Great Western Hospitals NHS Foundation Trust

TRUST BOARD

Thursday 11 December 2025, 9.30am to 12.45pm
By MS Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Simon Wade	Verbal	LC	-	09.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 11 September 2025 (draft)	6 – 16	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	17	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	18 – 20	LC	Note	-
6.	**Staff Story Presentation – Victim of Modern Slavery and Human Trafficking** Jade Booy, Named Professional Safeguarding Children	Presentation	JB	Receive	09.35
7.	**Chair's Report** Liam Coleman, Chair • Revised Board Committee Membership	21 – 27	LC	Note Approval	10.15
8.	**Chief Executive's Report** Cara Charles-Barks, Chief Executive Lisa Thomas, Managing Director	28 – 41	CCB/ LT	Note	10.30
BREAK (10 minutes) at 11.10 to 11.20					
9.	**Integrated Performance Report** • Performance, Population & Place Committee Board Assurance Report (October & December) – Bernie Morley, Non-Executive Director & Committee Chair • Quality & Safety Committee Board Assurance Report (September, October & November) – Claudia Paoloni, Non-Executive Director & Committee Chair	42 – 47 48 – 60	BM CP	Assurance Assurance	11.20

		PAGES	BY	ACTION	TIME
	• People & Culture Committee Board Assurance Report (October) – Julian Duxfield, Non-Executive Director & Committee Chair	61 – 63	JD	Assurance	
	• Finance, Infrastructure & Digital Committee Board Assurance Report (September, October & November) – Faried Chopdat, Non-Executive Director & Committee Chair	64 – 69	FC	Assurance	
	• Integrated Performance Report	70 – 124	All	Receive	
10.	**Audit, Risk & Assurance Committee Board Assurance Report (November)** Helen Spice, Non-Executive Director and Committee Member	125 – 126	HS	Assurance	12.00
11.	**Charitable Funds Committee Board Assurance Report (November)** Julian Duxfield, Non-Executive Director and Committee Member	127 – 128	JD	Assurance	12.10
12.	**Perinatal Services Six Month Summary (Q1 & Q2 2025/26)** Luisa Goddard, Chief Nurse Kat Simpson, Director of Midwifery & Neonatal Services	129 – 138	LG/KS	Receive	12.20
	CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**				
13.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	None	CC	Approve	12.40
14.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-
15.	**Date and time of next meeting** Thursday 15 January 2026 at 9.30am, Great Western Hospital, Swindon	Verbal	LC	Note	-
16.	**Exclusion of the Public and Press** The Board is asked to resolve:- *"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest"*	-	-	-	12.45

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF TRUST BOARD HELD IN PUBLIC
AT TRUST HQ BOARDROOM, GREAT WESTERN HOSPITAL, SWINDON, SN3 6BB AND VIA MS TEAMS
11 SEPTEMBER 2025 AT 9.30AM

Present:

Liam Coleman (LC)	Chair
Cara Charles-Barks (CCB)	Chief Executive
Faried Chopdat (FC)*	Deputy Chair/Non-Executive Director
Julian Duxfield (JD)	Non-Executive Director *(from 12noon)*
Luisa Goddard (LG)	Chief Nurse
Benny Goodman (BG)	Chief Operating Officer
Jude Gray (JG)	Chief People Officer
Bernie Morley (BM)	Non-Executive Director
Tobenna Onyirioha (TO)	Deputy Chief Medical Officer *(deputising for Steve Haig)*
Claudia Paoloni (CP)	Non-Executive Director/Senior Independent Director
Will Smart (WS)	Non-Executive Director
Lisa Thomas (LT)	Managing Director
Simon Wade (SW)	Acting Managing Director / Chief Financial Officer

In attendance:

Emily Beardshall (EB)	Acting Chief Officer of Improvement & Partnerships
Caroline Coles (CC)	Company Secretary
Jonathan Hinchliffe (JH)	Group Chief Transformation & Innovation Officer (Interim)
Deborah Rawlings (DR)	Board Secretary
Sue Morgan	Associate Director of Health, Safety, Fire & Security (agenda item 078/25)
Nick Harvey	Fire Safety Officer (agenda item 078/25)
Kathryn Harrison	Delivery Suite Manager (agenda item 078/25)

Apologies

Steve Haig (SH)	Acting Chief Medical Officer
Helen Spice (HS)	Non-Executive Director

Number of members of the Public: There was 1 member of public in attendance (Sarah Marshall, Governor)

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
073/25	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public, in particular the Chair wished to welcome Lisa Thomas as the Trust's new Managing Director and to thank Steve Haig in his role as interim Chief Medical Officer Apologies were received as above.	
074/25	**Declarations of Interest** There were no declarations of interest.	
075/25	**Minutes of the previous meeting (public)** The minutes of the Board meeting held in public on 10 July 2025 were adopted and agreed as a correct record.	
076/25	**Outstanding actions of the Board (public)** The Board received and considered the outstanding action list. The following update was noted:-	

Minute	Description	Action

050/25 : IPR Quarterly Pillar Metric Deep Dive – Our Performance – It was confirmed that initiatives to drive improvement around the operational performance metric was being shared across the Group and that this data was of good quality. Action was closed.

