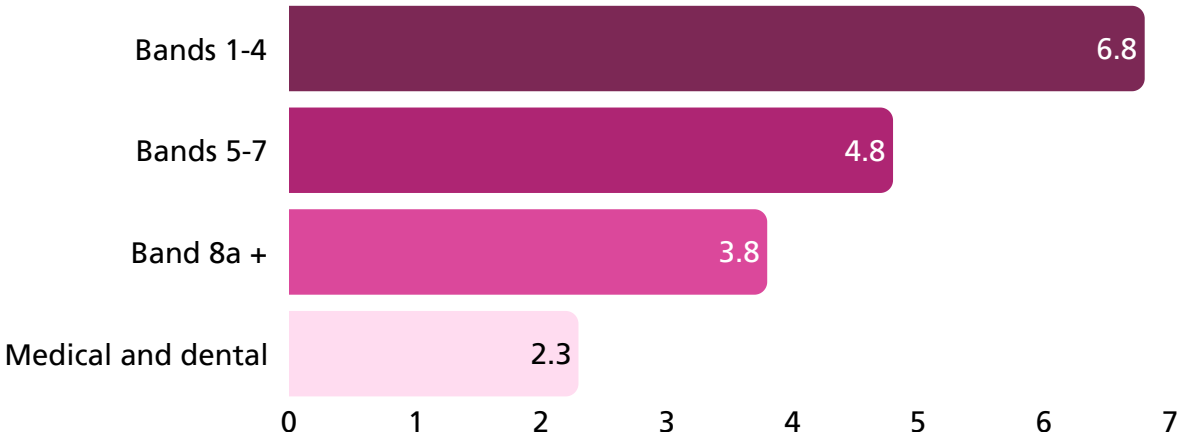
Representation by staff group

Staff group	Headcount	Disabled	Unknown
Non-clinical	3,993	7.2%	10.6%
Clinical (Non-medical)	10,608	4.9%	10.8%
Medical and dental	2,328	2.3%	8.9%
All staff	16,929	5.1%	10.2%

Our data also indicates that declared disability falls steadily as the pay bands rise and is lowest in the medical and dental workforce.

This pattern mirrors the national picture and suggests that senior and medical staff are less likely to share their disability and that they face barriers to progression. The care organisations will continue to engage with disabled staff to address this.

Staff with a disability recorded by pay band group, 2025-26 (%)



Board representation

Of the 37 board members across all three care organisations, three (8.1%) have declared a disability – close to the 7.3% national NHS board average, but this is not representative of the population we serve. Each board has one disabled member (GWH 6.7%, RUH 10.0%, SFT 8.3%).

With six of the thirty-seven board members (16.2%) not having their status recorded, our board figures are likely to understate the true picture; improving declaration rates across the workforce will strengthen our data and in turn, our action plans.

The group is keen to improve representation and will continue to promote opportunities across multiple channels and recruit from a diverse candidate pool and interview panel for every vacancy.

Board	Total members	Disabled	%	Non-disabled	%	Not recorded	%
GWH	15	1	6.7%	10	66.7%	4	26.7%
RUH	10	1	10%	8	80%	1	10%
SFT	12	1	8.3%	10	83.3%	1	8.3%
Group	37	3	8.1%	28	75.7%	6	16.2%

Improving Together

The three care organisations undertake work throughout the year to improve the working life experience of our disabled staff including provision of an extensive health and wellbeing offer and occupational health service, training and development for all staff and training to equip staff to address unprofessional behaviours, and we support a number of networks – including disabled staff networks, EDI/Inclusion champion networks, recruitment champions, mental health first aiders and health and wellbeing champions.

We are Disability Confident Employers and Equal Opportunity Employers and have adopted a continuous improvement approach to addressing inequalities experienced by staff.

Over the year we have been strengthening our collaboration across the Group and our EDI staff work together to coproduce and deliver training, events and respond to national priorities. In 2026-27, we will combine these teams to capitalise on the strengths each organisation has developed, reduce duplication, streamline our offer, and build capability and capacity.

The table below highlights changes in our WDES metrics since our last report:

Harassment / bullying / abuse from colleagues - GWH (-4.4%); RUH (-5.4%)	Staff satisfied with the extent to which their organisation values their work - RUH (-2.8%)
Staff entering a formal capability process - GWH (-1.5); SFT (-1.8)	Staff reported harassment / bullying / abuse - SFT (-3.8%)
Harassment / bullying / abuse from managers - GWH (-1.3%)	Felt pressured from their manager to come to work despite not feeling well enough to perform their duties SFT (+6.0%)
Staff reported harassment / bullying / abuse - GWH (+1.5%)	Staff satisfied with the extent to which their organisation values their work - SFT (-3.6%)
Harassment / bullying / abuse from patients - RUH (-2.0%)	

Work will take place during 2026-27 to address the metrics that have significantly declined (right column). The remaining metrics have remained relatively the same since last year.

Although SFT's metric 'Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process' has improved (-1.8), this is significantly higher than the rest of the group (GWH 0.51 and RUH 0.0) – Employee Relations will continue to take appropriate action.

The Staff Survey Working Group will address the metrics that have declined for non-disabled staff including 'feeling pressured to work despite not being well enough to perform their duties' and 'feeling valued'; and addressing unprofessional behaviours will benefit all staff including non-disabled. This report is supported by an action plan that responds to the Group as a whole and the individual care organisation needs.

Key messages

- **Declaration is improving:** The share of staff with a disability recorded rose at GWH (5.3% to 5.5%) and RUH (4.9% to 5.3%) and the Group rate of 5.1% is 1.6 percentage points below the national NHS average.

- **But our records understate reality:** Nationally, around one in four NHS staff state they have a disability or long-term health condition in the annual NHS staff survey, far more than the one in twenty recorded on staff records. We acknowledge further improvements are required and we will continue to promote the need to share this voluntary information with our staff, including an annual reminder which is sent via the Electronic Staff Record system.

- **Representation falls with seniority:** 6.8% of staff in Bands 1-4 have a disability recorded, falling to 3.8% at Band 8a and above, and just 2.3% of medical and dental staff.

- **Data completeness varies:** More than one in ten staff at GWH (13.4%) and RUH (11.7%) have no disability status recorded, compared with 4.1% at SFT, highlighting opportunities to identify good practice across the group.

- **Our 2026-27 focus:**
  - We will build trust and confidence to share information about protected characteristics;
  - Support managers to provide timely reasonable adjustments, working in partnership with the Business Disability Forum (BDF) to implement best practice and provide all staff access to BDF and internal resources;
  - Engage with disabled staff and disabled staff networks to promote 'training and development' opportunities and identify barriers to access and career progression;
  - And tackle bullying and harassment and discrimination from patients, members of the public and staff.

We recognise progress towards a more inclusive NHS can only be achieved through partnership. We will continue to work collaboratively with staff, governors, volunteers, patients and the communities we serve to deliver our inclusion objectives and improve outcomes for all.



Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is a set of ten measures, introduced in 2019, that compare the workplace and career experiences of disabled and non-disabled staff. NHS Trusts use their WDES data to understand where experiences differ and to publish action plans to close the gaps.

This joint report focusses on the workforce profile of the standard: how many of our staff have a disability recorded, in which roles, and at what level of each organisation and the report highlights elements of their working life experience in comparison to non-disabled staff.

Why declaration matters: Our figures are based on what staff choose to record on the NHS Electronic Staff Record (ESR) system. When staff feel safe to share a disability or long-term health condition or recognise the importance of sharing this information, we can put the right support and adjustments in place and allocate the right level of resources to address disparities for this group of staff; and our data becomes a truer picture of our workforce.

Metric / Breakdown	GWH	RUH	SFT	NHS
1) Percentage of staff in the Trust with a Disability or Long Term Health Condition (AfC Bands 1-9 and VSM) – see workforce profile				
Disabled staff	5.49%	5.34%	4.36%	6.65%
Non-disabled staff	81.15%	82.96%	91.54%	81.42%
2) Relative likelihood of non-Disabled candidates compared to Disabled candidates being appointed from shortlisting across all posts.				
	0.97*	1.1*	0.62	0.95
3) Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.				
	0.51*	0	4.84	N/A
4a1) Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months				
Disabled staff	34.14%	27.64%	24.62%	29.14%
Non-disabled staff	24.72%	21.98% Δ	20.2%	22.64%
4a2) Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months				
Disabled staff	12.89%	12.69%	13.17%	14.12%
Non-disabled staff	6.89%	6.62%	6.19%	7.6%

Metric / Breakdown	GWH	RUH	SFT	NHS
4a3) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months				
Disabled staff	22.37% Δ	18.57%	24.38%	24.45%
Non-disabled staff	15.99%	14.90%	14.32%	15.75%
4b) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.				
Disabled staff	53.12%	50.52%	49.51% Δ	53.16%
Non-disabled staff	51.98%	50%	55.19% Δ	52.89%
5) Percentage of Disabled staff compared to Non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion (question updated and therefore not compared to 2024-25 data)				
Disabled staff	50.58%	44.71%	50%	47.79%
Non-disabled staff	57.08%	52.88%	55.42%	55.09%
6) Percentage of Disabled staff compared to Non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties				
Disabled staff	28.55%	23.28%	27.67% Δ	27.19%
Non-disabled staff	19.39% Δ	16.94% Δ	19.15%	18.19%
7) Percentage of Disabled staff compared to Non-disabled staff saying that they are satisfied with the extent to which their organisation values their work				
Disabled staff	34.27%	32.96%	34.58% Δ	32.09%
Non-disabled staff	46.39%	44.6%	46.42% Δ	45.1%
8) Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work				
	74.40%	78.22%	78.27%	73.65%
9a) The staff engagement score for Disabled staff, compared to Non-disabled staff and the overall engagement score for the organisation				
Disabled staff	6.32	6.38	6.4	6.29
Non-disabled staff	6.96	6.96	7	6.91

Metric / Breakdown	GWH	RUH	SFT	NHS
9b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? See relevant organisation in the next section.				
10) Percentage difference between the organisation's Board voting membership and its organisation's overall workforce - See each care organisation below:	+1.2	+4.7	+4	+0.7%

We undertake a range of initiatives each year to improve equity for our staff including setting Board objectives, delivering EDI training and development, supporting our staff networks, reviewing our recruitment process to ensure it is fair and consistent and addressing unprofessional behaviours. We also offer an extensive suite of support for our workforce led by our Occupational Health and Wellbeing Services.

Key
Improvement for staff
Similar findings
Deterioration for staff
Δ = differs by 2.5 points or more

Great Western Hospitals

When analysing the WDES data, metrics have remained relatively the same for the number of disabled staff employed; shortlisting to appointment ratio; harassment, bullying and abuse from patients, disabled staff who have felt pressure to work from a manager despite not feeling well enough to perform their duties; disabled staff saying they are satisfied with the extent to which their organisation values their work, staff saying their employer has made adequate adjustments and metrics 6, 7, 8 and the engagement score for disabled staff.

GWH employed 5,794 staff at the snapshot date of 31 March 2026. 318 (5.5%) are disabled, 4,702 (81.1%) non-disabled and 774 (13.4%) have not shared their status.

The percentage of disabled staff has increased by +0.2% from 5.3% to 5.5%; the medical and dental declaration is 1.8% which could signal under-representation of disabled staff in that group or that fewer staff are willing to share their information; but overall the percentage of staff with 'unknown' status has improved by 2.5 percentage points from 15.9% to 13.4%.

Staff group	Headcount	Disabled	Unknown
Non-clinical	1,180	8.5%	12.2%
Clinical (Non-medical)	3,726	5.4%	14.5%
Medical and dental	888	1.8%	10%
All staff	5,794	5.5%	13.4%

The GWH board consists of fifteen members; one (6.7%) is disabled, no change from last year; 10 (66.7%) are non-disabled and four (26.7%) are 'unknown'.

GWH 2025-26 Board Membership			
	Disabled	**Non-disabled**	**Unknown**
Voting	1	10	4
Non-voting	0	0	0
Executive	0	6	1
Non-executive	1	4	3
Total	1	10	4
Board %	6.67%	66.67%	26.67%
Overall workforce %	5.49%	81.15%	13.36%

There has been a small improvement in relative likelihood of disabled staff entering a formal capability process(-1.5); harassment bullying and abuse from managers (-1.3%) and disabled staff or a colleague reporting their experience of abuse (+1.5%); and significant improvement in harassment, bullying and abuse from colleagues (-4.4%).

Notably, shortisting to appointment is 0.97, which is close to parity (1) with non-disabled staff; and disabled staff are less likely to enter a formal capability process (0.5).

Metrics have not worsened (where this is statistically significant) for disabled staff. However, 34.1% of disabled staff experience harassment, bullying and abuse from patients, relatives and the public, this is the group's highest and well above the NHS average (29.1%). Strengthening GWH's Never OK campaign will support improvement in this metric.

Supporting disabled staff at GWH

The Differently Abled Network's chair sits on the Inclusion & Health Inequalities Subcommittee, a strategic group that oversees the Inclusion and Health Inequalities agenda. All network chairs are invited to an annual workshop with the board, in June 2025 they met to review WRES, WDES and Pay Gap data and their feedback was used to inform the action plan for 2025-26.

GWH has achieved Level 3 Disability Confident Leader accreditation. Staff have access to 24/7 support, Mental Health First Aiders, Wellbeing Champions and EDI Champions and the wider workforce receive training on addressing unprofessional behaviours, civility, bystander training and compassion training, focussing on emotional regulation. GWH launched its Guide to supporting staff with long-term health conditions and impairments in December 2025 and provide a range of resources to help line managers provide reasonable adjustments for their staff.

The EDI team implemented, Improving Together, GWH's continuous improvement methodology into the workstream, and this has enabled staff to get involved in informing what work is undertaken and in co-designing key projects.

Royal United Hospitals Bath

The WDES metrics for RUH have remained relatively the same for 7 of the 10 metrics, with no statistically significant movements – including workforce profile; shortlisting to appointment ratio; likelihood of disabled staff entering a formal capability process; experiencing harassment bullying and abuse from managers; reporting this experience; feeling pressured to come to work despite not being well enough to perform their duties; receiving reasonable adjustments; and their engagement score.

RUH employed 6,480 staff at the snapshot date of 31.03.2026. 346 (5.3%) are disabled, 5,376 (83.0%) are non-disabled and 758 (11.7%) have not shared their status.
The percentage of disabled staff has remained relatively the same, an increase of 0.4%, the 'unknown' rate has edged down from 12.2% to 11.7% but remains above one in ten staff. As elsewhere in the group, representation is markedly lower among medical and dental staff (2.4%), which could signal under-representation or that staff are unwilling to share this information.

Staff group	Headcount	Disabled	Unknown
Non-clinical	1,470	6.9%	14.4%
Clinical (Non-medical)	4,182	5.4%	10.7%
Medical and dental	828	2.4%	12%
All staff	6,480	5.3%	11.7%

RUH has ten board members. One (10.0%) is disabled; 8 (80.0%) are non-disabled and one (10.0%) is recorded as 'unknown'. The number of disabled board members is unchanged since last year, board membership has reduced from seventeen to ten, which will skew the percentages when comparing year-on-year.

RUH 2025-26 Board Membership			
	Disabled	**Non-disabled**	**Unknown**
Voting	1	8	1
Non-voting	0	0	0
Executive	0	4	1
Non-executive	1	4	0
Total	1	8	1
Board %	10%	80%	10%
Overall workforce %	5.34%	82.96%	11.7%

Metric 4a.1 percentage of disabled staff experiencing harassment, bullying and abuse from patients and the public has improved by 2% and the percentage of disabled staff experiencing harassment, bullying and abuse from colleagues has significantly improved by

5.4%. RUH will continue to support its Inclusion Champions and deliver training to address unprofessional behaviours.

Notably, no disabled staff (0.0%) have entered a formal capability process.

Metric 7, disabled staff saying that they are satisfied with the extent to which their organisation values their work, has significantly declined by 2.8% to 33%. The group will take steps to address this in 2026-27.

Supporting disabled staff at RUH

RUH supports a number of staff networks including their disabled staff network, Enable, the network meets regularly to inform its members and hosts events and activities. RUH also facilitates a Neurodivergence Support Group for staff with autism, ADHD, dyslexia, dyspraxia, dyscalculia and Tourette syndrome as well as managers or staff who want to support their neurodiverse colleagues.

The care organisation has also rolled out Inclusion Champion training which includes conversations around equality vs equity for disabled staff, reasonable adjustments and support; and a dedicated counselling and psychological support service is available to all staff. RUH has achieved Level 2 Disability Confident Employer accreditation.

Salisbury Hospital

SFT WDES data has remained relatively the same for six of the ten metrics (no statistically significant difference) – including the percentage of disabled staff employed; relative likelihood of appointment from shortlisting; likelihood of staff entering a formal disciplinary process; experiencing harassment, bullying and abuse from either patients/visitors; managers or colleagues; and percentage of disabled staff who feel their managers have made adequate adjustments for them to carry out their work.

SFT employed 4,655 staff at the snapshot date of 31 March 2026. 203 (4.4%) are disabled, 4,261 (91.5%) are non-disabled and 191 (4.1%) have not shared their disability status.

The number of disabled staff has reduced by 1.1% since last year, to 4.4% from 5.5%. The number of staff with an 'unknown' status is the lowest in the group at 4.1%, this represents an opportunity to share good practice across the group.

Staff group	Headcount	Disabled	Unknown
Non-clinical	1,343	6.5%	5.2%
Clinical (Non-medical)	2,700	3.6%	3.7%
Medical and dental	612	2.9%	3.6%
All staff	4,655	4.4%	4.1%

The SFT board consists of twelve members. One (8.3%) is disabled, an increase from zero last year; and ten (83.3%) are non-disabled; one (8.3%) member is recorded as 'unknown'. The board has reduced by two members since last year, due to the size of the board, any changes will result in a significant impact on this metric.

SFT 2025-26 Board Membership			
	Disabled	Non-disabled	Unknown
Voting	1	10	1
Non-voting	0	0	0
Executive	1	4	0
Non-executive	0	6	1
Total	1	10	1
Board %	8.33%	83.33%	8.33%
Overall workforce %	4.36%	91.54%	4.1%

Metrics have significantly worsened for the following benchmarks – the percentage of disabled staff or a colleague reporting that they have experienced harassment, bullying and abuse (-3.8%); the percentage of disabled staff saying they have felt pressure to come to work despite not being well enough to perform their duties (+6%); and percentage of disabled staff who are satisfied with the extent to which their organisation values their work (-3.6%).

Although metric 3, the capability ratio has improved (-1.84), it is significantly higher than the rest of the group (GWH 0.51 and RUH 0.0), the process is monitored annually by the Employee Relations team and there are opportunities to strengthen this work by sharing good practice across the Group.

SFT will do more in year to improve awareness amongst line managers, including access to Business Disability Forum resources and training opportunities and to encourage staff to report abuse. As disabled staff across the group are less likely to feel they have equal opportunities or feel the organisation values their work, this will provide an opportunity to address this disparity at Group level.

Supporting disabled staff at SFT

SFT supports several staff networks including a disabled staff network, Ability Confident, that meets regularly to inform its members and hold events and activities. Neurodiversity training has been rolled out across the care organisation and the Supporting People with Disabilities at Work Policy has been updated and Health Passports have been launched.

In addition, a Reasonable Adjustments Policy, centralised budget and consistent approach is in place to support equitable access; staff have access to dedicated counselling and psychological support service and approximately 30 Mental Health First Aiders. SFT has achieved Level 3 Disability Confident Leader accreditation.

Looking ahead

BSW Hospitals Group will collectively address the disparities experienced by our disabled staff, capitalising on opportunities to share resources, expertise and good practice across the care organisations.

Over the coming year, we will strengthen our partnership working, including joint engagement with our workforce, the delivery of EDI-related training, the coproduction of resources and EDI-materials and working across organisational boundaries to implement legislative and policy change.

Our data and the voice of our staff in recent engagement points us towards five opportunities:

- Build a culture where staff feel safe and see the benefit of sharing information about their disability or long-term health condition.
- Promote the need for timely, consistent reasonable or workplace adjustments utilising tools like the NHS health passport, management and staff guides and providing all staff with access to Business Disability Forum resources including advice and guidance for managers and People professionals and staff will have access to training and events to help improve awareness.
- Monitor existing learning and development opportunities to ensure access is equitable and that over time, staff are able to progress as a result of these interventions.
- Seek to understand the lived experience of disabled staff who disproportionately feel less valued and have fewer opportunities to develop and progress and take action on findings.
- Addressing discrimination, harassment, bullying and abuse of disabled staff, whether from colleagues, managers or patients, their families or members of the public.

As an anchor institution, we are committed to the progress and wellbeing of the diverse communities in Bath and North East Somerset, Swindon and Wiltshire that we serve; and we are eager to become an employer of choice for minoritised groups of people.

With that in mind, we will continue to align our plans with NHS England's EDI Improvement Plan High Impact Actions (HIAs) and with our obligations as an employer under the Equality Act 2010 and we will work with our disabled staff to address the disparities they face and to shape a future that improves their access, experience and outcomes.

Notes:

- Headcount figures in the data are taken from ESR as of 31 March each year.
- 'Unknown' means no disability status is recorded.
- Percentages in the text have been rounded to one decimal point. At board-level and senior bands, staff numbers are small, therefore single leavers or joiners can move percentages notably.
- National comparator figures are from NHS England WDES 2025 data analysis report.

WDES Action plan

Action	Measure	HIA	Lead	Timescale
'Data & You' campaign to improve disability declaration rates	Unknown rate below 8% at all organisations	1	EDI / Comms	Mar 2027
Roll out of BDF across the group: improve awareness and access to resources, including advice/guidance, webinars, BDF networks and events	BDF metrics demonstrate widespread usage Year-on-year improvements to Metric 8 scores (currently above national average)	4	EDI	Q3 2026-27
The relative likelihood of Disabled staff entering a formal capability process is monitored on an annual basis through the Employee Relations workstream – this work will continue, capitalising on a Group approach	Year-on-year improvement to metric 3 – ratio reduced towards parity	6	EREP	Q3 2026-27
Establish a Group benchmark for completed appraisals monitored by protected characteristic to ensure staff have training and development needs formalised	Disabled staff are as likely to have completed their appraisal as any other demographic Year-on-year improvement to metrics 5, 7 and 9a Increase in percentage of disabled staff in senior roles	2 3	L&D	Q2 2026-27
Monitor take-up of leadership and development opportunities by demographic group and triangulate with progression to senior roles	Staff who invest in training and demonstrate capability are being promoted Increase in the number of Disabled staff promoted to B7 and above Improved Metric 7	2 3	L&D	Q4 2026-27
Engagement with disabled staff and networks: identify improvements to address equal opportunities (particularly in clinical roles) and reasonable adjustments	Improvements to metrics 6, 7	4	EDI / Networks	Q2 2026-27
Encourage speaking up and promote reporting routes across the Group, including resources and engage with staff and line managers to understand barriers	Recovery of Metric 4b at SFT and improvement at RUH and GWH Increased incident reporting via Datix or similar channels	6	EDI / FTSU	Ongoing
Develop Disability Pay Gap framework to enable reporting	Data available to enable reporting – report published by 31/3/27	3	WIT	Mar 27
Carry forward GWH workforce health inequalities dashboard action from 2025	Data available to inform health inequalities action plans	4	WIT / BI	Q4 2026-27

BSW HOSPITALS GROUP

Workforce Race Equality Standard (WRES) Report

April 2025 – March 2026



BSW Hospitals Group Workforce

The following data shows our Group workforce at a glance.

- Black and minority ethnic (BME) staff: 4,929 (29.1%)
- White staff: 11,283 (66.6%)
- Ethnicity not recorded: 717 (4.2%)

NHS comparator: 30.7% for WRES, ethnicity recorded on Electronic Staff Record (ESR) in March 2025.

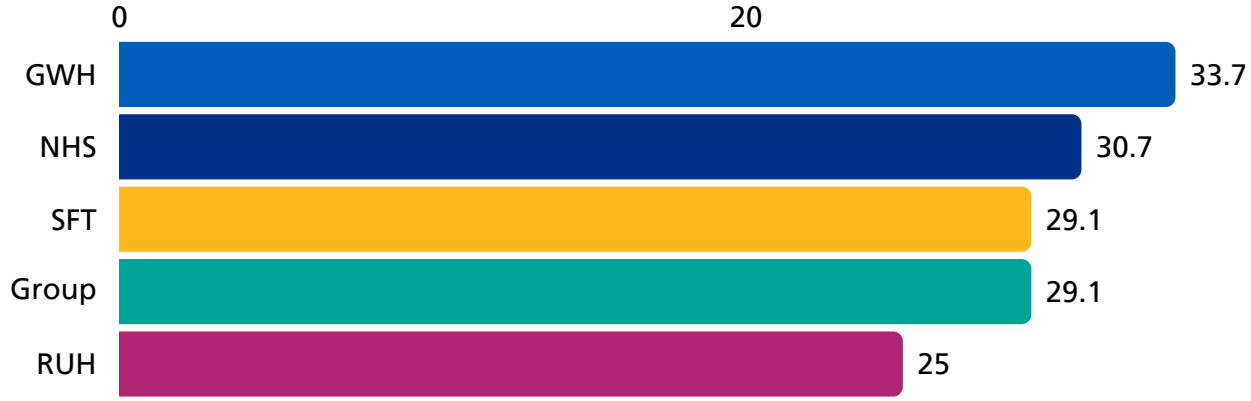
16,929

BSW Hospitals Group staff

Workforce profile

Across the three care organisations, 4,929 (29.1%) staff are from an ethnic minority background, with GWH having the most diverse workforce; and RUH has the least although this is growing in number with time. Based on our electronic staff records, the ethnic minority staff group is over-represented when compared to the local populations (Bath & North East Somerset 7.8%, Swindon 18.5%, Wiltshire 5.7% - Census 2021).

Ethnic minority staff as a percentage of the group workforce, 2025-26 (%)



Staff from ethnic minority backgrounds are more likely to be employed in clinical roles (34.6%) and medical and dental roles (29.3%) and are under-represented in non-clinical roles (14.3%).

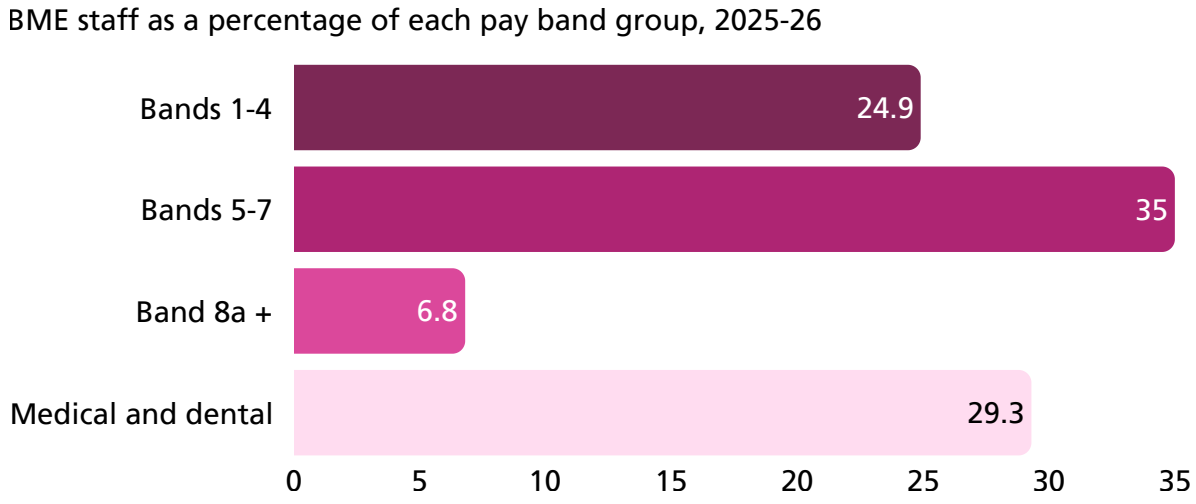
When looking at the Group as a whole, our ethnicity recording is relatively robust with only 4.2% of staff recorded as 'unknown'. GWH has some ground to make up 13.1% of its medical and dental workforce has an unknown status.

Note, to align with national data reference points, the term Black Minority Ethnic (BME) is used in the data tables.

Representation by staff group

Staff group	Headcount	BME	Unknown
Non-clinical	3,993	14.3%	3.4%
Clinical (Non-medical)	10,608	34.6%	3.8%
Medical and dental	2,328	29.3%	7.8%
All staff	16,929	29.1%	4.2%

Our data highlights that ethnic minority staff are strongly represented in Bands 5 to 7, typically made up of our registered nurses, midwives and allied health professionals (clinical staff), but hold only 62 of the 914 (6.8%) senior posts at Band 8a and above. An under-representation in senior roles mirrors the national picture and is a core driver for our initiatives to improve equal opportunities.



Board representation

BSW Hospitals Group has a total of 37 board members, four (10.8%) of whom are from an ethnic minority background, this is below our 29.1% workforce figure and the 17.3% national NHS board average. RUH board has become smaller in year, falling from seventeen to ten members – losing two ethnic minority board members, and with such small numbers, any change in demographics will move the percentages sharply.

With five of the thirty-seven board members (13.5%) not having their ethnicity recorded, our board figures are likely to understate the true picture; improving declaration rates across the workforce will strengthen our data and in turn, our action plans.
Our boards are committed to recruiting from a diverse candidate pool and interview panel for every vacancy.

Board	Total members	Disabled	%	Non-disabled	%	Not recorded	%
GWH	15	2	13.3%	10	66.7%	3	20%
RUH	10	1	10%	7	70%	2	20%
SFT	12	1	8.3%	11	91.7%	0	0%
Group	37	4	10.8%	28	75.7%	5	13.5%



Improving Together

The three care organisations undertake work throughout the year to improve the working life experience of our ethnic minority staff including provision of an extensive health and wellbeing offer and occupational health service, training and development for all staff, training to equip staff to address unprofessional behaviours, and we support a number of networks, including our race equality staff network, EDI/Inclusion champion network, recruitment champions, mental health first aiders and health and wellbeing champions. We are equal opportunity employers and have adopted a continuous improvement approach to addressing inequalities experienced by staff.

Over the year we have been strengthening our collaboration across the Group and our EDI staff work together to co-create and co-deliver training, events and to respond to national priorities. In 2026-27, we will combine these teams to capitalise on the strengths each organisation has developed, reduce duplication, streamline our offer, and build capability and capacity.

The table below highlights changes in our WRES metrics since our last report:

Discrimination from colleagues (-5.2%) (GWH)	SFT shortlisting to appointment ratio (+1.8)
Harassment/bullying/abuse from patients (-3.0%); and colleagues (-2.9) (RUH)	RUH Board representation – a loss of two ethnic minority board members
Shortlisting to appointment likelihood (-0.5%) (GWH)	Harassment/bullying/abuse from patients (GWH +1.2%, SFT +1.4%)
Harassment/bullying/abuse from colleagues (-1.4%) (GWH)	RUH discrimination (+1.5%)

Note, the Group's programme of work to address unprofessional behaviours in all its forms and our Health and Wellbeing offer and flexible working opportunities will benefit all staff irrespective of their protected characteristics.

This report is supported by an action plan that responds not only to BSW Hospitals Group as a whole but also the individual care organisation needs.

Key messages

- **We are diverse employers:** 29.1% of our staff are from an ethnic minority background, in line with national NHS figures (30.7%). Representation rose at GWH (30.3% to 33.7%) and RUH (23.6% to 25.0%). Ethnic minority staff representation at SFT has remained relatively similar at 29.11% (+1.07%).

- **But diversity thins sharply with seniority:** Ethnic minority staff make up 35.0% of staff in Bands 5-7, yet only 6.8% at Band 8a and above and just 1 of our 18 very senior managers.

- **Non-clinical teams are much less diverse:** 14.3% compared to clinical teams (34.6%) and medical and dental staff (29.3%), however, this is representative of the local populations, further analysis of the shortlisting to appointment data will identify any disparities.

- **Staff experience is improving in places:** At GWH the proportion of staff experiencing discrimination fell by 5.23%, at RUH fewer staff are experiencing harassment, bullying and abuse from patients (-3%) and colleagues (-2.9%) since 2024-25. WRES performance at SFT has remained largely unchanged since last year, with metrics showing stability and an incremental decline in one metric.

- **Our 2026-27 focus:**
  - We will continue to build trust and confidence to share information about protected characteristics.
  - We will address bullying and harassment and discrimination from patients, members of the public and staff.
  - We will improve equal opportunities including a fairer recruitment journey from shortlisting to appointment; promote and monitor access to leadership learning and development opportunities that will support promotions into senior roles; promote and monitor access to our talent management workstreams including coaching and career conversations and monitor the number of appraisals by ethnicity to ensure staff have timely conversations about their career goals.
  - We will continue to focus on staff engagement: we will engage with staff and involve them in change to ensure our EDI programmes of work meet their needs.
  - We will take an antiracism stance: following the recent publication of the Lord Mann review, NHS organisations like the BSW Hospitals Group, will implement a set of recommendations from NHS England, including publishing an antiracist statement, strengthening our mandatory training, providing tailored training to our boards and people services staff to improve their awareness and capability to address structural racism.

We recognise that progress towards a more inclusive NHS can only be achieved through partnership. We will continue to work collaboratively with staff, governors, volunteers, patients and the communities we serve to deliver our inclusion objectives and improve outcomes for all.

Workforce Race Equality Standard

The NHS Workforce Race Equality Standard (WRES) is an initiative aimed at addressing racial inequalities within the NHS workforce. It focuses on ensuring that employees from ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The WRES requires NHS organisations to collect, analyse, and publish data on race equality indicators such as recruitment, career progression, and disciplinary actions. By highlighting disparities and holding organisations accountable, the WRES seeks to create a more inclusive and equitable working environment for all NHS staff.

The 2025-2026 WRES Report is based on a snapshot of our workforce data as at 31 March 2026. Benchmark data, used for comparison, is based on staff survey results from NHS organisations of a similar size and nationally compiled data.

There are nine WRES indicators or metrics. This report summarises where we have made improvements and where there are further opportunities to drive change (see WRES metrics section).

We acknowledge that language, terminology and acronyms used in our reports align with national reporting standards and does not always reflect the identities and lived experience of individuals.

We undertake a range of initiatives each year to improve equity for our staff including setting Board objectives, delivering EDI-related training to our staff, supporting our Staff Networks, reviewing our recruitment process to ensure there is a fair and consistent approach to recruitment, delivering a range of learning and development opportunities and addressing unprofessional behaviours. We also offer an extensive suite of support for our workforce led by our Occupational Health and Wellbeing Services.

WRES Metrics

The following table includes the nine WRES metrics, RAG rated (improved, remained relatively the same or worsened).

Metric / Breakdown	GWH	RUH	SFT	NHS
1) Percentage of staff by ethnicity (AfC Bands 1-9 and VSM) – see workforce profile				
White staff	58.78%	75.95%	67.67%	65.4%
BME staff	33.71%	25.02%	29.11%	30.7%
2) The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants				
	1.46*	1.95*	6.04*	1.77
3) The relative likelihood of BME staff entering the formal disciplinary process compared to white staff				
	0.78*	1.67*	1.7*	1.11

Metric / Breakdown	GWH	RUH	SFT	NHS
4) The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff				
	1.03*	0.95*	1.24*	1.02
5) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months				
White staff	25.56%	21.55%	20.17%	22.93%
BME staff	29.17%	31.29%	24.37%	28.98%
6) Percentage of staff experiencing harassment, bullying or abuse from colleagues in last 12 months				
White staff	19.72%	18.27%	20.17%	20.48%
BME staff	22.16%	24.07%	18.46%	24.06%
7) Percentage of staff believing that their trust provides equal opportunities for career progression or promotion				
White staff	59.42%	52.34%	56%	55.46%
BME staff	49.11%	47.03%	50.4%	49.11%
8) Percentage of staff experiencing discrimination at work from other staff in the last 12 months				
White staff	6.43%	5.94%	5.89%	6.4%
BME staff	13.34%	17.63%	13.69%	14.7%
9) Percentage difference between the organisation's Board voting membership and its organisation's overall workforce – (see each care organisation below)				
	-20.4%	-15%	-20.8%	-13.39%

Key
Improvement for staff
Similar findings
Deterioration for staff
Δ = differs by 2.5 points or more

Great Western Hospitals

GWH employed 5,794 staff at the snapshot date of 31 March 2026. 1,953 (33.7%) were from an ethnic minority background and 3,406 (58.8%) White. Although the overall workforce fell by 336, the number of ethnic minority staff has increased by 97 (3.4%). Nearly four in ten clinical staff (39.7%) and medical staff (36.8%) are from an ethnic minority background, compared to 12.4% of non-clinical staff. Ethnicity recording at GWH is the Group's least complete (7.5% unknown overall, 13.1% unknown among medical staff).

Staff group	Headcount	BME	Unknown
Non-clinical	1,180	12.4%	5.3%
Clinical (Non-medical)	3,726	39.7%	6.9%
Medical and dental	888	36.8%	13.1%
All staff	5,794	33.7%	7.5%

The board consists of fifteen members, two (13.3%) are from an ethnic minority background, an increase of one since last year; 10 (66.7%) board members are White; and three (20.0%) Board members do not have their ethnicity recorded. There have been some changes to the Board in year; as a result the metrics have worsened because the number of members with ethnicity unknown has increased slightly, due to the small sample size; thus any change in representation will significantly impact the data.

Although, not included in the table below, GWH appointed two associate non-executive directors – one of whom is from an ethnic minority background, the Associate-NED role provides valuable Board experience; and this opportunity has further increased Board diversity. The board has also developed succession plans.

GWH 2025-26 Board Membership			
	BME	**White**	**Unknown**
Voting	2	10	3
Non-voting	0	0	0
Executive	0	5	2
Non-executive	2	5	1
Total	2	10	3
Board %	13.3%	66.67%	20%
Overall workforce %	33.71%	58.78%	7.51%

The Equal Opportunities metric has the widest gap: 49.1% of ethnic minority staff believe GWH provides equal opportunities vs 59.4% of White staff.

Staff survey data has indicated that the proportion of ethnic minority staff experiencing discrimination has significantly fallen by 5.2% since last year, as a result of an organisation-wide effort to address unprofessional behaviours. In addition, small improvements have been made in the following metrics: relative likelihood of being appointed from shortlisting – although achieving parity remains a priority; percentage of ethnic minority staff experiencing harassment and bullying and abuse from staff. The remaining metrics have stayed relatively similar to last year: staff entering a formal disciplinary process and ethnic minority staff accessing CPD and non-mandatory training.