077/25 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

078/25 **Staff Story – Improving Together**
Sue Morgan, Associate Director of Health, Safety, Fire & Security, Nick Harvey, Fire Safety Officer and Kathryn Harrison, Delivery Suite Manager joined the meeting to present this item.

The Board received reflections on how Improving Together training had supported staff to create a culture of continuous improvement and sustainability within the organisation, with a clear focus on supporting frontline teams to deliver improvements in their own areas of work.

Sue Morgan and Nick Harvey provided an outline of improvement initiatives introduced around fire safety at the Trust that had been developed working through the A3 methodology which had also allowed the Health & Safety Team to refine their understanding and approach, leading to a more effective problem resolution. The results following initial improvements made included improved training compliance and helping the organisation to achieve fire safety and HTM0501 standards.

Kathryn Harrison also outlined project actions which had been undertaken within the Delivery Suite to implement staff huddles and the theatre caps diversity project and how this had benefited a more collaborative approach around improvements by staff within the unit.

The Board thanked Sue, Nick and Kathryn for their presentations and welcomed the ongoing success of the Trust-wide Improving Together approach for a consistent methodology for innovation and continuous improvement across the organisation.

The Board **noted** the staff story.

079/25 **Chair's Report**
The Board received and considered the Chair's Board Report which highlighted activities and shared information on governance developments within the Trust and externally, together with key meetings, training and events during July and August 2025 in which the Governors participated.

The Notice of Elections to the Council of Governors had been published on the Trust's website on 1 August 2025 which indicated that nominations were open from that date. There were 10 public governor seats and 3 staff governor seats up for election. The elections will run from August to September 2025.

A BSW Hospitals Group Joint Council of Governors had taken place on 5 August 2025 and that there had been positive engagement from all 3 organisations, with future joint workshops planned.

The Board **noted** the report.

<u>BSW Hospitals Group Partnership Agreement – revised</u>
The Board received and considered a paper which had set out proposed variations to the May 2025 Partnership Agreement, Schedule 3 – Group Joint Functions, and Schedule 5 – Joint Committee Terms of Reference, of the BSW Hospitals Partnership Agreement to strengthen delegations.

Minute	Description	Action

It was also noted that the BSW Hospitals Group Joint Committee at its meeting on 16 July 2025 had approved changes to Schedules 3 and 5, noting that Clause 18 of the BSW Hospitals Group Partnership Agreement required:

- *18.1 - Except as set out in Clause 18.2 or otherwise in this Agreement, any Variation of this Agreement, including the introduction of any additional terms and conditions, shall only be binding when agreed by written resolutions of each Trust's Board.*

Following review by the Board, the following amendments were requested:

- Section 4.3 – to delete "*Director of Estates & Facilities*" as this role will not be a member of the Joint Committee.
- Section 5.2 – to delete "*but not take part in making decisions*" as this phrase may imply that non-voting attendees cannot contribute meaningfully to decisions, which was not the intention.

The revised document is to be circulated to both Boards of the Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust for approval as the final version.

RESOLUTION:

The Board approves the proposed variations to Schedule 3 (Group Joint Functions) and Schedule 5 (Joint Committee Terms of Reference) of the BSW Hospitals Partnership Agreement subject to the requested amendments.

081/25 **Chief Executive's Report**

The Board received and considered the Chief Executive's Report, and the following highlighted:

Approach to Assessing Provider Capability

As set out in the recently published NHS Oversight Framework (NOF), NHS England now required an annual self-assessment submission from provider Boards to inform not only its organisation's delivery, as evidenced by its NOF segment, but also its capability. Provider self-assessments are to be completed by 22 October 2025, and a joint and consistent approach was being developed for the Group. This would also provide a benchmarking opportunity to assess the capability and requirements to design the governance framework as the Group moves towards meeting as a joint board.