There has been a slight increase in staff experiencing harassment, bullying and abuse from patients (+1.2%). GWH will continue to deliver 'Addressing Unprofessional Behaviours' training which was codesigned with staff across the Group; continue to recruit and support EDI champions and promote the Never OK campaign to combat both discrimination and bullying, harassment and abuse.

There was no statistically significant decline in any metrics for ethnic minority staff.



Royal United Hospitals Bath

RUH employed 6,480 staff at the snapshot date of 31 March 2026. 1,621 (25.0%) staff were from an ethnic minority background, an increase of 129 staff (+1.4%) since last year; growth is concentrated in the clinical workforce. RUH has the lowest representation of ethnic minority staff in the group, and lower than the national average (30.7%) – 7.8% of the BANES population is from an ethnic minority background.

Ethnicity recording at RUH is excellent, only 2% of staff have no ethnicity recorded: the best in the group.

Staff group	Headcount	BME	Unknown
Non-clinical	1,470	15.4%	2.4%
Clinical (Non-medical)	4,182	29.6%	1.6%
Medical and dental	828	19%	3.6%
All staff	6,480	25%	2%

RUH has ten board members, one (10%) is from an ethnic minority background; seven (70.0%) are White; and two (20%) do not have their ethnicity recorded. Board membership has reduced from seventeen last year to ten this year, including the loss of two ethnic minority Board members causing the metrics to worsen.

RUH 2025-26 Board Membership			
	BME	**White**	**Unknown**
Voting	1	7	2
Non-voting	0	0	0
Executive	0	3	2
Non-executive	1	4	0
Total	1	7	2
Board %	10%	70%	20%
Overall workforce %	25.02%	72.95%	2.04%

Three of the nine WRES metrics have remained relatively the same with no statistically significant changes – relative likelihood of being appointed from shortlisting; the likelihood of ethnic minority staff entering a formal disciplinary process (both above national average); and the likelihood of staff accessing non-mandatory training and CPD.

There were significant improvements in the percentage of ethnic minority staff experiencing harassment, bullying and abuse from patients, their family and members of the public (-3%) and from staff (-2.9%).

The percentage of ethnic minority staff experiencing discrimination has slightly worsened (+1.5%). This is the Group's highest discrimination rate (17.6%) and well above the national average (14.7%). To address discrimination, during the year RUH have increased the number of Inclusion Champions, adopted Report+Support (a 24/7 reporting tool) and have developed their People Hub to facilitate equitable support and guidance to improve resolutions. Staff can access training across the group and the planned merging of EDI teams and antiracism work will pave the way for Group-wide improvements.

Salisbury Hospital

SFT employed 4,655 staff at the snapshot date of 31 March 2026. 1,355 (29.1%) are from an ethnic minority background, overall representation matches the group average, with a strongly diverse clinical workforce (35.4%). Almost two-thirds of its Band 5 clinical staff are from an ethnic minority background. SFT's workforce has remained relatively the same since last year. Ethnicity recording is strong, only 3.2% of staff's ethnicity is unknown.

Staff group	Headcount	BME	Unknown
Non-clinical	1,343	14.9%	2.8%
Clinical (Non-medical)	2,700	35.4%	2.9%
Medical and dental	612	32.5%	5.7%
All staff	4,655	29.1%	3.2%

The SFT Board consists of 12 members. One (8.3%) is from an ethnic minority background; 11 (91.7%) are White. All board members have recorded their ethnicity. Membership has remained relatively the same since last year (7.1% BME).

SFT 2025-26 Board Membership			
	BME	**White**	**Unknown**
Voting	1	11	0
Non-voting	0	0	0
Executive	0	5	0
Non-executive	1	6	0
Total	1	11	0
Board %	8.33%	91.67%	0%
Overall workforce %	29.11%	67.67%	3.22%

Two metrics require improvement: The percentage of ethnic minority staff experiencing harassment, bullying and abuse from patients, their relatives and members of the public has slightly increased (+1.4%). In addition, the relative likelihood of ethnic minority staff being appointed from shortlisting has significantly worsened (+4.2). Shortlisting to appointment data will be further evaluated to inform the 2026-27 actions.

The remainder of SFT's metrics have remained relatively similar since last year, with no statistically significant changes; including the relative likelihood of BME staff entering a formal disciplinary process compared to White staff (1.7) which is above parity (1), the disciplinary process is monitored annually by the Employee Relations team and there are opportunities to strengthen this work by sharing good practice across the Group.

Looking ahead

BSW Hospitals Group will collectively address the disparities experienced by our staff from ethnic minority backgrounds, capitalising on opportunities to share resources, expertise and good practice across the three care organisations.

Over the coming year, we will strengthen our partnership working, including joint engagement with our workforce, the co-creation of resources and EDI-materials, a similar approach to the delivery of EDI-related training, and working together across organisational boundaries to implement legislative and policy change.

Our data and the voice of our staff in recent engagement points us towards four opportunities:

- Build a culture where all staff feel safe and see the benefit of sharing information about their ethnicity or other protected characteristics.
- Make recruitment and promotion demonstrably fair from shortlisting to appointment and build stronger routes for ethnic minority staff into Band 8a+ and board level roles. We will produce our Ethnicity Pay Gap report for the second year running and triangulate findings with relevant WRES metrics.
- Address discrimination, harassment, bullying and abuse, whether from colleagues, managers or patients, their families or members of the public.
- Implement NHS England Lord Mann Review recommendations, including publishing a group Antiracism Statement.

As an anchor institution, we are committed to the progress and wellbeing of the diverse communities in Bath and Northeast Somerset, Swindon and Wiltshire that we serve; and we are eager to become an employer of choice for minoritised groups of people. With that in mind, we will continue to align our plans with NHS England's EDI Improvement Plan High Impact Actions (HIAs) and with our obligations as an employer under the Equality Act 2010 and we will work with our ethnic minority staff to address the disparities they face and to shape a future that improves their access, experience and outcomes.

We recognise that progress towards a more inclusive NHS can only be achieved through partnership. We will continue to work collaboratively with staff, governors, volunteers, patients and the communities we serve to deliver our inclusion objectives and improve outcomes for all. If you would like to play a role in shaping this work, please contact sft.bswedi@nhs.net.

WRES Action plan

Action	Measure	HIA	Lead	Timescale
Implement the Lord Mann Review recommendations – including publishing a Group Antiracism Statement	Board approval Action plan developed and all actions have been completed	1 4 6	EDI	Mar 2027
Evaluate shortlisting to appointment ratio data – with a priority deep dive at SFT and act on disparities	Metric 2 ratios moved towards parity at all three organisations	2	Recruitment	Q3 2026-27
Monitor take-up of leadership and development opportunities by demographic group and triangulate with progression to senior roles	Staff who invest in training and demonstrate capability are being promoted Increase in the number of BME staff promoted to B7 and above Improved Metric 7	2 3 5	L&D	Q4 2026-27
Evaluate and standardise EDI-related training across the Group, including RUH's Root to Success leadership programme.	Staff access high quality training with demonstrable impact	2 3	EDI / L&D	Q4 2026-27
The relative likelihood of BME staff entering the formal disciplinary process is monitored on an annual basis through the Employee Relations workstream - SFT EDI data will be considered in the next reporting period	EDI data will be monitored across the group and appropriate actions taken	4	ERBP	Q4 2026-27
Publish Ethnicity Pay Gap reports	Report published by 31 Mar 2027	3	EDI / WIT	Mar 2027
'Data & You' campaign to improve ethnicity declaration rates	GWH unknown below 5% Board unknown reduced	1 2 3 6	EDI / Comms	Mar 2027
Act on 'Let's Talk Inclusion' Survey findings – this will benefit all minoritised groups of staff	Staff informed and findings reflected in action plans where appropriate	All	EDI	From Q3 2026-27

Notes:

- Addressing discrimination will form part of the Lord Mann Review workstream.
- Rollout of Group People Plan and its actions will be managed by People Operations.
- Headcount figures taken from ESR as of 31 March each year, covering non-clinical, clinical and medical & dental staff by pay band. 'BME' (Black and minority ethnic) is the standard WRES reporting category.
- 'Unknown' - no ethnicity status is recorded, incl. prefer not to say and blank records.
- Workforce totals fell during 2025-26 due to structural reasons – care should be taken when interpreting year-on-year workforce data, as changes reflect both the transfer of community staff to HCRG Care Group under TUPE arrangements and reduced recruitment activity linked to financial recovery and cost-improvement programmes. This mostly affected white staff as they represent the largest proportion of the workforce.
- Percentages have been rounded to one decimal point. At board-level and senior bands, staff numbers are small, therefore single leavers / joiners can move percentages notably.
- National comparator figures are from the NHS England WRES 2025 data analysis report (2025 Workforce Race Equality DCF Returns and 2024 NHS Staff Survey).

BSW HOSPITALS GROUP

Pay Gap Reports

- Gender pay gap
- Ethnicity pay gap
- Disability pay gap

April 2025 – March 2026



Pay Gap Reports 2025-26

Under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, public sector employers in England and Wales with 250 or more staff are required by law to publish an annual gender pay gap report based on a snapshot of their workforce on 31 March of each year. This report presents the pay gap position, for the three care organisations within the BSW Hospitals Group – GWH, RUH and SFT. The pay gap reporting has been expanded to include the Ethnicity Pay Gap, for the second year running and Disability Pay Gap for the first time.

The Gender Pay Gap report covers the measures each organisation is required to publish – Mean and Median Pay Gap, Bonus Pay Gap, the proportion of men and women who receive bonus pay and the proportion of men and women in each pay quartiles. We have used the same metrics for the Disability and Ethnicity Pay Gaps. This year the Group are producing a shortened report and corresponding actions are noted at the end of this report. Note, a Gender Pay Gap Deep Dive will be undertaken during autumn and winter 2026 to identify the drivers of the pay gap, including movement between Bands and a review of the adoption of Mend the Gap recommendations across the Group and further actions will be identified as a result.

Key definitions	
Mean pay gap	• The difference between the average hourly pay of all men and all women, expressed as a percentage of men's average hourly pay. • Likewise, the Disability and Ethnicity pay gaps are the difference between the average hourly pay of all White and BME staff, expressed as a percentage of the average hourly pay of White staff and the difference between the average hourly pay of all non-disabled and disabled staff, expressed as a percentage of the average hourly pay of Non-disabled staff. • The mean is sensitive to a small number of very high earners.
Median pay gap	• The difference between the hourly pay of the middle-ranked man and the middle-ranked woman when each group is ordered from lowest to highest paid. The same principles are applied to the Disability Median and Ethnicity Median pay gap. • The median is not affected by extreme values.
Equal pay	• Equal pay refers to the requirement for men and women to receive the same pay for work of equal value, this is mandated in the Equality Act 2010.
Pay quartiles	• All staff ordered by hourly pay and divided into four equal groups, from the lowest paid (lower quartile) to the highest paid (upper quartile), showing the proportion of men and women, disabled and non-disabled, and White and BME staff in each.
Bonus pay gap	• The mean and median difference in bonus pay between men and women, disabled and non-disabled or White and BME staff who received a bonus. Bonus payments relate almost entirely to Clinical Excellence Awards, therefore recipient numbers are small.
Snapshot date	• Figures are calculated for staff employed on 31 March. Bonus figures cover the 12 months up to the snapshot date.

Note, a positive gap means men, non-disabled staff or White staff are paid more on average than their counterparts (women, disabled and BME staff), a negative gap means the opposite, e.g. women are paid more than men.

Equal Pay Statement

BSW Hospitals Group is committed to ensuring that all employees receive equal pay for equal work, irrespective of sex, ethnicity, disability or any other protected characteristic. The Group applies nationally agreed NHS Terms and Conditions of Service (Agenda for Change) for the majority of staff, supported by the NHS Job Evaluation Scheme, which provides a consistent and objective framework for determining pay based on the knowledge, skills, responsibilities and demands of each role. Medical and Dental staff are employed under nationally agreed contractual arrangements.

A pay gap does not indicate unequal pay for equal work. Pay gaps reflect the distribution of different groups across grades, professions and seniority levels within the workforce. The findings within this report therefore highlight differences in representation across the workforce rather than evidence of unequal pay for employees undertaking the same or equivalent roles.

BSW Hospitals Group is confident that its pay policies, job evaluation processes and recruitment and reward arrangements support the principle of equal pay for equal work. We will continue to review workforce data, monitor equality outcomes and take action to address the factors that contribute to gender, ethnicity and disability pay gaps.

Our EDI annual report highlights several initiatives that we undertake across the year to improve our pay gaps including access to career development and training, providing access to coaching and career conversations, appointing and supporting volunteer EDI Champions who sit on interview panels for senior roles and reviewing our recruitment practices to ensure we attract a diverse candidate pool. Staff also participate in an annual appraisal process, which supports career development conversations, identifies learning opportunities and helps managers to plan for future talent and succession needs – this contributes to improving equality of opportunity and increasing representation in senior positions over time.



Gender Pay Gap Report

Women comprise approximately three-quarters of the workforce across all three care organisations (GWH 79.7%, RUH 73.5% and SFT 74.2%). Despite this, we have retained a gender pay gap because women continue to be underrepresented in some of the highest paid roles, particularly within medical and dental career pathways and they are more likely to work less-than-full-time and be impacted by occupational segregation.

Although there is a pay advantage in favour of men, men are underrepresented in the NHS when compared with the population which is closer to 50/50 representation, this is exacerbated by traditional views about roles which tend to attract more women applicants. Our 2026 data show differing levels of progress across the three organisations, with continued improvement in some areas.

At a glance, the Gender Pay Gap for 2025-26 at each care organisation is:

Gender Mean and Median Pay Gap 2025-26

	No of employees in scope	Workforce female	Workforce male	Mean pay gap	Median pay gap
GWH	5,586	79.7%	20.3%	27%	17.3%
RUH	6,247	73.5%	26.5%	15%	-3.9%
SFT	4,710	74.2%	25.8%	17.4%	0.8%

There is a small increase in the mean pay gap since last year's report: GWH +1%; RUH +0.5% and SFT +1.9% (gap is 27.0%, 15.0% and 17.4% respectively). The mean pay gap remains in favour of men.

There is a large increase in the median pay gap at GWH +3.53% since last year, a small increase at SFT +0.8, both in favour of men and the pay gap has slightly increased in favour of women at RUH by 0.7 percentage points.

Gender Bonus Pay Mean and Median Gap 2025-26

	No of employees in scope	Female receiving bonus	Male receiving bonus	Mean pay gap	Median pay gap
GWH	5,586	0.29%	2.91%	5%	54.3%
RUH	6,247	0.45%	3.03%	21.9%	7.6%
SFT	4,710	0.65%	3.17%	16.3%	5%

Only a small percentage of consultants receive a bonus, in the form of Clinical Excellence Awards and men are more likely to receive this payment, reflecting the profile of the consultant workforce. Because the recipient numbers are small, the bonus gap percentages can move sharply year to year and should be read with caution.

The mean bonus pay gap has reduced significantly by 25.8% at GWH (to 5.0%) and 3.7% at SFT (to 16.3%) and increased by +2.16% at RUH (21.9%).

The median bonus pay gap has reduced by 8.2% at GWH (to 54.3%) and 8.7% at SFT (to 5.0%) and increased significantly at RUH by 20.0% (to 7.6%) – this was previously in favour of women, -12.4%.

Pay quartiles - Lowest to highest pay

	Overall		Q1		Q2		Q3		Q4	
	F	M	F	M	F	M	F	M	F	M
GWH	79.7%	20.1%	83.5%	16.5%	83.9%	16.1%	86.3%	13.7%	65.1%	34.7%
RUH	73.5%	26.5%	71.3%	28.7%	74.3%	25.7%	82.3%	17.7%	66.5%	33.5%
SFT	74.2%	25.8%	73.4%	26.5%	75.6%	24.4%	82.8%	17.3%	65%	35%

Women in each pay quartile

The pattern across the Group is consistent and mirrors the national NHS picture; women make up around three-quarters or more of the lower (Q1), lower middle (Q2) and upper middle(Q3) quartiles, but their representation falls to around 65-67% in the upper (Q4) quartile, well below their share of the overall workforce. Men are therefore disproportionately over-represented among the highest earners and under-represented in Q1 to Q3.

	Lower	Lower middle	Upper middle	Upper
GWH	83.5%	83.9%	86.3%	65.1%
RUH	71.3%	74.3%	82.3%	66.5%
SFT	73.4%	75.6%	82.8%	65%

Five-year progress

Progress is slow, reinforcing the need to understand the specific workforce factors driving the gap in each organisation.

	2022	2026	Mean GPG change since 2022
GWH	30.3%	27%	3.3% ⌄
RUH	18.8%	15%	3.8% ⌄
SFT	19.7%	17.4%	2.2% ⌄

What is driving the gap?

- Women are concentrated in nursing, midwifery, administrative and support roles in the lower and middle pay bands (occupational segregation).
- Men are over-represented in senior roles across all three organisations, particularly in the upper pay quartile and at consultant level.
- The medical pay gap is amplified by seniority-related pay and Clinical Excellence Awards, where men predominate among the longest-serving consultants.
- There are some long-standing differences in the terms and conditions of service for medical staff, this is being improved gradually over time.
- Our data shows that more women than men work less than full time, research indicates that this can have a knock-on effect on career progression as fewer senior roles are available as part-time opportunities; career breaks and childcare responsibilities can also have an impact on accumulated years of experience which can also be a factor. Engagement with staff is required to understand the unique needs of women in the Group.



Looking ahead

The 2026 report demonstrates a mixed picture, there are small increases in the mean gender pay gap which is more sensitive to outliers in the data (staff on very low and very high pay) and the gap remains in favour of men at all three organisations; and small increase in the median pay gaps at GWH and SFT in favour of men; and small increase in the median gap in favour of women at RUH.

There are improvements in the mean bonus gender pay gaps – a significantly reduced gap at GWH and smaller reduction at SFT. The mean gap has slightly worsened at RUH. The median bonus pay gap is in favour of men and have considerably improved at GWH and SFT, but worsened at RUH, where it was previously in favour of women.

At the current rate of progress (see five-year progress) it would take over 14 years to achieve pay parity at RUH and closer to 30 years at GWH and SFT. Therefore, our priority going forward is to understand the workforce factors that are impeding progress. In response to this need, a Gender Pay Gap Deep Dive will take place during Winter 2026.

These findings will inform our strategic medical workforce planning, succession/talent management plans and training and development needs and our 2026-2027 pay gap action plans. We acknowledge reducing the pay gap is a long-term ambition, but we are keen to identify some short- and medium-term goals that will increase the rate of progress.

An action plan is included at the end of the pay gap reports.



Ethnicity Pay Gap Report

The Ethnicity Pay Gap report, follows the same formatting as the Gender Pay Gap report. The Ethnicity Pay looks at the difference in the average hourly rate of all White staff and all staff from an Ethnic Minority background, The report measures the Mean and Median Pay Gap, Bonus Pay Gap, the proportion of White and Ethnic Minority staff (BME) who receive bonus pay and the proportion of White and Ethnic Minority Staff in each pay quartiles.

Although we are not legally mandated to produce an Ethnicity Pay Gap report, we undertake this work as part of our commitment to implement the NHS England EDI Improvement Plan, High Impact Action 3 – to publish and take action on the ethnicity and disability pay gaps.

Ethnicity Mean and Median Pay Gap 2025-2026

	No of employees in scope	Workforce white	Workforce BME	Mean pay gap	Median pay gap
GWH	5,586	59.4%	32.9%	6.4%	2.9%
RUH	6,247	73.2%	24.9%	8.2%	0.4%
SFT	4,710	67.8%	28.1%	3.9%	-4.4%

The mean pay gap (6.4%) continues to be in favour of White staff at GWH, and the gap has increased by 2.81% since last year. The median pay gap which was slightly in favour of Ethnic Minority staff last year* (-1.4%), is now in favour of White staff (2.9%), an increase of 4.3%.

Both the RUH mean and median bonus pay gaps are in favour of White staff. The mean ethnicity pay gap (8.2%) has increased by 1.7% since last year and the median ethnicity pay gap has increased by 2.6% and is now close to parity (0.4%), the median was previously in favour of Ethnic Minority staff (-2.2%).

SFT did not produce an Ethnicity Pay Gap report last year. The mean and median ethnicity pay gap in 2026 is 3.9% in favour of White staff and -4.4% in favour of Ethnic Minority staff.

**A Median gap in favour of Ethnic Minority staff occurred because these staff tend to be more concentrated around the middle two quartiles (occupying middle-banded roles).*

Ethnicity Mean and Median Bonus Pay Gap 2025-26

	No of employees in scope	Workforce white Receiving bonus	Workforce BME Receiving bonus	Mean pay gap	Median pay gap
GWH	5,586	0.5%	0.9%	1.8%	-26.7%
RUH	6,247	1.4%	0.4%	-33.1%	-121.8%
SFT	4,710	1.8%	0.7%	20.1%	0%

The mean ethnicity bonus pay gap at GWH remains in favour of White staff but is now much closer to parity at 1.8%, the gap has reduced by 6.4%. The median ethnicity bonus pay gap remains in favour of Ethnic Minority staff (-26.7%)*, the gap has reduced significantly by 9.1%.

The RUH report in 2025 did not include the ethnicity bonus pay gap. The gap this year is in favour of Ethnic Minority staff, with a mean gap of -33.1% and median gap of -121.8%. (See below**).

SFT did not produce an Ethnicity Pay Gap report last year. The mean ethnicity bonus pay gap in 2026 is 20.1%, the median is zero (parity). The mean is sensitive to extremely high and low hourly rates.

**The median gap in favour of Ethnic Minority staff at GWH occurred because fewer of these staff received a bonus; and the distribution of payments was more compact (fewer very low and very high values).*

***The extremely large median bonus pay gap in favour of RUH Ethnic Minority staff this year is affected by two factors – a small number of Ethnic Minority staff received a bonus (8 staff), but those who did were concentrated in high-value award categories; in comparison, White staff received a larger volume of bonuses (74 staff) but payments were distributed across lower and higher value categories.*

Caveat, where the Median bonus is in favour of Ethnic Minority staff, this should be interpreted with caution because of the small number of staff receiving the bonus payment. Small numbers can lead to substantial fluctuations in median calculations and may not be representative of the wider workforce.

Staff (GWH 6, RUH 1 and SFT 4 staff) with an unknown or undisclosed ethnicity status have been excluded from the ethnicity bonus analysis.

Pay quartiles - Lowest to highest pay

	Overall		Q1		Q2		Q3		Q4	
	White	BME	White	BME	White	BME	White	BME	White	BME
GWH	64.4%	35.6%	72.5%	27.5%	53.9%	46.1%	56.8%	43.2%	74.7%	25.3%
RUH	73.5%	24.9%	79.7%	18.3%	65.9%	32%	65.5%	36.1%	83.8%	13.8%
SFT	74.2%	25.8%	29%	14.6%	22.4%	31.7%	21.2%	34.5%	27.4%	19.2%

Ethnic minority staff in each pay quartile

Ethnic Minority staff are concentrated in the Lower Middle and Upper Middle pay quartiles. When compared with the wider workforce, these staff are under-represented in the Lower and Upper quartiles, thus affecting the Median pay.

GWH has the highest concentration of staff in lower and upper middle bandings (GWH >40%, RUH and SFT >30%).

	Lower	Lower middle	Upper middle	Upper
GWH	27.5%	46.1%	43.2%	25.3%
RUH	18.3%	32%	36.1%	13.8%
SFT	14.6%	31.7%	34.5%	19.2%

What is driving the gap?

- The mean pay gap has occurred because White staff earn more per hour on average, there are more White staff in the Upper Quartile, significantly more at GWH and RUH.
- The median pay gap, however, is not affected by extreme values, it looks at the two middle values. BME staff are more concentrated around the middle two quartiles.
- The percentage of staff who are of an unknown ethnicity (GWH 7.7%, RUH 1.9% and SFT 4.0%) can distort the pay gap accuracy, both representation and pay statistics for Ethnic Minority staff could be under or overstated.
- A small number of Ethnic Minority staff receiving high bonuses has resulted in median bonuses in their favour.

Disability Pay Gap Report

The Disability Pay Gap report, follows the same formatting as the Gender Pay Gap report. The Disability Pay looks at the difference in the average hourly rate of all Non-Disabled staff and all Disabled staff, The report measures the Mean and Median Pay Gap, Bonus Pay Gap, the proportion of Non-Disabled and Disabled staff who receive bonus pay and the proportion of Non-Disabled and Disabled staff in each pay quartiles.

Although we are not legally mandated to produce a Disability Pay Gap report, we undertake this work as part of our commitment to implement the NHS England EDI Improvement Plan, High Impact Action 3 – to publish and act on the disability and ethnicity pay gaps.

All three care organisations have produced a Disability Pay Gap report for the first time.

Disability Mean and Median Pay Gap 2025-2026

	No of employees in scope	Workforce non-disabled	Workforce disabled	Mean pay gap	Median pay gap
GWH	5,586	81.2%	5.4%	17.9%	11.8%
RUH	6,247	83%	5.3%	19.6%	18.8%
SFT	4,710	93.9%	4.4%	13.3%	15.4%

The GWH mean and median disability pay gaps are in favour of non-disabled staff (17.9% and 11.8% respectively). Disabled staff remain underrepresented in middle-banded and senior roles and a significant proportion of the workforce has not shared their disability status (see Group WDES report).

The RUH mean (19.6%) and median (18.8%) disability pay gaps are in favour of non-disabled staff.

The SFT mean (13.3%) and median (15.4%) disability pay gaps are in favour of non-disabled staff.

Disability Mean and Median Bonus Pay Gap 2025-2026

	No of employees in scope	Workforce non-disabled	Workforce disabled	Mean pay gap	Median pay gap
GWH	5,586	0.6%	0.7%	262.4%	52.1%
RUH	6,247	0.9%	0%	N/A	N/A
SFT	4,710	1.3%	0%	N/A	N/A

The mean (262.4%) and median (52.1%) bonus payments at GWH are in favour of non-disabled staff. 46 staff received a bonus, 2 Disabled, 29 Non-disabled and 15 Unknown status, therefore the results should be interpreted with caution, a significant mean gap could be driven by one or two comparatively large awards and not representative of the wider workforce.

As bonuses at RUH and SFT were awarded to non-disabled staff and staff with an unknown status, a disability bonus payment gap cannot be meaningfully calculated and has therefore been reported as 'not applicable'.

Pay quartiles - Lowest to highest pay

	Overall		Q1		Q2		Q3		Q4	
	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled
GWH	81.2%	5.4%	90.5%	9.5%	93.5%	6.4%	94.6%	5.4%	96.1%	3.9%
RUH	83%	5.3%	79.9%	9.2%	82.7%	5.1%	86.6%	4.3%	82.9%	2.4%
SFT	93.9%	4.4%	92.1%	6.5%	94.2%	4%	94.9%	3.6%	94.6%	3.5%

Disabled staff in each quartile

Disabled staff are concentrated in the Lower pay quartile (Q1). When compared with the wider workforce (5.1% Group), these staff are under-represented in the Lower Middle (Q2) at SFT; Upper Middle (Q3) at RUH and SFT and Upper quartile (Q4) in all three organisations.

High levels of 'unknown status' affect the accuracy of this data, representation is over or understated (Unknown GWH 13.4%, RUH 11.7%, SFT 1.7%).

	Lower	Lower middle	Upper middle	Upper
GWH	9.5%	6.4%	5.4%	3.9%
RUH	9.2%	5.1%	4.3%	2.4%
SFT	6.5%	4%	3.6%	3.5%

Impact of unknown status

Our ESR records indicate that disabled staff across the Group are under-represented (5.1%), when compared to the national comparator (6.7%), however, when we compare this data with our NHS Staff Survey results, more staff have stated they have a disability or long-term health condition (GWH 22.0%, RUH 24.5%, SFT 22.1%), signalling that our staff records do not reflect reality. The Disability Pay gap data quality is impacted by this anomaly.

Disability Pay Gap Unknown Status data

- GWH - 13.43%
- RUH - 11.7%
- SFT - 1.67%

What is driving the gap?

The mean gap which is in favour of non-disabled staff at all three organisations occur because Disabled staff on average earn less per hour, Disabled staff are more concentrated in the lower pay quartile and representation diminishes progressively in the remaining quartiles. This is corroborated by the median pay gap which is also in favour of non-disabled staff, which is less affected by extreme values (very low or very high pay).

More non-disabled staff received a bonus leading to a bonus pay gap, in favour of this group, in addition approximately 50% of those receiving a bonus had no status recorded.

Pay gap actions

An action plan is included in this report to address the pay gap disparities.
In addition to the actions noted below, we will continue to provide leadership and development opportunities, coaching and Scope for Growth conversations across the Group to support career progression; and engage with our staff, Staff Networks and other stakeholders to better understand the barriers and to shape future interventions.

Action	Measure	HIA	Lead	Timescale
Engagement with Group Women's Staff Network	Feedback from staff incorporated into actions	2 3	Head of EDI	Dec 2026
Gender Pay Gap Deep Dive analysis	Targeted actions identified – include improving access to relevant training and development, coaching, and adopting relevant Mend the Gap report recommendations.	2 3	Head of EDI	Mar 2027
Standardised datasets	A standardised approach to pay gap reporting across the Group that will support improved analysis.	2 3	WIT	Sep 2027
Disability Pay Gap	See WDES Report Actions*	N/A	Head of EDI (Multi-professional working group)	Mar 2027
Ethnicity Pay Gap	See WRES Report Actions*	N/A	Head of EDI (Multi-professional working group)	Mar 2027
Publish Ethnicity Pay Gap reports	Report published by 31 Mar 2027	3	EDI / WIT	Mar 2027

**Disability and Ethnicity Pay Gap Actions to improve Equal Opportunities for Disabled and Ethnic Minority staff are highlighted in the Workforce Disability and Race Equality Standard reports. Work will include a campaign to encourage staff to share their protected characteristics (improve quality of data), engagement with staff to understand their experience, the promotion and monitoring access to leadership development opportunities, and reviewing Recruitment processes. See WDES and WRES reports in this appendix.*

Report to the Care Organisation Management Committee

Care Organisation	**Great Western NHS Foundation Trust**
Committee	Quality and Safety Assurance Committee
Meeting date	23/09/26
Author	Luisa Goddard, Chair
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance
Linked to Strategic Priority (s)	Outstanding care; Valued teams; Better together; Sustainable future
Linked BAF principal risk(s)	R6 Reducing waits R8 Reducing avoidable harm R9 Improving staff satisfaction
Reporting period	August 2026

1. Executive summary

The Committee received the August 2026 quality position, including the Integrated Performance Report, nutrition and hydration deep dive, maternity and neonatal oversight and the NHS England 10 Point Plan baseline assessment, divisional governance escalation reports, gynaecology deep dive, learning from deaths, PSIF update, dementia, cervical screening, safe staffing, transfusion safety and CQC preparedness. The Trauma and Orthopedic deep dive was delayed due to presenter availability.

Overall assurance is partial. Although the total reported harms are stable, the level of harm in August has deteriorated, especially falls with severe harm and blood stream infections. This has been triangulated with the fall in the safe staffing fill rates.

Residual risks remain in patient flow and corridor care, whole-pathway stroke performance, maternity triage estate and time to medical review, neonatal workforce non compliance with standards, incident and Duty of Candour backlogs, gynaecology pathway tracking, theatre cancellations, and the reliability of evidence that actions are embedded.

2. Alert, Advise, Assure

2.1 Alert

Trust quality performance and patient flow

- Total reported harms reduced to 111 in August from 122 in July. Falls were relatively stable but there was a significant rise in the level of harm seen with five resulting in moderate harm or above.
- The Trust remains above the South West average for health care associated infections especially MSSA and E.Coli blood stream infections. There is also one MRSA bloodstream infection was under investigation.
- Four-hour performance in the Integrated Front Door reduced to 63%. Corridor care increased, and prolonged waits and ambulance handover pressures continue to affect timely assessment, observation, privacy, dignity and patient experience.
- Stroke remains the highest divisional quality risk at score 13. Early measures improved, including imaging, consultant assessment, thrombolysis and thrombectomy transfer times, but SSNAP remains at level E and whole-pathway reliability remains inconsistent.

Maternity and neonatal services

- Maternity triage is the principal area of risk within the NHS England 10 Point Plan baseline assessment. The current estate does not fully meet the national specification, and the local audit found 73.3% of women assessed within 15 minutes and 56% receiving obstetric review within the required timeframe. Full compliance is dependent on estate, medical workforce and data developments.

- Neonatal nursing and medical establishments remain below BAPM standards. Daily staffing and capacity review, escalation arrangements and 12-hour, seven-day ANNP cover provide mitigation, but sustainable workforce plans remain required. GWH was identified as an NNAP Alarm outlier for high-risk neonatal follow-up, a plan to address this is in place.
- On track for CNST submission with no current areas of concern for escalation.

Divisional governance and pathways

- All divisions reported overdue incidents and it was agreed for further focus is required with an emphasis on learning. This is being addressed with support of the Associate Director of Quality.
- Delays in Critical Care discharges exceeding four hours and short-notice theatre cancellations at 16.6%.
- The gynaecology deep dive identified unreliable end-to-end ownership of referrals, results, follow-up and treatment. Twelve of 91 incidents were moderate harm or above, RTT performance was 55.1% against a 67% target, and 16 incidents remained open.
- The Trauma and Orthopaedics deep dive was postponed to next month.

Workforce

- Safe staffing processes remained robust, but sickness increased above the 3.5% threshold and 39% of shifts were recorded amber or red. CHPPD validation identified previously overstated figures because some occupied bed days were not included.

2.2 Advise

Risk, learning and governance

- The corporate register contained 10 approved risks scoring 12 or above. Controls were assessed as partially effective or planned/minimal across the portfolio. Risk compliance was 80%, with 108 overdue risk reviews and 219 overdue risk actions reported as at 1 September 2026.
- Family and Specialist Services reported four new score-10 paediatric follow-up capacity risks require a consolidated workforce and mitigation plan.
- The Q1 Patient Safety Learning Report identified recurring themes in recognition and escalation, professional communication, clinical records, consent and capacity, Duty of Candour and under-reporting. Nine PSIIs were in progress, three overdue, with operational demands affecting investigation timeliness.

Clinical effectiveness and digital safety

- Nutrition-related incidents did not increase overall; however, five moderate-harm incidents remain under review, including two relating to the PEG pathway. Dysphagia education, reliable access to meals and enteral feeds, and specialist oversight remain priorities.
- Following a recent audit NG tube practice needs improvement and an action plan will be taken through Nursing and Midwifery Group.
- Fifteen digital programmes are undergoing clinical safety review, including PACS, RIS, DAWN, Dragon Ambient Voice Technology, Concentric and Microsoft 365 Copilot and AI tools. Safety cases are required before deployment or material live-service change.
- Learning from Deaths indicators remain within expected ranges, but concerns persist regarding medical examiner collaboration, engagement with mortality review, Trauma and Orthopaedics governance and the future resource model for the mortality function.
- Update was given on JAG accreditation, responses have been submitted to JAG following initial submission with governance arrangements being flagged as needing strengthening.

2.3 Assure

Quality improvement and clinical outcomes

- Deconditioning performance improved to 48% of inpatients sitting out for lunch in August. Ward-level improvement was supported by leadership, daily huddles, the ICAN tool and planned patient activity coordination.
- Hip-fracture mortality is reported in line with the national average and the service is no longer identified as a national outlier. Formal NJR governance, multidisciplinary review and ongoing surveillance are established.
- The Cervical Screening Service met the majority of national standards, maintained robust multidisciplinary governance and received strong patient feedback. The principal service-level gap was timeliness of treatment following high-grade CIN diagnosis.
- Mortality indicators, including SHMI, remained within the expected range. Of 75 scored Structured Judgement Reviews, 57 rated care good or excellent, with learning shared through established routes.

Governance controls and safe practice

- Family and Specialist Services closed 239 incidents in August and the Sexual Health Never Event immediate controls were embedded, including re-confirmation of consent and device, verbal WHO checklist use and separated stock storage. The full review remains due for completion in October.
- The Trust remains rated Good overall by CQC. Governance arrangements are in place for inspection actions, supported by the Accreditation Programme and a focused Well-Led improvement programme.

3. Risk review

3.1 Risks requiring continued executive oversight

Risk ID & title	Score	Controls	Committee view
GWH-1267: Stroke pathway delays and timely intervention risks	13	Planned / minimal	SSNAP remains at level E despite early pathway improvement. Whole-pathway delivery and sustained outcomes require executive oversight.
GWH-570: Surgical Assessment Unit demand, delayed triage and assessment	12	Partially effective	Demand, unsuitable care environments and delayed assessment continue to affect safety and experience.
GWH-1560: Maternity Care Centre and Day Assessment Unit layout	12	Planned / minimal	The environment does not fully meet the national maternity triage specification. Estate, workforce and data actions require prioritisation.
GWH-1577: Suboptimal clinical environment	12	Planned / minimal	Environmental limitations continue to affect patient experience and clinical effectiveness.
GWH-1382: Interventional radiology staffing shortage	12	Planned / minimal	Out-of-hours arrangements commenced on 1 September; in-hours resilience and substantive capacity remain under development.

4. Good practice and innovation

- Incident recovery in Family and Specialist Services, including focused perinatal action and strengthened weekly oversight.
- Ward-led deconditioning work, including ICAN mobility goals, social dining and spread from higher-performing wards.
- Gynaecology triangulation of incidents, complaints, RTT and risks into a single improvement plan, supported by new operational management capacity.
- Nutrition Consultant appointment and multidisciplinary education across dietetics, speech and language therapy and clinical practice education.
- Cervical screening access, training and patient-experience initiatives, with sustained national programme compliance.
- Dementia and frailty developments, including FAST, trolley training, dementia champions and collaborative education across the Group.

5. Committee approvals and recommendations

Papers presented for approval / endorsement

- Approve the NHS England Maternity and Neonatal 10 Point Plan baseline assessment for submission, noting 10 compliant, 13 partially compliant, two non-compliant and one not-applicable deliverable, with maternity triage the principal risk.
- Approve the updated General and Chronic Transfusion Prescription Pathways as interim risk-reduction measures before EPR implementation.
- Approve the Cervical Screening Programme Lead Annual Report for assurance of national programme compliance and governance.