Lead Appointed for National Maternity Investigation

An independent investigation into NHS Maternity and Neonatal Care had been announced by the Secretary of State and an initial set of national recommendations would be produced by December 2025.

NHS Publishes Strike Impact Data

NHS England had published data which outlined the impact of recent industrial action by Resident Doctors, which showed the results of a more robust approach by NHS leaders with staff working around the clock to keep services open for patients. The data showed that the GWH position was similar to the reported national position. Cara Charles-Barks, Chief Executive thanked the teams at the Great Western Hospital for their continued efforts to ensure that services were delivered as safely and robustly as possible.

NHS League Tables

It was reported that new NHS league tables had been launched to introduce a more transparent way for patients to review local healthcare services. The Department of Health and Social Care, working with NHS England, had published a new public dashboard, calculated by NHSE to a set criteria, to provide an easy and fair comparison across trusts, covering A&E waits, surgery backlogs, mental health services, and patient satisfaction.

Minute	Description	Action

GWH has been ranked at mid-table when compared with other acute trusts in the country and that the Royal United Hospitals Bath and Salisbury also ranked similarly. Board members discussed the challenges ahead for the Group in addressing the current position, highlighting the importance of managing the Trust's reputation and ensuring effective staff communication.

It was noted that national guidance was awaited around the new foundation trust approach and that reapplication would only be permitted by trusts ranked in Tier 1 or 2 segment of the National Oversight Framework and that this would be reviewed against the delivery elements of the 10 Year Plan.

Care Quality Commission inspection reports
Following unannounced inspections by the CQC of both Surgery and Urgent and Emergency Care, reports had now been published which confirmed surgery services rated as 'Good' and urgent and emergency care services rated as 'Requires Improvement'. The Trust's overall rating remained as 'Requires Improvement'.

GWH latest operational position
In July, 95% of planned operational activity was delivered, despite the impact of industrial action taken by resident doctors. However, the overall waiting list continued to grow, including an increase in the number of patients waiting 52 weeks or longer for treatment. On a more positive note, there were notable improvements in ambulance handover times, a reduction in pressure-related harms, and a decrease in the average length of stay for non-elective admissions.

Bed reconfiguration
The latest phase of work had been completed with gastroenterology beds being relocated from Saturn Ward to Ampney Ward to consolidate medical patients and improve continuity of care. The move also benefited the Surgery and Planned Care division by co-locating gastroenterology with other surgical teams.

Finance
The GWH financial position continued to present a significant challenge and that the Trust was £7.6m behind plan. Key to the delivery of the Trust's plan for the year was the achievement of the efficiency savings target and work continued with the divisions to deliver this. A BSW Hospitals Group Financial Recovery Plan had been developed to address the system-wide deficit.

Faried Chopdat, Non-Executive Director reported on recent discussions held with the Group Vice-Chairs around development of the Group strategy and the requirement to develop and deliver the strategy for April 2026. Faried also reflected on the importance of engaging stakeholders effectively throughout the process, aiming to ensure efficiency and minimise duplication of efforts, particularly in relation to the existing work undertaken for the GWH strategy.

Faried Chopdat, Non-Executive Director added that the Vice-Chairs also discussed the considerable opportunities to look at AI more broadly and requested that Jonathan Hinchliffe, Group Chief Transformation & Innovation Officer (Interim) investigate this potential further.

Faried Chopdat, Non-Executive Director, also commented on the launch of the Trust's Green Plan for 2025–2028 and acknowledged the Trust's ambition and commitment to achieving its sustainability and Net Zero targets. However, Faried noted that the current financial constraints posed risks to the successful delivery of certain elements of the plan.

The Board **noted** the report.

Minute	Description	Action

081/25 **Integrated Performance Report**

The Board received the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in July 2025.

Board Assurance Reports

Our Performance

Performance, Population and Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population and Place Committee (PPPC) at its meetings on 6 August 2025 and 27 August 2025 the following was highlighted:

- The Trust was in Tier 1 for Urgent and Emergency Care.
- Ambulance handover target was achieved in the second half of August with an average time of 24 minutes following the introduction of improvement measures.
- 292 outpatient appointments were affected by the recent industrial action.
- Referral to Treatment (RTT) figures continued to reduce and ahead of the operating for August.
- Cancer diagnosis performance continued to show an improved position. Noted that GWH was the only TVCA trust not in tiering and was currently helping other trusts with challenged specialties.
- In future, Performance Assessment Framework segmentation was to be based only on delivery metrics with capability assessed alongside delivery. GWH had been placed in segment 3 since organisations in receipt of deficit support funding had their overall segment limited to 3. Before application of the financial override, the segmentation score was 2.31 (91 of 205 providers). GWH's top score was 1.8 in the patient safety domain.