Recommended to the Management Committee

- Maintain Executive focus on patient flow and corridor care, stroke recovery, maternity triage estate and medical review, neonatal workforce, incident and Duty of Candour recovery, gynaecology pathway reliability, Trauma and Orthopaedics governance, theatre cancellations and infection prevention.
- Require recovery trajectories to evidence sustained reduction in overdue incidents, learning actions, Duty of Candour cases and risk reviews, with clear owners, dates and measures of impact.
- Support prioritisation of the maternity triage estate and workforce requirements and the development of a strengthened perinatal data and reporting model.

6. Looking ahead

- October reporting should include the Maternal Care Bundle implementation plan, Perinatal Workforce Report, Sexual Health Never Event review outcome and evidence of sustained divisional backlog recovery.
- November reporting should provide further Integrated Front Door assurance, including patient-feedback triangulation, effectiveness of mitigations and expected benefits of the acuity tool.
- December reporting should include the gynaecology improvement-plan progress report and the NHS England Maternity and Neonatal 10 Point Plan progress update ahead of the 31 December submission.
- Continue oversight of the independent Trauma and Orthopaedics review recommendations, NJR knee revision actions, mortality governance and the corporate 12+ risk profile.

FP&I September 2026
Report to the Care Organisation Management Committee

Care Organisation	Great Western Hospitals NHS Foundation Trust
Committee	Finance, Performance and Infrastructure Committee
Meeting date	22 September 2026
Author	Committee Chair
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance, with escalations and recommendations for action
Linked strategic priorities	Outstanding Care; Valued Teams; Better Together; Sustainable Future
Linked BAF principal risks	Operational performance and flow; financial sustainability and efficiency delivery; workforce; digital and clinical safety; estates, infrastructure and PFI expiry; patient safety and access.
Reporting period	August 2026 performance and September 2026 committee review

1. Executive summary

The Committee reviewed the operational, financial, workforce, digital, estates, health and safety, national oversight and strategic infrastructure position. The overall Committee position is Partial Assurance. Positive controls and improvement activity are evident, but assurance remains constrained by continued underperformance in urgent and emergency care, RTT and cancer; a material financial deficit and efficiency shortfall; workforce growth above plan; uncertainty around overdue outpatient follow-ups; and unresolved capacity and infrastructure risks. The September 2026 12+ Risk Report confirms that five risks within the Committee portfolio remain at a residual score of 12. There was no movement in risk ratings or assurance since the previous report, and controls remain either partially effective or planned but not yet in place.

The Committee retained Limited Assurance for urgent and emergency care recovery.

2. Alert, Advise, Assure

2.1 Alert

- **Risk portfolio.** Five risks within the Committee remit remain above the escalation threshold at a residual score of 12: high hospital occupancy and patient flow (GWH-1085), Building Safety Act delivery (GWH-1401), financial improvement capacity and capability (GWH-1576), sub-optimal clinical environment (GWH-1577), and PFI expiry betterment funding (GWH-1608).
- **Operational performance and patient flow.** August combined four-hour performance was 63.6%, 15.5 percentage points adverse to plan. Ambulance handover performance averaged 41 minutes and remained above the 33-minute trajectory. September showed some improvement, but the Committee did not receive sufficient evidence of sustained recovery and retained Limited Assurance.
- **Outpatient follow-ups and patient safety.** The follow-up waiting list was 32,059, including 10,169 patients overdue by more than one year. The Committee was concerned that the clinical risk within the cohort was not sufficiently understood and requested a focused review of potential harm, validation and mitigation, aligned to Risk 1290 and EPR migration.

- **RTT and elective recovery.** RTT performance was 57.7%, 4.3 percentage points below plan. The total waiting list remained controlled at 43,128 against a plan of 44,000, but 1,000 patients were waiting over 52 weeks and pre-operative assessment capacity remained a material constraint.
- **Cancer.** Cancer performance improved across the 28-day, 31-day and 62-day measures, supported by additional capacity and Cancer 360. However, performance remained below trajectory, demand was 5.3% higher year on year, and further recovery depended on continuation of additional capacity funding.
- **Financial position and efficiency delivery.** At Month 5 the Trust reported a £17.7m deficit, £13.2m adverse to plan. Efficiency delivery was £8.5m against a £14.9m year-to-date plan, with a forecast full-year shortfall of approximately £16.5m against the £47.2m target. NHS England rated delivery confidence as a significant concern because recurrent benefit realisation remained insufficient.
- **Workforce and cost base.** Workforce stood at 5,372 WTE against a plan of 5,187, an adverse variance of 185 WTE. Substantive staffing had increased without a corresponding reduction in temporary staffing. The Committee requested clearer analysis of the elective cost base, recovery costs, income and workforce/vacancy effects.
- **Cash and capital.** The Trust remained cash positive at the reporting point, but the forecast indicated a potential £5.2m overdrawn position at March 2027 before revenue cash support. Capital commitments exceeded available funding by approximately £5.3m, although further national digital funding was being pursued.
- **Digital clinical safety and infrastructure.** Clinical Safety Officer capacity was materially below that required for three care organisations, EPR deployment and legacy system decommissioning. Ageing infrastructure, storage constraints and the cardiac monitoring compatibility issue also required continued oversight.
- **Estates, fire and security.** Building Safety Act delays, PFI expiry resourcing, ACM cladding, BTC evacuation arrangements, fire safety staffing and mortuary security remained material concerns. The Committee requested formal reporting from the mortuary security review group.

2.2 Advise

- The proposed overdue follow-up review should define clinical validation methodology, specialty prioritisation, harm surveillance, accountable owners and milestones, with explicit linkage to EPR migration risk.
- Efficiency governance should clarify the respective roles of the delivery team, Executive team and SROs during the transition from Hunter, identify where Group schemes are reviewed, and maintain a regular operational-financial triangulation forum.
- EPR workforce readiness requires a clear ownership and assurance route. Detailed operational readiness should remain within governance of the DCOO, DCNO and CCIO, with escalation to Group forums for unresolved cross-organisational risks.
- Premises Assurance findings should be aligned with the corporate risk register and a clear owner established for long-term estate utilisation and service capacity planning.

2.3 Assure

- Imaging diagnostic modalities remained strong, and an outsourcing plan was in place for Respiratory Physiology activity.
- Cyber and information governance assurance remained positive, statutory requirements were met, and no material cyber incident affecting patient safety or critical service delivery was reported.
- The Premises Assurance Model showed Good ratings for Hard FM Safety, Soft FM Safety and Helipad, with Patient Experience rated Outstanding. The Committee approved the submission and noted the improvement programme.
- Health, Safety, Fire and Security KPIs exceeded target in Quarter 1. Thirty-five audits were completed and 83% of departments achieved Green or Amber ratings, although manual handling compliance remained below expectation.
- The Way Forward Programme reported no risks above 10, no overdue reviews and no actions without identified mitigation.
- The Committee supported progression to the next approval stage for procurement of a commercial Sterile Services operator partner, recognising the patient safety and business continuity case.

3. Risk review

The Committee considered the principal risks evidenced through the agenda papers and discussion. The risk picture is interconnected: high occupancy and poor flow constrain planned care, drive temporary staffing and escalation costs, and weaken financial recovery; constrained capital and digital capacity increase operational and patient-safety exposure.

3.1 Risks requiring formal escalation or sustained management attention

Risk ID & title	5+5+5 score	Controls assessment	Reason for escalation
GWH-1085 High hospital occupancy and patient flow	12	Partially effective	High occupancy continues to affect safe flow, ED crowding, corridor care and delivery of elective activity.
GWH-1576 Financial improvement capacity and capability	12	Partially effective	The deficit, efficiency gap and competing operational pressures continue to constrain confidence in delivery of the financial plan.
GWH-1401 Building Safety Act delivery risk	12	Planned / minimal assurance	Approval and competency requirements continue to delay works required.
GWH-1608 PFI expiry resourcing / betterment funding	12	Planned but not in place / minimal assurance	Current resource is materially below national guidance and a decision on the future FM model and programme resource is required.
GWH-1577 Sub-optimal clinical environment	12	Planned but not in place / minimal assurance	Physical constraints and clinical environments continue to affect service delivery, transformation and patient experience.

3.2 Narrative on escalated risks

- **GWH-1085 High hospital occupancy and patient flow.** The risk is consistent with 63.6% four-hour performance, corridor care, prolonged waits and NCTR pressures. Recovery controls are in place, but good assurance requires sustained improvement against trajectory and delivery of partner actions, particularly Pathway 3.
- **GWH-1576 Financial improvement capacity and capability.** Governance and external support have strengthened, but the year-to-date deficit and recurrent efficiency gap remain material. Risk reduction depends on cash-releasing delivery, proven run-rate reduction and quality-assured implementation.
- **GWH-1401 Building Safety Act delivery risk.** Alternative delivery arrangements and legal clarification provide some mitigation, but certain fire and infrastructure projects remain delayed. Further focus required on gateway approvals, competent resource, programme dates and consequences of further slippage.
- **GWH-1608 PFI expiry resourcing and betterment.** The Committee requires a costed resource plan, clarity on future FM delivery and alignment between premises assurance, condition survey findings and the corporate risk register.
- **GWH-1577 Sub-optimal clinical environment.** The physical estate continues to constrain service redesign and capacity. Long-term estate utilisation planning should link operational demand, clinical strategy, transformation, PFI expiry and investment priorities.

4. Good practice and innovation

- Cancer 360 has strengthened pathway visibility and patient tracking across tumour sites, supporting clearer governance of cancer recovery.
- Live operational reporting across front-door areas is improving visibility of patients approaching performance breaches and supports more targeted operational action.
- The six-week whole-hospital flow sprint, discharge lounge use, ward standard work and long-length-of-stay escalation demonstrate a structured improvement approach.
- The Premises Assurance Model provides a structured baseline for estate compliance and identifies a prioritised improvement programme across ventilation, ligature reduction, sustainability, water safety and governance.
- The Sterile Services procurement proposal presents a pragmatic route to address a longstanding safety and resilience issue where NHS capital and alternative local capacity are unavailable.
- The Committee applied challenge to causality, affordability, governance ownership and sustainability.

5. Committee approvals and recommendations

5.1 Approved or supported by the Committee

- Approved submission of the 2025/26 Premises Assurance Model return and supported development of prioritised action plans and business cases.
- Approved the Quarter 1 Health, Safety, Fire and Security report and noted progress against the strategy and KPIs.
- Supported commencement of procurement for a commercial Sterile Services operator partner and progression to the next approval stage.
- Noted the NHS National Oversight Framework Quarter 1 position, including movement to Segment 3 with the financial override in place.
- Noted the assurance reports from the Health and Safety Group, ORBIT and the Way Forward Programme.

5.2 Recommended to the Management Committee

- Endorse the overall Partial Assurance position and Limited Assurance for urgent and emergency care recovery until sustained improvement against trajectory is demonstrated.
- Support the executive review of overdue outpatient follow-ups, potential patient harm, mitigation and EPR migration requirements, with clear milestones and onward assurance reporting.
- Require an integrated elective recovery report showing activity, cost, workforce, income, commissioner affordability and benefits, distinguishing baseline expenditure from incremental recovery expenditure.
- Confirm ownership and governance for EPR workforce readiness and sustainable Clinical Safety Officer capacity, including the distinction between programme assurance and care-organisation responsibilities.
- Require a costed PFI expiry resource plan, decision timetable for the future FM operating model, and alignment of Premises Assurance findings with corporate risk entries and long-term estate strategy.
- Require strengthened efficiency delivery reporting focused on recurrent cash-releasing benefits, quality impact assurance, Group scheme governance and continuity through the transition to Hunter.
- Receive confirmation of mortuary security actions and lessons learned from the cardiac monitoring procurement issue.

6. Looking ahead

- The October cycle should test whether improvements in urgent care have been sustained and whether system actions are delivering measurable impact on demand, discharge and Pathway 3 delays.
- Future planned-care reporting should include the focused overdue follow-up review, pre-operative assessment workforce impact, RTT long waiter trajectories, cancer funding decisions and diagnostic recovery.
- Finance reporting should show recurrent efficiency delivery, run-rate reduction, workforce movement, temporary staffing, elective recovery, cash risk and capital prioritisation.
- Digital reporting should return with sustainable CSO arrangements, EPR workforce readiness, storage constraints assurance, cardiac monitoring governance learning and evidence of benefits realisation.
- Estates reporting should include PFI expiry resource and operating-model decisions, the condition survey, premises assurance action plan, Building Safety Act progress, mortuary security and long-term estate utilisation.
- The Committee will continue to refine the assurance format so each paper clearly states the assurance rating, evidence, residual risk, decision required, owner and timescale.

Report to the Care Organisation Management Committee

Great Western Hospitals NHS Foundation Trust People & Culture Committee Assurance Report | DRAFT

Care Organisation	Great Western Hospitals NHS Foundation Trust
Committee	People & Culture Committee
Meeting date	22 September 2026
Author	Chair, GWH People & Culture Committee
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance, with matters for attention and recommendation
Linked priorities	Engaged workforce; diverse and inclusive teams; safer services; staff experience; financial sustainability
Reporting period	July to September 2026

1. Executive summary

Overall assurance is partial. Positive assurance is available on GWH sickness performance against the Group comparison, local medical governance, Freedom to Speak Up arrangements, preparation for the Staff Survey, and the increased maturity of workforce and risk reporting. However, concerns remain about workforce and pay delivery, the recent rise in sickness, staff confidence that speaking-up concerns will be acted upon, medical learner experience, workforce equality gaps, temporary staffing fill, and two significant workforce risks with minimal assurance. The private FPPT paper provides substantial assurance for the four GWH Executive files but limited Group-wide assurance.

2. Alert, Advise, Assure

2.1 Alert

- **Workforce and pay delivery:** At Month 5 GWH was 185 WTE above plan, a deterioration of 29 WTE from July. Substantive staffing was 133 WTE above plan and bank was 57 WTE above plan, although agency was below plan.
- **Sickness and staff availability:** GWH sickness increased to 4.86% in August from 4.24% in July, above the 3.5% Trust target. The effectiveness of hotspot interventions is being reviewed.
- **Significant workforce risks:** GWH-1382 Interventional Radiology shortage and GWH-1493 insufficient clinical leadership capacity both score 12, have minimal assurance and overdue reviews. Immediate review and refreshed trajectories are required.
- **Psychological safety and organisational response:** The FTSU report records 54 concerns and an 11.8 percentage-point gap between staff feeling safe to speak up and confidence that concerns will be addressed. Visible action, feedback and leadership accountability are required.

2.2 Advise

- **Medical learner experience:** NETS results improved in 11 of 13 domains, but bullying, discrimination, sexual safety, wellbeing, underreporting, Geriatric Medicine and Gastroenterology quality-of-care concerns require measurable action.
- **EDI:** GWH ethnic minority representation increased to 33.7% and discrimination reduced by 5.2 percentage points, but equal-opportunity, senior representation and pay gaps remain. Disabled staff harassment by patients is 34.1%, above the cited NHS comparator.
- **Transgender inclusion:** Assurance remains partial while a Group policy, facilities audits, communications, training, stakeholder engagement and governance are incomplete.
- **Temporary staffing and nursing expenditure:** Agency reliance has reduced, but bank use and nursing expenditure remain above plan and overall fill performance requires continued scrutiny.
- **FPPT:** All four GWH Executive files were assessed compliant. The wider Group audit found 12 of 32 files fully compliant, so Group remediation and retrieval of evidence should continue.

2.3 Assure

- **Responsible Officer and medical governance:** The previous Committee received strong assurance on appraisal, revalidation, job planning and professional standards, with the report approved for Board sign-off.

- **Freedom to Speak Up infrastructure:** A dedicated Lead Guardian model has improved accessibility, oversight and thematic reporting.
- **Workforce improvement practice:** Radiology roster redesign reduced bank use and delivered 800 additional scans in July; targeted attendance audits in several services were 90% or above.
- **Staff Survey and flu readiness:** Structured plans are in place for the 2026 Staff Survey and flu campaign, with targeted activity for lower-response and lower-uptake groups.

3. Risk review

3.1 Risks formally escalated

Risk ID and title	Score	Controls	Reason for escalation
GWH-1382 Interventional Radiologist shortage	12	Minimal assurance	Single substantive capacity, service gaps and reliance on bank, agency, transfers and a future regional model.
GWH-1493 Clinical leadership capacity and training	12	Minimal assurance	Only a small proportion have completed training, effectiveness is not yet evaluated and Deputy CMO recruitment was unsuccessful.

3.2 Risks reviewed for context

- Monitor workforce risks below 12, particularly recruitment and retention, mandatory training, staff engagement, morale and FPPT evidence completion.
- Monitor Group People risks relating to financial baselining, digital enablement, communication through change and redundancy funding through their designated governance routes.

4. Good practice and innovation

- Responsible Officer and medical governance: The previous Committee received strong assurance on appraisal, revalidation, job planning and professional standards, with the report approved for Board sign-off.
- Freedom to Speak Up infrastructure: A dedicated Lead Guardian model has improved accessibility, oversight and thematic reporting.
- Workforce improvement practice: Radiology roster redesign reduced bank use and delivered 800 additional scans in July; targeted attendance audits in several services were 90% or above.

5. Committee approvals and recommendations

5.1 Proposed approvals

- Approve the EDI Annual Report for onward governance, subject to amendments agreed at the meeting.
- Note the FTSU Annual Report and support its 2026/27 priorities.
- Confirm the two 12+ risk scores and required review actions.

5.2 Recommended to the Management Committee

- Require a single GWH workforce recovery trajectory linking WTE, pay, bank usage, sickness and recurrent savings.
- Require immediate review of GWH-1382 and GWH-1493, with refreshed controls, evidence, owners and dates.
- Require a measurable response to FTSU and NETS themes, including feedback loops and targeted service action.
- Maintain oversight of EDI, transgender inclusion and Group FPPT remediation.

6. Looking ahead

The next cycle should test the impact of workforce controls on WTE, pay and bank usage; review sickness hotspots; track the two significant risks; monitor Staff Survey response; receive progress on NETS, FTSU, EDI and transgender inclusion actions; and confirm completion of Group FPPT remediation.

Quality and Safety Committee Report to the Care Organisation Management Committee

Care Organisation	Salisbury
Committee	Quality and Safety Committee
Meeting date	22 September 2026
Author	Duncan Murray, Chief Medical Officer / Committee Chair
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance and Action
Linked to Strategic Priority (s)	Quality, safety and patient experience; workforce and clinical sustainability; operational performance
Linked BAF principal risk(s)	2; 9
Reporting period	September 2026

1. Executive summary

The Committee received positive assurance in several areas but identified material gaps requiring management attention. The dominant cross-cutting theme was increasing clinical demand against constrained or reduced capacity, threatening patient safety, workforce resilience and the ability to sustain improvement. Priority escalations relate to the fertility storage incident, maternity and neonatal responses to recent national reports, paediatric diabetes sustainability, and potential harm associated with urgent and emergency care pressures.

2. Alert, Advise, Assure

2.1 Alert

- Fertility storage incident: A longstanding misinterpretation of commissioner funding policies has resulted in inconsistent charging for gamete and embryo storage. Incorrect charges or expectations of charges may have influenced storage, disposal or treatment decisions. Immediate invoicing, debt recovery and storage decisions have been suspended to ensure no further incidence occurs. A task and finish group will be established promptly to investigate the incident and to understand the clinical, ethical, legal, financial and reputational implications, and to recommend appropriate actions.
- Maternity and neonatal 10 Point Plan: Salisbury was reported to be in the most vulnerable position across the Group, with triage representing the area of greatest risk and the biggest compliance gap. Of 82 maternity triage standards, 26 were in place, 37 partially in place and 17 not in place. Principal gaps are 24/7 telephone and face-to-face triage, estates and workforce. The estimated requirement was approximately £6 million, mainly for estates, with progress due for review by Trust Board and NHS England in December 2026. Additional resources will be needed to deliver the 10PP requirements.
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- Paediatric diabetes: Glycaemic outcomes were poorer than regional and national comparators and DKA admissions were approximately double comparator averages. Staffing, psychology, point-of-care testing and school-support capacity threaten best practice tariff compliance and service sustainability.
- ED pressure and mortality: ED attendances were approximately 7,600 in August compared with around 7,080 in the same period the previous year. Staff availability was reported at 25.7%. ED deaths increased during July, August and September, requiring review of possible links with corridor and escalation care. In response, mortality review templates will be amended to include a prompt around corridor care and to collate any learning to identify any themes.

2.2 Advise

- Patient safety learning: Quarter 1 showed increases in falls, pressure ulcers and incidents causing moderate or greater harm. Work is underway in Medicine's Learning from Incidents Forum to strengthen the "so what" element of learning and resultant change in practice. FASS and Surgery divisions acknowledge the need to improve organizational learning from patient safety review work and show evidence of impact.
- Audiology look-back (national newborn screening incident): Three cohorts (78+12+39) totaling 129 children have been identified to require recall. To date, 6 cases of low or moderate harm have been identified, and 58 children have been discharged. Recall appointments are intended to be completed by December 2026, with full harm review and learning continuing into 2027. NHSE oversight continues, although support is de-escalating as confidence in service improves.
- Mental health risk SFT7807: The risk score is 10. Reduced agency fill rates and recurring ligature attempts prompted referral back to the Mental Health Governance Group to review the description and scoring and consider whether two separate risks are required describing low likelihood of catastrophic incidents separate from more commonly occurring moderate incidents.
- Safeguarding and clinical alerts: Safeguarding and other clinical alerts held in Lorenzo are not reliably visible to specialties using separate systems, including Fertility, Maternity, Sexual Health, Audiology and Radiology. This is a national issue which may be partially resolved by new EPR.
- Adult safeguarding: Training remains below required levels in some areas and there remains some lack of confidence in data quality. Case-law changes relating to Mental Capacity Act and deprivation of liberty arrangements have required change in practice. Communication and education has been provided but vigilance around good practice is required.
- End of life care: Referral demand is rising against static resource. The Committee received limited assurance regarding capacity, sustainable funding, education, bereaved-relative feedback and the wider system response to frailty at end of life alongside good assurance of 7 day access to the Palliative Care team and consultant led advice and support 24/7.

2.3 Assure

- Call for Concern and Martha's Rule arrangements are becoming embedded, with positive outcomes reported following calls from patients and relatives.
- Overall mortality benchmarking remains within the expected range, with positive assurance on governance while the recent increase in ED deaths is reviewed.
- NHS England reduced direct audiology oversight after receiving assurance that current neonatal auditory brainstem response testing had improved.
- Maternity maintained 100% one-to-one care in labour and 100% supernumerary labour ward coordinator status in August. There were no stillbirths or PMRT reviews during the month.
- Women and Newborn services received positive patient feedback and complaints response performance improved to 83%.
- The paediatric diabetes service demonstrated strong governance, annual health-check completion, patient engagement and innovation despite sustainability concerns.

3. Risk review

3.1 Risks formally escalated to the Managing Director

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation
SFT6412 - Lack of dedicated second obstetric theatre	12	Controls score 3	Risk of harm to women and babies; continuing single-theatre constraint requires executive oversight and a deliverable capacity plan.
SFT9003 - Clinical information stored outside the patient record	11	Controls score 5	High control weakness and EPR transition dependency. Not reviewed in the meeting because of time constraints.

3.2 Narrative on escalated risks

SFT6412: No new actions to update. Work on business case continues.

SFT9003: The risk concerns clinical information held outside the formal patient record. Management action should require review of current controls, handover arrangements and EPR dependencies, and ensure that residual clinical safety risks are explicitly owned and monitored. Work has commenced to understand scope of issue. Trust wide comms have alerted clinical teams to the need to use EPR as single version of truth for the clinical record.

No other Q and S owned corporate risks were discussed in the meeting due to time constraints. This remains an area of need for further development of committee processes. All risks had been reviewed pre-meeting by risk owners.

3.3 Risks reviewed for context (scoring 10–11)

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
SFT7807 - Specialist mental health needs	Clinical / operational	10	Controls score 3; fill rates reduced	Return to Mental Health Governance Group to review risk description and scoring and consider separate risks.
SFT8264 - Management of reduced mental capacity	Clinical governance	10	Controls score 3	Not reviewed because of time constraints; assurance required in light of legal changes and training gaps.

4. Good practice and innovation

- The paediatric diabetes service demonstrated committed multidisciplinary working, strong annual health-check completion, patient engagement and innovative use of intensive intervention.
- Call for Concern and Martha's Rule arrangements are becoming embedded and have produced positive outcomes.
- Current neonatal audiology testing has improved sufficiently for NHS England to reduce direct oversight.
- The Female Genital Mutilation guideline has been approved, providing a standard Trust-wide process.
- Mortality review is increasingly embedded within morbidity and mortality meetings and routine governance.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- Reports received: The Committee noted and received the reports presented. No formal approvals were made.

5.2 Recommended to the Management Committee

- Confirm executive governance and resources for the fertility incident review, including patient identification, Duty of Candour assessment, reimbursement and claims, communications, and intended notifications to the ICB and NHS England.
- Evaluate need for project support and a deliverable estates and workforce response for the maternity 10 Point Plan and triage gaps before the December review.
- Require an obstetric theatre options paper with interim mitigations, implementation milestones and evidence on access to a second theatre.
- Require a time-bound divisional response for paediatric diabetes covering workforce, point-of-care HbA1c testing, psychology, school support, DKA reduction and use of best practice tariff income.
- Monitor outputs of reviews of ED deaths and corridor or escalation-care harm, including the revised mortality-review prompt and resulting learning.
- Ensure risks not reviewed because of time constraints return through the appropriate governance route and receive appropriate operational representation at Quality and Safety Committee.

6. Looking ahead

- October 2026: glaucoma, cataract and laser waits; National Inpatient Survey
- November 2026: follow-up backlog and dementia assurance updates.
- December 2026: Trust Board and NHS England review of maternity 10 Point Plan progress.
- March 2027: further audiology update following recall completion and harm review.

Report to the Care Organisation Management Committee

Care Organisation	Salisbury Care Organisation
Committee	Finance and Performance Committee
Meeting date	23 September 2026
Author	Niall Prosser, Chief Operating Officer and Committee Chair
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance and Decision
Linked to Strategic Priority (s)	Improving timely access; making services safer; financial sustainability; digital maturity; workforce
Linked BAF principal risk(s)	Financial sustainability and cash; operational flow and access; Central Booking; EPR readiness; capital affordability; digital and cyber
Reporting period	Month 5 / August 2026 performance and matters considered on 23 September 2026

1. Executive summary

The Committee received mixed assurance. The papers confirm a material cluster of financial, cash, flow, booking, EPR and capital risks, alongside positive assurance on national oversight performance, cancer improvement, the recovery programme, cyber controls and progress of the DASH programme. Management Committee attention is requested on the pace of recurrent financial recovery, the Central Booking control framework, winter delivery, EPR resourcing and prioritisation of scarce capital.

2. Alert, Advise, Assure

2.1 Alert

• EPR readiness: The papers identify risks 8820 and 8950 relating to organisational readiness and Clinical Safety Officer capacity. Unfilled SME roles, a £1.5m training-backfill requirement, device costs, data-quality work and legacy-system decommissioning remain unresolved dependencies. Further work is also required to support activity planning around the EPR go live. This work is being developed through the organisation EPR readiness group. The committee were assured that SFT planning is progressing well but further work remains required. The launch of the heat maps will help bring to live the work that is required in each team.

• Urgent and emergency care: August performance remained materially below plan. Four-hour performance was 67.3% against a 78.5% plan, average ambulance handover time increased to 37 minutes, 12-hour breaches increased to 885, and corridor-care measures increased. Bed occupancy was 96.7% and average NCTR remained 76 against a target of 45. The committee reviewed the first draft of the winter plan, with further work requested to support readiness. This includes further assessment of the bed requirement and the emerging plans to help mitigate.

• Central Booking, risk 8102, score 12: The service had approximately 8.17 WTE vacancies, 30% of staff with less than six months' experience and 19% of establishment not yet providing productive capacity. Backlogs, inconsistent processes and weak KPI controls have contributed to booking errors, delayed follow-up, under-utilisation and

reported patient-safety incidents. The Intensive Support programme must evidence delivery of the KPI dashboard, backlog trajectories, standard work and a sustainable operating model with an update coming back to the committee within the next 6 months.

• CIP delivery: £9.3m was delivered against a £10.3m year-to-date target. The £32.5m annual programme was 129% identified, but delivery risk remains concentrated in Group Clinical Services Transformation, workforce efficiencies and the key-worker accommodation transaction. Most-likely and worst-case modelling identified a £1.5m to £8m risk without immediate mitigation. CIP cell is continuing to support delivery of the programme whilst also starting to develop the 27/28 plan, with the intent of starting the improvement work now.

• Financial sustainability and cash: The Month 5 position was reported as on plan after inclusion of deficit support and £3.0m of BSW transitional funding brought forward into August. The underlying year-to-date position excluding deficit support was a £7.2m deficit. Internal forecasts ranged from an £11.5m best-case deficit to £33.2m worst case. Revenue Support PDC of £14.3m was requested across November 2026 to March 2027; without support the papers identify risk to supplier payments, BPPC, medicines and consumables supply, and operational continuity.

• Capital: After commitments considered at the Strategic Capital Committee, approximately £0.5m remained for the rest of the year. This limits resilience against urgent safety, estate, digital and equipment pressures.

2.2 Advise

• Health and safety: Q1 lost-time injury measures were better than target, but the report noted possible under-reporting. Sharps injuries remained above expectation, including avoidable exposure caused by unsafe disposal and handling practices. Committee supported the launch of the sharps campaign.

• DASH: The outline business case was supported and development of the full business case and RIBA4 design is under way. The programme remained amber, with high risks relating to electrical infrastructure and affordability.

• Operational performance: Cancer improved to 79.5% for the 28-day standard and 73.5% for 62 days, but remained below plan. RTT fell to 69.5%, 52-week waits increased to 130, diagnostics fell to 81.6%, and time to first outpatient appointment increased to 107 days.

• Winter plan: The draft assumes activity 4.4% above the October 2026 to March 2027 mean, with 48 additional weekly attendances and an unmitigated requirement of up to 70 additional beds. Delivery depends on nine linked priorities covering demand management, streaming, alternatives to admission, flow, length of stay, leadership, workforce and data. The Committee discussion should be reflected through clear scheme ownership, milestones, costs, QIAs and quantified contribution to closing the bed gap.

• Digital: Assurance was positive on cyber and information governance, with all three care organisations achieving DSPT/CAF standards met and no material cyber incident in the reporting period. However, specialist digital capacity, ageing infrastructure, clinical safety and capital remain constraints.

2.3 Assure

• DASH and capital enabling works: The national Joint Investment Committee supported progression from outline to full business case, and the Committee approved the £137,390.40 DASH electrical substation connection.

• Cancer: July performance improved for both the 28-day and 62-day standards, supported by timed-pathway work and rollout of Cancer 360.

• Central Booking recovery: Continuous recruitment, induction and competency-based training were in place; daily huddles and backlog reviews had restarted; baselines had been established; and a real-time KPI and capacity dashboard was in development.

• Recovery governance: NHS England's Level 2 review gave moderate assurance, recognising credible governance and programme infrastructure. SFT reported that almost all plan-acceptance conditions were met, with continued weekly and monthly reporting.

• National Oversight Framework: The average metric score improved from 2.38 to 2.29 and the Trust's rank improved from 79th to 48th of 134 organisations. The Trust remained in segment 3 because deficit support funding applies a financial override.

• Cyber and information governance: The papers provided positive annual assurance, including standards-met DSPT/CAF submissions and established governance, incident management and improvement plans.

3. Risk review

3.1 Risks formally escalated to the Managing Director

The committee didnt have sufficient time to complete a formal review of the risks but had discussion to review if there is a better way to ensure the committee is reviewing and aligning the risk scores. These changes will be finalised by the next meeting.

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation
7573	Sustained use of escalation areas	13	Daily flow controls and winter-plan interventions in place; control effectiveness remains limited while occupancy and NCTR stay high.
8759	Unavailability of cash balances	13	Daily cash monitoring, payment controls and PDC application in progress; external approval remains a critical dependency.
8791	Financial position 2026/27	13	Turnaround governance and CIP controls are active; underlying deficit and forecast range indicate material residual exposure.
8800	Failure to reduce NCTR to 9%	13	Daily/system oversight and improvement work continue; August average NCTR of 76 remained above the target of 45.
6229	DSU estate infrastructure failure	12	DASH provides the long-term mitigation; interim issues remain dependent on local management and capital delivery.
7734	Limited capital funding	12	Capital prioritisation and five-year planning are in place; only c£0.5m headroom remained after current approvals.
7917	Fire risk in Main Theatres corridors	12	Daily/weekly checks and housekeeping controls remain; lack of alternative storage prevents full mitigation.
8102	Central Booking instability	12	Intensive Support and recruitment are mobilised; KPI, process and capacity controls are not yet fully embedded.
8789	Failure to meet emergency access standards	12	Recovery plan and UEC interventions are active; August flow and handover indicators remained materially off plan.
8926	DASH capital shortfall	12	Cost control and value engineering continue; the identified £6m funding gap remains unresolved.

3.2 Narrative on escalated risks

The meeting papers identify nine Finance and Performance risks scoring 12 or above. The Committee did not complete the scheduled live risk review, so no changes to scores or escalations are recorded in this report. A dedicated calibration session is required to test control effectiveness, confirm ownership and agree onward escalation.

3.3 Risks reviewed for context (scoring 10–11)

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
5664	Backlog maintenance	11	Static	Capital plan and Estates Safety Fund provide partial mitigation; long-term capital remains constrained.
7946	Transformation delivery	11	Improving	Portfolio controls are active, but transformation capacity and Group/system dependencies remain gaps.
8820	EPR readiness and resourcing	11	Static	Readiness governance is established; SME, CSO, device, data-quality and training dependencies remain.
5955	Management control procedures	9	Static	SFI, audit and training controls in place; consistency of application remains a gap.
7931	Electrical infrastructure in theatres	9	Static	Inspection controls continue; permanent infrastructure solution remains subject to funding.
7949	Emergency bleep system	9	Static	Interim charging and supplier controls in place; replacement programme is required.
8068	Switchboard lone working	8	Improving	Recruitment and rota changes reduced exposure; single-point-of-failure risk remains.
8272	Ambulance handover W45	8	Deteriorating	Operational controls are in place, but August average handover time increased to 37 minutes.

4. Good practice and innovation

• The DASH outline business case was supported, enabling progression to full business case and RIBA4 design.

• Cancer performance improved in July, with the 28-day standard at 79.5% and the 62-day standard at 73.5%.

• The Trust improved its national oversight ranking from 79th to 48th of 134 and improved its average metric score to 2.29.

• Central Booking launched an Intensive Support programme with continuous recruitment, refreshed induction and competency training, daily huddles, backlog baselining and development of real-time KPI reporting. Recognition of the role of the new local leadership is having in supporting improvement was noted.

• All three BSW care organisations achieved DSPT/CAF standards met for 2025/26.

5. Committee approvals and recommendations

5.1 Approved by the Committee

• Approved the Telepath archive solution and ratified the Rubrik backup-storage expansion.

• Approved £137,390.40 for the DASH electrical substation connection and approximately £255,000 for aseptic-unit flooring, lighting and hatch works, subject to procurement and charitable-funding checks.

• Approved detailed development of EPR activity scenario 2: 5% reductions in elective inpatient, day case and outpatient procedures, and 15% reductions in new and follow-up outpatients across October and November 2027.

• Approved submission of Revenue Support PDC totalling £14.3m across November 2026 to March 2027 and delegated final cashflow updates to the Director of Finance. To be escalated to COMC.

• Approved progression of an outsourced operating model for the future integrated Finance and Procurement function, subject to full business case and competitive procurement.

• Supported in principle the obstetric theatre proposal proceeding to STARS and confirmed the Functional Neuro-Urology and Spinal Cord Injury CNS business case should be revised and return to ORBIT.

• Management Committee is asked to note the nine Finance and Performance risks scoring 12 or above and require confirmation of controls, trajectories and escalation following the dedicated risk-calibration session.

• Management Committee is asked to ensure that EPR SME, Clinical Safety Officer, training-backfill and device requirements are resolved through Group governance.

• Management Committee is asked to support rapid completion of the Central Booking KPI, backlog and patient-safety assurance framework and the proposed six-monthly F&P assurance cycle.

• Management Committee is asked to note the significant financial and cash exposure and require tracking of recurrent run-rate improvement alongside reported CIP delivery.

• Management Committee is asked to maintain oversight of winter-plan deliverability, including quantified bed-gap impact, QIAs, workforce and financial requirements.

6. Looking ahead

The next cycle should receive the outcome of the dedicated risk-calibration session; Month 6 financial and cash forecasts; progress on the Revenue Support PDC application; Central Booking KPI and backlog trajectories; winter-plan mobilisation; EPR activity-planning, SME and CSO actions; and updated DASH affordability and capital risks. A UTC impact deep dive was proposed for October, with a focused EPR deep dive to follow.

Report to the SFT Care Organisation Management Committee (COMC)

Salisbury NHS Foundation Trust People & Culture Committee Assurance Report

Care Organisation	Salisbury NHS Foundation Trust
Committee	People & Culture Committee
Meeting date	23 September 2026
Author	Chair, SFT People & Culture Committee
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance, with matters for attention and recommendation
Linked priorities	Engaged workforce; diverse and inclusive teams; safer services; staff experience; financial sustainability
Reporting period	July to September 2026

1. Executive summary.

Overall assurance is limited. The Committee approved the EDI Annual Report, supported the direction of travel for the developing Group People Plan and noted both the workforce position and Responsible Officer Report. However, it recorded limited assurance on workforce risks and equality outcomes and only partial assurance on delivery of the Resident Doctor 10 Point Plan. The principal concerns are sustained sickness absence and staff unavailability, low appraisal and mandatory-training compliance, workforce affordability and skills mix, limited Organisational Development and change capacity, and the need for clearer risk evidence, ownership and alignment with the Group Board Assurance Framework.

2. Alert, Advise, Assure

2.1 Alert

- **Workforce IPR performance:** Staff unavailability increased to 25.7% in August. Long-term absence accounted for 53% of sickness, with anxiety, stress and depression the leading cause and approximately 2,000 days lost in the month. Mandatory training remained below the 90% target and appraisal compliance was 69.4%. The Committee received limited assurance and requested stronger divisional performance challenge.

- **Sustainable workforce risk SFT-7472:** The risk remained at a score of 10, but the Committee considered its scope too broad and requested clearer wording, evidence, patient-safety consequences, controls, scoring and alignment with the Group Board Assurance Framework.

- **OD&P and change capacity risk SFT-8780:** Limited Organisational Development, people and change-management capacity may constrain support for concurrent consultations and transformation activity.

- **Workforce affordability and mix:** SFT was 153 WTE and £1.45m above plan. Workforce mix differed materially from plan, with fewer administrative and clerical staff and more clinical and medical staff, and pay CIP delivery was slightly behind trajectory.

2.2 Advise

- **Equality, diversity and inclusion:** Statutory reporting requirements were met, but SFT showed limited movement and deterioration in several workforce race and disability equality indicators. The Committee requested more granular data, practical guidance for leaders and learning from across the Group, with clear accountability through a shared action plan.

- **Resident-doctor 10 Point Plan:** Most actions within local control were compliant or progressing, but permanent rest facilities, locker management and the feasibility of correcting pay errors within one week remained unresolved. The paper did not reflect the latest position, so the Committee received partial assurance and requested a corrected assurance return.

- **EHRC guidance:** Provision and staff guidance varied across the Group and, on legal advice, SFT had deliberately issued no specific guidance ahead of the supreme court ruling and subsequent NHS guidance. The Committee agreed that a single Group approach should be developed, based on dignity and protection for all, and return through the agreed governance route within six months.

- **People Plan and assurance routes:** The Committee supported development of a Group People Plan with local delivery, organised around colleagues having value, feeling valued and adding value.

2.3 Assure

- **Responsible Officer arrangements:** The report evidenced compliance with statutory and regulatory requirements for medical governance, appraisal and revalidation. Areas of partial assurance were supported by improvement actions, and the Committee noted the report.

- **People Plan direction:** The Committee supported the proposed three-horizon approach: making current services more reliable, building capability and creating future workforce models, with meaningful engagement before the plan is finalised.

- **Governance development:** The Committee agreed to strengthen the forward planner through a standing SFT People and Organisational Development Meeting (POD) escalation report and further consideration of divisional, staff-side/JLNC and Group POD highlight reporting.

3. Risk review

3.1 Risks formally escalated

Risk ID and title	Score	Committee assessment	Required action
SFT-7472 sustainable workforce	10	Limited assurance: scope, evidence, consequences, control effectiveness and patient-safety impact require clearer articulation.	Review with risk and governance leads, including alignment with the Group BAF.
SFT-8771 culture and leadership interventions	8	Clearer evidence is required on impact for staff and patients and on mitigations while future leadership capacity and programmes are determined.	Strengthen evidence and mitigation reporting.
SFT-8780 OD&P and change-management capacity	12	Capacity is limited while supporting concurrent consultations and transformation.	Clarify ownership, controls and oversight alongside related workforce risks.

3.2 Risks reviewed for context

- The Committee requested clarification of dependencies with the nursing workforce pipeline risk, including ownership and committee oversight.
- Governance and risk leads are reviewing application of the revised risk framework across committees.
- The Group Chief People Officer will provide visibility of emerging Group workforce risks so that local and Group assurance routes remain aligned.

4. Good practice and innovation

- A three-horizon People Plan framework is being developed across the Group, balancing service reliability, capability building and future workforce models while retaining local delivery.
- Immediate wellbeing support is being promoted through the Employee Assistance Programme, alongside a standardised hot-debrief pilot.
- The Responsible Officer report demonstrated established arrangements for medical governance, appraisal and revalidation, with improvement actions identified for areas of partial assurance.

5. Committee approvals and recommendations

5.1 Decisions taken

- Approved the EDI Annual Report for onward submission, while recording limited assurance on the pace of improvement.
- Received limited assurance on workforce risks and Workforce IPR performance, and partial assurance on the resident-doctor 10 Point Plan.
- Supported the direction of travel for the developing Group People Plan and agreed that the material should progress through the agreed governance route.
- Agreed that an SFT People Pod escalation report should become a standing Committee item.
- Agreed that a consistent Group approach to EHRC guidance should be developed and reported in six months.
- Noted the workforce position against plan and the Responsible Officer Report.

5.2 Recommended to the Management Committee

- Note the Committee's limited assurance on workforce risks, EDI and Workforce IPR performance, and partial assurance on the resident-doctor 10 Point Plan.
- Support intensified divisional performance review challenge on sickness absence, mandatory training and appraisal compliance.
- Require the review of SFT-7472 to clarify scope, patient impact, controls, scoring and alignment with the Group Board Assurance Framework.
- Maintain oversight of workforce numbers, skill mix, pay and CIP delivery as inputs to 2027/28 operational planning.
- Ensure that agreed assurance returns and updates are routed back through governance, including granular EDI data, EHRC guidance, the People Plan, resident-doctor actions and Fit and Proper Person assurance.

6. Looking ahead

The next cycle should review progress on sickness absence, staff unavailability, appraisal and mandatory-training compliance; the revised SFT-7472 risk and wider risk-governance alignment; workforce, skill-mix and financial-plan alignment for 2027/28; delivery of the shared EDI action plan; development of the Group People Plan; the corrected resident-doctor 10 Point Plan assurance return; and progress on Group EHRC guidance. An assurance update on remedial Fit and Proper Person checks is due in January 2027.

Report to	Care Organisation Management Committee
Committee	Quality and Safety Committee
Meeting date	23 September 2026
Author	Jason Lugg, Chief Nursing Officer and Committee Chair
Status	For Assurance and Information
Links to Strategic Priority(s)	Making our services safer; improving timely access; improving patient experience; developing an engaged workforce; improving health equity; improving financial sustainability.
Links to Risk Register	Quality and safety risks scoring 12 or above, including 2683, 2973, 3230, 3308 and 3391; wider risks referenced within committee reports.
Reporting period	August–September 2026

1. Executive summary

The Committee scrutinised the integrated quality position, vulnerable people, pressure injury improvement, medicines governance, children and young people, Martha's Rule, radiation protection, maternity and neonatal assurance and the quality and safety risks. Overall assurance was mixed: progress was evident across several programmes, but significant attention remains necessary on system mental health constraints, pressure injury harm, workforce resilience, infection prevention and control, maternity delivery dependencies, regulatory capacity and the reliability of quality data.

2. Alert, Advise, Assure

2.1 Alert

- **Mental health and eating-disorder pathways:** increasing complexity, limited specialist and out-of-hours provision, prolonged acute admissions and workforce impact require stronger executive, commissioner and system escalation.
- **Medicines governance:** repeated failure of the Medicines Committee to achieve quorum, particularly medical representation, created a governance risk. Any further failure must be escalated urgently.
- **Maternal Care Bundle:** baseline implementation was approximately 21%; the March 2027 deadline is highly challenging and delivery depends on digital capability, workforce and system-owned pathways, requiring Care Organisation and ICB support.
- **Radiation protection:** specialist workforce constraints and late engagement in insourcing, outsourcing and service redesign create statutory compliance risk. Updated employer procedures remain to be ratified.

2.2 Advise

- **Pressure Injury Improvement Plan:** the Committee received and endorsed the plan, which set out the key actions underway to reduce pressure injury harm. Bi-monthly progress updates were requested to maintain oversight of delivery and impact.
- **Integrated performance:** quality, safety, workforce, operational performance and finance require clearer triangulation during financial recovery, supported by Equality and Quality Impact Assessments for investment, disinvestment, service-change and staffing decisions.
- **Safe staffing and deteriorating patients:** day registered-nurse fill averaged 78%, 66 red flags were reported, NEWS2 compliance was 92% against a 95% target and further clinically meaningful sepsis and AKI assurance is being developed.
- **Infection prevention and control:** C. difficile and E. coli remain priorities. The external review is continuing, with final findings awaited; early feedback suggests the improvement portfolio may require tighter focus.
- **Martha's Rule:** implementation is progressing, but sustainable capacity after pilot funding and triangulation of calls with complaints, incidents and patient experience require further work.
- **Children and young people:** CAMHS pathway misalignment, transition arrangements and the governance route for the Surgery in Children network review require continued oversight and escalation.

2.3 Assure

- **Safeguarding and vulnerable people:** assurance was received across adult, children and maternity safeguarding, learning disability and autism, dementia, mental capacity and enhanced therapeutic observation. Annual audit findings showed substantial compliance, alongside defined improvement priorities.
- **Maternity and neonatal services:** the 10-Point Plan baseline reported 14 compliant and 11 partially compliant deliverables, with none non-compliant and one not applicable. No stillbirths or neonatal deaths and no MOSS alerts were reported for August.
- **Medicines improvement:** electronic controlled-drug registers were live in four clinical areas with substantial improvement in documentation compliance; revised barcode-scanning accreditation thresholds were approved.
- **Regulatory assurance:** the May CQC nuclear medicine inspection was positive, with minor recommendations and an action plan in place.

3. Risk review

3.1 Risks formally escalated to the Managing Director

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation
2683 – ED overcrowding and delayed emergency treatment	12	Partially effective	Overcrowding, corridor care, delayed assessment, vacancies and constrained flow continue to expose patients to avoidable harm.

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation
2973 – Insufficient medical palliative care provision	12	Planned but not in place	Substantive medical provision remains below professional expectations, with gaps in cover and associated risks to timely specialist support.
3230 – Insufficient patient safety, risk, audit and quality-improvement resource	12	Planned but not in place	Capacity constraints limit statutory, regulatory and improvement delivery and create reliance on single postholders.
3308 – Obstetric ultrasound and fetal-growth system interoperability	12	Partially effective	Manual transcription and fragmented systems create recurrent reliability failures and risk delayed recognition of fetal compromise.
3391 – Perinatal team capacity	12	Absent	Required specialist leadership, governance and patient-safety capacity is not yet funded or embedded while national requirements continue to increase.

3.2 Narrative on escalated risks

Risk 2683: The risk remains above tolerance because emergency demand, constrained bed flow, corridor care and workforce gaps continue. Existing escalation, streaming and flow controls mitigate but have not changed the underlying trajectory.

Risk 2973: Six-day nurse-led provision and partnership arrangements provide partial mitigation, but gaps in substantive medical cover remain. Risk reduction requires a sustainable funded medical model.

Risk 3230: Core governance processes continue, but investment identified for the revised quality-governance model has not yet been released. Reduction depends on funded capacity, protected clinical engagement and reduced single-person dependency.

Risk 3308: Manual workarounds and audit provide limited mitigation; repeated transcription events demonstrate ongoing exposure. Implementation of an integrated obstetric solution and strengthened digital resource are required.

Risk 3391: Governance arrangements are strengthening, but key roles within the Perinatal Business Case are not yet funded or operational. Interim support is not a sustainable control against the volume and pace of national requirements.

3.3 Risks reviewed for context (scoring 10–11)

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
3359 – Oliver McGowan Mandatory	Compliance / operational	10	Partially effective	External provision may not meet future demand; the proposed Group in-house model requires

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
Training provision				formal business-planning review.
3272 – Radiotherapy capacity	Operational	10–11 pending full migration	Partially effective	Recruitment, training and extended hours are mitigating demand, but capacity and workforce resilience require continued oversight.

4. Good practice and innovation

- **Personalised care:** adoption of the concise "What Matters to Me" document supports patients with dementia, delirium, stroke, brain injury, cognitive impairment or communication needs.
- **Neonatal improvement:** the neonatal team's work to improve preterm growth through continuation of breastmilk fortifier at home received regional recognition.
- **Martha's Rule:** components two and three are established across inpatient services, and the digital Patient Wellness Questionnaire is progressing toward wider adult rollout.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- Approved the revised Medicines Committee Terms of Reference, including bi-monthly meetings and strengthened medical representation.
- Approved revised Barcode Medication Administration accreditation thresholds: patient scanning at 90%, 80% and 70%, and medicines scanning at 60%, 50% and 40%, for Gold, Silver and Bronze respectively.
- Supported the Recognition and Escalation of the Deteriorating Patient in Adults Policy subject to amendment; formal approval was deferred when the meeting became non-quorate.
- Endorsed escalation of the quality and safety risks meeting the score-12 threshold in accordance with the Committee Terms of Reference.

5.2 Recommended to the Assurance Committee

- **Receive** the mixed assurance position and note the principal escalations concerning mental health and eating-disorder pathways, pressure injury harm, medicines governance, radiation protection capacity and maternity delivery dependencies.
- **Support** a concise, routine approach to triangulating quality, safety, workforce, operational performance and finance during financial recovery.
- **Support** system escalation by the Chief Nursing Officer and Chief Medical Officer regarding Maternal Care Bundle, mental health pathways and other dependencies outside the Trust's direct control.

- **Note** the quality and safety risks meeting the threshold for upward escalation and the temporary vulnerability created by transition to the 5+5+5 methodology.

6. Looking ahead

The next cycle will review progress on the pressure injury improvement programme and data reconciliation; the final external infection prevention and control findings; Human Tissue Authority and clinical audit governance; sustainable capacity for Martha's Rule; maternity triage and Maternal Care Bundle delivery; and the revised regulatory assurance map and committee workplan.

Report to	Care Organisation Management Committee
Committee	Finance and Performance Committee
Meeting date	22 September 2026
Author	John Palmer, Managing Director and Chair Stephanie Spottiswood, Executive Assistant Abby Strange, Corporate Governance Manager
Status	For Assurance
Links to Strategic Priority (s)	Developing an engaged workforce; Making our services safer; Improving timely access; Improving patient experience; Improving financial sustainability; Improving health equity
Links to Risk Register	See section 3.
Reporting period	August to September 2026

1. Executive summary

The Committee identified significant concerns relating to urgent and emergency care (UEC), financial recovery, EPR readiness and estates risks. It received moderate assurance from the Grip and Control report, assurance on the National Cost Collection, and partial assurance from the Food Alert Audit. Key actions were an urgent reset of UEC standards and escalation arrangements, further development of the financial recovery plan, and continued oversight of EPR, digital capacity and fire-safety risks.

2. Alert, Advise, Assure

2.1 Alert

- **UEC:** Corridor care, ambulance handovers, patient flow and delayed discharge remained serious concerns. The Committee called for an urgent organisational reset, supported by clear standards, escalation triggers and defined ownership across downstream services.
- **Financial recovery:** The year-to-date deficit was £13.8m, £8.6m adverse to plan, and savings were £3.1m below plan, largely because schemes were not sufficiently developed. A do-nothing-different forecast indicated a £33.1m year-end deficit; identified actions reduced this to £23.4m, while £20m remained a stretch position without a fully identified route. The Committee supported further iteration of the plan, including simple divisional control totals and explicit assumptions, ahead of submission on 28 September 2026.
- **Food safety:** The Food Alert Audit identified issues across six wards, and hot food service in the Emergency Department remained withdrawn pending completion of controls and evidence of staff competency. The action plan is monitored monthly by the Estates and Facilities Management Board and by the independent auditor. The Committee took partial assurance, kept the audit trail open and requested a progress update in December 2026.

- **Fire safety:** Fire safety remains a significant risk and will be subject to a Group deep dive.

2.2 Advise

- **Cancer and diagnostics:** Cancer performance continued to fluctuate, with Dermatology demand a significant pressure. The Committee requested a more controlled and sustainable position, including monitoring of time to first outpatient appointment. Elective and diagnostic performance was comparatively positive, but credible second-half recovery plans were required for the remaining specialty and diagnostic pressures.
- **EPR readiness:** Clinic scheduling, data quality and workforce capacity remained the principal operational risks. Workshops were addressing administrative practices affecting fixed clinic schedules, while flexible clinician job plans required further work. Vacant funded Subject Matter Expert posts created additional risk to validation and standardisation before go-live. A Data Quality subgroup had been established and readiness work continued across operational, clinical and technical workstreams.
- **Contracting and commissioner escalation:** The Committee emphasised the need for a clear audit trail covering contractual non-compliance, structural underfunding and in-year demand pressures. It agreed that outstanding correspondence should be finalised and formal escalation to the Integrated Care Board should continue.

2.3 Assure

- **National Cost Collection:** The Committee received assurance that the 2025/26 submission was completed to the national timetable without resubmission or data-quality failure. Published 2024/25 benchmarking showed a reference cost index of 96. The Committee agreed that this evidence should inform specialty benchmarking and the Group turnaround programme.
- **Digital, cyber and information governance:** The Committee received assurance that Digital Services were stable, governance was strengthening and major programmes were broadly on track. Cyber security and information governance compared favourably with peers. This assurance was qualified by continuing risks relating to workforce capacity, ageing assets, clinical safety officer provision and untested clinical business-continuity arrangements.

3. Risk review

3.1 Risks formally escalated

Risk ID and title	5+5+5 score	Controls assessment	Reason for escalation
3165 Delivery of Annual Financial Plan	14	Absent	Material adverse variance, savings under-delivery and potential regulatory intervention.
3235 Outdated Policies and Limited Governance Resource	14	Absent	No dedicated policy-management resource or automated expiry controls.

3273 Insufficient electrical infrastructure for future RUH site development	13	Planned but not in place	Site supply is nearing full load and no funded capacity upgrade is in place.
1882 Non-compliance with fire compartmentation	12	Partially effective	Current statutory compliance gap; estimated £5.9m investment requirement remains unfunded.
2110 Business interruption from backlog maintenance and critical infrastructure.	12	Partially effective	Backlog maintenance and ageing infrastructure threaten safe and reliable service delivery.
3243 IT asset lifecycle replacement	12	Partially effective	Current capital provision does not meet the full age-replacement requirement.
3280 Absence of retrospective building fire strategies	12	Partially effective	The Trust cannot evidence a complete fire-safety compliance baseline for several buildings.
3289 Working capital cash shortfall	12	Planned but not in place	There may be insufficient cash to meet day-to-day liabilities, with pace of savings delivery and commissioner funding uplift remaining control gaps.
3400 Shared EPR cutover activity reduction	12	Planned but not in place	A planned activity reduction for six weeks is not yet fully modelled, funded or mitigated.

3.2 Narrative on escalated risks

Delivery of Annual Financial Plan (Score 14)

The risk remains above threshold because the underlying deficit exceeds available support funding and savings delivery remains below plan. Controls are absent, with insufficiently granular delivery plans, unidentified savings and limited short-term mitigation for UEC, no-criteria-to-reside and high-cost-drug demand pressures outside the Trust's direct control. The Committee noted that the risk was growing and expected further Group turnaround actions. Reduction depends on stronger savings delivery and closer alignment between activity, income and commissioner funding.

Outdated Policies and Limited Governance Resource (Score 14)

The risk remains above threshold because policies are out of date and there is no dedicated resource, automated tracking or effective escalation process. The Committee requested a fresh review aligned with emerging Group arrangements. Reduction requires dedicated capacity, clearer ownership and an effective Group-wide policy-management framework.

Insufficient Electrical Infrastructure for Future RUH Site Development (Score 13)

The Combe Park electricity supply and on-site infrastructure are nearing full load, potentially restricting future developments. Technical reviews, demand monitoring and scheme

assessments are under way, but controls are not fully in place. The Committee supported retaining the risk pending confirmation of the capacity gap. Reduction depends on completing the assessments and, if required, funding an upgraded supply.

Non-compliance with Fire Compartmentation (Score 12)
Defects in fire doors and compartmentation create an ongoing statutory compliance and life-safety risk. Monthly Fire Improvement Programme meetings and a tracked action plan provide oversight, but controls remain partially effective because funding is insufficient to address all known breaches. The Committee recognised fire compartmentation as a major risk and noted ongoing mitigation, alongside the wider Fire and Rescue Service inspection and planned Group fire-safety deep dive. Reduction requires completion of prioritised remedial works and sustained capital investment.

Business Interruption from Backlog Maintenance and Critical Infrastructure (Score 12)
Ageing estate, historic underinvestment and a growing maintenance backlog continue to threaten safe and reliable services. Condition surveys, technical prioritisation and planned and reactive maintenance provide partial mitigation, but investment remains materially below the level required. The Committee noted continuing exposure despite planned capital allocations. Reduction requires sustained investment, updated condition information and continued prioritisation of critical infrastructure.

IT Asset Lifecycle Replacement (Score 12)
Funding is insufficient to replace all devices at the end of their supported lifecycle, increasing operational and cyber-security exposure. RUH has a rolling replacement programme, but it does not keep pace with ageing assets; approximately 42% of desktops and laptops were over five years old. The Committee considered the score appropriate and noted that reliance on capital funding would worsen the position. Reduction requires a sustainable recurrent replacement programme.

Absence of Retrospective Building Fire Strategies (Score 12)
Several buildings lack documented retrospective fire strategies, preventing the Trust from evidencing a complete compliance baseline for fire precautions, compartmentation and evacuation arrangements. Controls remain partially effective because design intent and the interaction of fire-safety systems are not fully documented. The Committee noted that procurement was progressing and that the wider fire-safety position would remain under external and Group review. Reduction depends on completing the strategies and addressing any resulting remedial actions.

Working Capital Cash Shortfall (Score 12)
The deficit, savings shortfall, commissioner funding pressures and emerging costs may leave insufficient cash to meet day-to-day liabilities. Daily cash-flow forecasting, cash-management arrangements, revenue support planning and senior oversight are in place or planned, but savings delivery and commissioner funding remain key gaps. The Committee noted that all reasonable mitigations were being pursued with the Group and the Integrated Care Board and that external support might remain necessary. Reduction depends on financial recovery, secured commissioner funding and any required revenue support.

Shared EPR Cutover Activity Reduction (Score 12)
The risk remains above threshold because an activity reduction is expected during Shared EPR cutover, with potential consequences for income and elective waiting times. Business planning has begun, but modelling, divisional validation and mitigation of lost activity remain incomplete. The Committee supported retaining the risk but cautioned against fixing the reduction at 25% before the requirement had been modelled by specialty and agreed across the Group. Reduction depends on validated assumptions, funded and deliverable divisional plans, and credible recovery arrangements before and after go-live.

3.3 Risks reviewed for context (scoring 10–11)

Risk ID and title	5+5+5 score	Controls assessment	Committee view
1885 FacNet unsupported building network	11	Partially effective	The Committee did not discuss this risk individually. It noted that RUH-1885 had been independently scored at 11, below the corporate escalation threshold.
2557 Isolation facilities	11	Partially effective	The Committee did not discuss this risk individually. It noted that RUH-2557 had been independently scored at 11, below the corporate escalation threshold.
3069 Face-fit testing compliance	10	Partially effective	The Committee noted that the Trust remained non-compliant, but that oversight, data and capacity had improved. It received assurance that the affected staff cohort was being clarified and that shared resource and a secondment were supporting work to reduce the compliance gap.

4. Good practice and innovation

- **Costing and productivity evidence:** The costing return and reference-cost benchmarking provide a sound evidence base for specialty-level analysis and the

Group turnaround programme. Year-end productivity improved by 4.9%, placing the Trust in the top quartile nationally for productivity improvement.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- The Committee agreed the de-escalation of one risk, approved the direction of travel for the Group finance-system procurement, and supported progression of the Pharmacy Pre-pack Insourcing, Trowbridge Community Diagnostic Centre Phase 1, and Ear, Nose and Throat workforce and insourcing proposals, subject to the conditions below.

5.2 Recommended to the Assurance Committee

- **Note** the requirement for an urgent reset of corridor care and Emergency Department standards, supported by clear escalation triggers and defined organisational ownership.
- **Note** that the financial recovery plan requires further iteration, including credible divisional control totals and explicit assumptions.
- **Support** the Pharmacy Pre-pack Insourcing and Trowbridge Community Diagnostic Centre Phase 1 business cases through the appropriate Group governance routes, subject to resolution of the recorded savings-allocation, workforce, activity, financial, contractual and commissioner conditions.
- **Approve** the Ear, Nose and Throat recurrent workforce and non-recurrent insourcing proposal, subject to completion of the radiology impact assessment and confirmation of the final tariff share and financial position.

6. Looking ahead

At its next meeting, the Committee is expected to receive second-half elective and diagnostic recovery plans and a revised visual risk report. A progress update on the Food Alert Audit is scheduled for December 2026. EPR organisational readiness will remain a standing agenda item, with continuing oversight of clinic scheduling, data quality, Subject Matter Expert capacity, clinical safety provision and business-continuity readiness.

BSW HOSPITALS GROUP

NHS Royal United Hospitals Bath NHS Foundation Trust

Report to the Care Organisation Management Committee

RUH People & Culture Committee Assurance Report

Care Organisation	Royal United Hospitals Bath Care Organisation
Committee	People & Culture Committee
Meeting date	23 September 2026
Author	Jude Gray, Chair, RUH People & Culture Committee
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance, with matters for attention and recommendation
Linked to Strategic Priority(s)	Developing an engaged workforce; Making our teams diverse and inclusive; Making our services safer; Improving timely access; Improving staff and patient experience; Improving financial sustainability
Linked BAF principal risk(s)	BAF 1 Safe, high-quality care; relevant workforce sustainability, culture and financial sustainability risks
Reporting period	July to September 2026

1. Executive summary

The Committee has scrutinised workforce performance, sickness and workforce availability, safe working for resident doctors, medical appraisal and revalidation, workforce planning, equality outcomes, temporary staffing, staff survey readiness, flu delivery and the Care Organisation workforce risk profile.

Overall assurance is partial: there is positive assurance on medical appraisal and revalidation arrangements, high medical job-planning compliance, preparation for the Staff Survey and flu campaign, and early implementation of the new temporary staffing model. However, Management Committee attention is required on deteriorating RUH sickness absence, significant Estates and Facilities absence, the gap between workforce and financial plans, persistent safe-working exceptions, the reduced temporary-staffing fill rate, and the formally escalated People risks scoring 12+.

2. Alert, Advise, Assure

2.1 Alert

- **Workforce affordability and delivery against plan:** At Month 4, RUH workforce was 44 WTE above plan, The position continues to be driven primarily by bank utilisation (51 WTE above plan).
- **RUH sickness and Estates and Facilities hotspot:** RUH rolling sickness increased from 5.55% in April to 5.67% in July, above plan throughout the period. Estates and Facilities reported August sickness of 8.1% and a rolling 12-month rate of 7.94%, with operational hotspots in Portering, Catering and Waste and anxiety, stress and depression the largest cause. Require a quantified RUH trajectory,

hotspot ownership and evidence that the Healthier Workforce Programme and divisional actions are changing outcomes.

- **Resident doctor safe working:** There were 590 exception reports between June 2025 and July 2026. Around 96% related to hours or patterns of work; Geriatric Medicine, General Medicine and General Surgery generated the highest reporting volumes. The post-reform dataset recorded 35 contractual breaches, including maximum-shift and rest requirements, and 22 reports remained pending when extracted. Require timely closure, divisional action and work-schedule review where patterns persist.
- **Escalated People-related service risks:** Three RUH risks remain above the escalation threshold: Oncology and Haematology workforce capacity (RUH-2124), Cellular Pathology demand and consultant capacity (RUH-2580), and the high-activity neonatal workforce model (RUH-3390). Current temporary staffing, outsourcing, activity controls and external oversight provide only partial mitigation, with continuing risks to service sustainability, timely diagnosis and treatment, patient experience, safety and staff wellbeing. Reduction depends on investment decisions, substantive recruitment, workforce and skill-mix redesign, digital and workflow improvements, and a fully funded neonatal transitional care and workforce model.

2.2 Advise

- **Temporary staffing:** Early performance shows 7,003 of 8,899 active workers registered with Bank Partners and agency fill lower than the prior comparator, with no initial increase in agency reliance. However, overall shift fill was 64% against an 85% target. Weekly implementation and monthly performance governance are in place; the Committee should require hotspot recovery, fill-rate improvement and validated benefits realisation.
- **Healthier Workforce Programme and violence prevention:** The programme has moved into delivery, the top 100 long-term sickness reviews have restarted and governance groups are in place. Assurance remains partial because baseline and incident-data quality are weak, enhanced manager guidance and reporting capability were not yet started, and five of seven violence-prevention domains were assessed Red or Amber/Red. Clear measures, owners and delivery checkpoints are required.
- **EDI outcomes:** The Group report provides moderate assurance. At RUH, ethnic minority representation increased to 25.0% and harassment, bullying and abuse reduced, but the ethnic minority discrimination rate was 17.6%, the Group's highest. The RUH mean disability pay gap was 19.6%, the median 18.8%, and 11.7% of staff had no disability status recorded. RUH ownership and measurable delivery are required for WRES, WDES, pay-gap and antiracism actions.
- **Transgender inclusion:** Assurance is partial. RUH guidance had not been updated, the facilities review and Group policy position were incomplete, and employer and patient guidance remained outstanding. Management Committee should require a consolidated RUH implementation plan covering estates, policy, equality impact assessment, communications, training, stakeholder engagement and governance.
- **Medium and long-term workforce planning:** The RUH discovery phase is intended to identify priority services and workforce groups, then assess supply, demand and capacity over three, five and ten years. The governance route, scope, milestones and outputs still require agreement before the Committee can take assurance on delivery.
- **Nursing, midwifery and AHP workforce:** The upward report describes a continuing cycle between sickness, vacancies, redeployment, workload and temporary staffing. It also identifies a 13.12 WTE

maternity clinical deficit and pressures in neonatal staffing and training compliance. These matters require reconciliation with the formal September risk register and continued oversight through the relevant business-case and risk-governance routes.

2.3 Assure

- **Responsible Officer and professional standards:** The annual report states compliance with the Medical Profession (Responsible Officers) Regulations 2010. During 2025/26, 553 doctors held a prescribed connection, 453 appraisals were completed and 87 revalidation recommendations were made. No doctors were referred to the GMC or excluded or suspended, and appraiser allocation and training were strengthened.
- **Medical workforce controls:** Medical job-planning compliance was 96.9%, comprising 96.7% for consultants and 98.4% for SAS doctors. HealthRota implementation had begun, with Anaesthetics, Intensive Care and Rheumatology live and further specialties scheduled. The programme reported no matter requiring escalation at this stage.
- **Staff Survey readiness:** The survey launched on 21 September and closes on 27 November 2026. A coordinated Group approach, targeted fieldwork, paper access for specified staff groups, consistent communications and local monitoring are prepared, with a 70% response ambition and focus on equitable participation.
- **Flu campaign readiness:** Invitations, communications, delivery locations, roving-team plans, night and weekend access, dashboard monitoring and targeted interventions are established. No local vaccine-supply concern was reported. Delivery will require temporary staffing support and active leadership promotion.
- **AHP and research workforce development:** The NMAWG report records delivery of all 141 planned learner placements, reductions in Band 5 turnover in occupational therapy and physiotherapy, a live AHP workforce dashboard, and strong appraisal and training compliance in the research workforce.
- **Employee relations report:** although not discussed at the meeting due to time constraints, the paper outlined employee suspensions and six Employment Tribunal claims, some of which carried financial, workforce, reputational and EDI risks. Assurance was received that cases were being managed in accordance with Trust policies and employment law requirements.
- **Fit and Proper Persons Test Review:** once completed the update will be brought back in January 2027. The KPMG audit will start in early October.

3. Risk review

3.1 Risks formally escalated to the People Committee

The formal September RUH risk paper identifies three People-related risk meeting the 12+ escalation threshold.

Ref	Risk	Key causes and impact	Current controls and assurance	Score / trend	Main gaps	Priority actions	Lead / due date
2124	**Oncology and Haematology workforce**	Insufficient funded establishment and limited availability	Controls include agency cover, additional nursing	**12**; previous **9**; **static**. Target	Establishment remains insufficient to	Recruit specialist oncology resource; review Community	**Karen Rye / Melanie Burcombe /**

	and service delivery	of specialist staff. Substantive staff are working beyond capacity, resulting in increased reliance on consultants and agency cover, overbooked clinics and potential impact on patient experience and staff wellbeing.	capacity, outpatient activity controls, pharmacy support, resilience arrangements and regular review of overbooked clinics. Controls are only partially effective because of continuing vacancies and activity pressures.	**10**.	meet current and future demand. Workforce resilience is dependent on temporary staffing and additional clinical cover.	Capacity for SACT; develop a three-year workforce plan; expand outpatient and nurse-led capacity; review skill mix, clinic configuration and administrative support; continue recruitment to consultant and clinical roles.	**Philip Robson and relevant clinical leads.** Multiple actions in progress.
2580	**Cellular Pathology demand and capacity**	Demand and activity have increased, with workforce capacity below establishment and vacancies remaining difficult to fill. This is delaying reporting, contributing to failure to meet cancer diagnostic standards and slowing diagnosis and treatment decisions.	Turnaround times have improved from approximately 57% to 10 days. Outsourcing and locum arrangements provide some mitigation, but the remaining workforce gap limits effectiveness.	**12**; previous **12**; **deteriorating**. Target **8**.	Existing consultant cover is not sustainable. A workforce gap remains and delays create missed opportunities for early treatment.	Complete the turnaround-time improvement project; implement laboratory workflow and digital pathology improvements, including AI-assisted fixed-term locum reporting; recruit substantive consultant cellular pathologists and continue advertising vacancies.	**Clive Abbott / Moya O'Doherty / Lucinda Edwards.** Actions due between August and December 2026.
3390	**High-activity neonatal workforce model**	Increasing neonatal activity, changing national maternity and neonatal safety expectations, establishment pressures and reliance on historic staffing assumptions. Current workforce arrangements may not support a safe, resilient and nationally aligned Local Neonatal Unit model.	Existing oversight identifies workforce, activity and acuity pressures through GIRFT, ODN, BAPM and Birthrate Plus reviews. Transitional care provides some resilience, but additional multidisciplinary requirements have not been fully funded or implemented.	**12**; previous **12**; **static**. Target **4**.	No active controls provide a sustainable workforce across a short-term mitigation and longer-term staffing model. Investment and regional oversight have not fully addressed local demand and service configuration.	Secure a fully funded transitional care model and establish the workforce requirements for a high-activity Local Neonatal Unit.	**Gemma Day.** Actions due August and October 2026.

3.2 Narrative on escalated risks

RUH-2124 – Oncology and Haematology workforce and service delivery: The risk remains above threshold because funded establishment and substantive capacity do not meet current and future service demand. Agency cover, additional nursing capacity, outpatient activity controls, pharmacy support and clinic oversight provide partial mitigation, but continuing vacancies and activity pressures create sustainability, patient-experience and staff-wellbeing concerns. Reduction depends on investment decisions, a three-year workforce plan, service and skill-mix redesign, and recruitment to substantive consultant and clinical roles.

RUH-2580 – Cellular Pathology demand and capacity: Increased demand, activity growth and persistent consultant vacancies are delaying reporting and affecting cancer diagnostic standards and treatment decisions. Turnaround times have improved and outsourcing and locum arrangements provide some mitigation, but existing cover is not sustainable. Risk reduction depends on completing the turnaround-time improvement project, implementing laboratory workflow, digital pathology and AI-assisted reporting improvements, and recruiting substantive consultant cellular pathologists.

RUH-3390 – High-activity neonatal workforce model: Increasing activity, changing national safety expectations and establishment pressures mean the current workforce model may not provide a safe, resilient and nationally aligned Local Neonatal Unit. GIRFT, ODN, BAPM and Birthrate Plus oversight and transitional care provide partial assurance, but multidisciplinary workforce requirements are not fully funded or implemented. Reduction depends on securing a fully funded transitional care model and establishing the workforce required for a high-activity neonatal service.

3.3 Risks reviewed for context (scoring 10–11)

The formal risk paper records five People-related risks that no longer meet the 12+ escalation threshold. They remain visible for Committee context and should continue to be managed through operational governance.

Risk ID & Title	Category	Score	Controls assessment	Committee view
2075 ED workforce gaps	Quality and safety	11	Mitigations in place	No longer meets escalation threshold; retain operational oversight of recruitment, sickness and nights cover.
3067 Speech and Language Therapy capacity	Quality and safety	11	Prioritisation controls in place	No longer meets threshold; monitor standards, demand and workforce capacity.
2806 Digital Clinical Safety capacity	Digital / safety	11	Clinical Safety Officer control in place	No longer meets threshold; capacity dependency remains relevant.
3242 Clinical-letter delays from vacancies and	Quality and safety	11	Temporary staffing and weekly oversight	No longer meets threshold; monitor backlog and

sickness				sustainable administrative capacity.
3295 Aseptics and radiopharmacy QA capacity	Quality and safety	11	Triage, outsourcing and recruitment	No longer meets threshold; retain regulatory and workforce oversight.
3324 Medlock nursing workforce challenges	Operational workforce	10	Redeployment, agency and recruitment	Below escalation threshold; monitor planned starters and safe staffing.

4. Good practice and innovation

- The appraiser allocation process, in-house training and ASPAT quality assurance strengthen medical appraisal consistency and oversight.
- The Healthier Workforce Programme has restarted systematic review of the 100 longest-term sickness cases and is testing an alternative-duties pilot for colleagues who are fit for work but unable to return immediately to their substantive role.
- The AHP programme delivered all 141 planned learner placements, achieved substantial reductions in Band 5 turnover in occupational therapy and physiotherapy and introduced a live workforce dashboard.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- Approve the Responsible Officer Annual Report and Statement of Compliance for onward submission through the required governance route.
- Approve submission of the Group EDI Annual Report, subject to any amendments agreed at the meeting.
- Acknowledge the RUH People risk meeting the 12+ escalation threshold and agree the listed risk de-escalations, subject to the Committee's review.
- The revised Terms of Reference for the Nursing, Allied Health Professional and Midwifery Workforce Group.

5.2 Recommended to the Management Committee

- Require a single RUH workforce recovery trajectory linking WTE, pay, sickness, bank and agency use, recurrent savings, medical workforce actions and safe staffing, with named owners and monthly milestones.
- Require targeted recovery plans for RUH sickness hotspots, including Estates and Facilities, with evidence of impact from the Healthier Workforce Programme.
- Note and escalate the three People risks scoring above 12.
- Require divisional assurance on persistent resident-doctor safe-working exceptions and closure of outstanding reports and contractual breaches.

- Note partial assurance on EDI and transgender inclusion and require clear RUH actions, responsible owners, governance routes and completion dates.

6. Looking ahead

The next cycle should review whether strengthened workforce controls have changed WTE, pay, bank use and recurrent savings; delivery against RUH and Estates and Facilities sickness trajectories; closure of resident-doctor exceptions; temporary-staffing fill and benefits realisation; Staff Survey participation; flu uptake; progress on EDI and transgender inclusion actions; the RUH-26/27 recovery plan; and agreement of the medium and long-term workforce-planning governance route.

The Committee reflected on the breadth of the agenda and agreed that future meetings should be more tightly focused on matters requiring assurance, decision or escalation. Members noted that several items could be managed through alternative governance routes or circulated for information.