A discussion took place regarding the ongoing challenges associated with ambulance conveyancing within BSW. Benny Goodman, Chief Operating Officer provided an overview of the actions currently being implemented to improve ambulance handover processes and drive overall performance in this area.

The Board **noted** the report.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the detailed discussions held at the Quality & Safety Committee (QSC) at its meetings on 24 July 2025 and 21 August 2025 and the following was highlighted:

- The trend for the reduction in total harms over the last 12 months had remained static.
- The Maternity and Neonatal Service continues to perform consistently well and has delivered on all metrics. A self-assessment update against the Immediate and Essential Actions from the Ockenden report and three-year maternity and neonatal delivery plan was received. The Trust had declared a position of compliance in Year 6 against all ten Ockenden safety actions and rebate funding being issued nationally was awaited. However, it was noted that QSC had scored the Maternity IPR as partial assurance due to training compliance rates and the outcome of the recent inquest.
- A deep dive into falls had demonstrated good progress with falls reduction and the reduction in harm from falls. There was much greater engagement and ownership of the falls prevention plan across divisions with good learning being identified.
- 24-hour turnaround of EDS performance remained stable at 55%, however assurance was provided that 90% of patients now received a discharge summary

Minute	Description	Action

within 48 hours. A report was to be received by the September 2025 QSC meeting on the improved position for EDS performance.

The Board **noted** the report.

Our People

People & Culture Committee Chair Overview

The Board received an overview of the detailed discussions held at the People & Culture Committee (PCC) at its meeting on 27 August 2025 and the following was highlighted:

- Robust assurance reports had been received from divisions on progress against improvement actions identified from the 2024 staff survey and delivery of workforce recovery targets.
- Usage of bank staff and temporary staff remained high, however good and sustainable controls remained in place.
- Good progress continued to be made at Group level which included the development of a group-wide approach to the staff survey, policy, and workforce transformation.

The Board **noted** the report.

Use of Resources

Finance, Infrastructure & Digital Committee Chair Overview

The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meetings on 28 July 2025 and 26 August 2025 and the following was highlighted:

- In relation to the GWH Electrical System (electrical incident July 2024), the generator and electrical system testing planned for June 2025 had been postponed due to cancellation by the generator specialist at the last minute. New dates were being arranged, but securing a commitment from the generator specialist remained a challenge and that revised dates were now likely to fall in October or November 2025, which was beyond the Trust Board's deadline. A reduced level of assurance score reflected the committee's ongoing concern until all the events and systems associated with the electrical incident had been investigated.
- The BSW financial position as at Month 4 was adverse to plan by £18.4m, which had been driven by deteriorating performance across all provider trusts. Efficiency and workforce plans remained off track, with high run rates and limited confidence in deliverability. Mitigation efforts were underway, but both the Trust and the wider BSW system faced significant financial challenges for the remainder of the year. FIDC's 'Limited' assurance rating reflects the scale of risk, lack of independent challenge at Group level, and evolving governance. Draft terms of reference were being developed to strengthen Group-level governance.

A robust discussion was held on the Group's overarching financial strategy and the need for strengthened governance to support delivery of the operational plan and decision-making around the future provision of services.

The Board **noted** the report.

082/25 **Charitable Funds Committee Board Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) at its meeting on 13 August 2025 and highlighted the following:

- Work had been undertaken to rationalise charitable funds across the Trust, shifting from a restrictive model to a more strategic and flexible approach. This report was

Minute	Description	Action

to be received by the private session of the Board at its September meeting for approval.
- Funds were to be diverted into the Clix prescription lockers to ensure that these were implemented as soon as possible.
- The launch of the new chemotherapy appeal campaign was to be slightly delayed, however some soft launch activity was to continue.

The Board **noted** the report.

083/25 **Audit, Risk & Assurance Committee Board Assurance Report**

The Board received a verbal overview of the detailed discussions held at the Audit, Risk & Assurance Committee (ARAC) at its meeting on 4 September 2025 and highlighted the following:

- The Surgery and Planned Care risk register had demonstrated robust governance around the management of risks and compliance with the Trust's risk management policy.
- A report was presented outlining the current progress on actions following the electrical incident in July 2024. ARAC discussed governance and controls related to single supplier agreements. An additional report detailing the remaining risks prior to the completion of all activities associated with the incident was requested.
- The External Audit Plan for 2025/26 from Deloitte was received and approved and it was noted that the external auditors would consider the Value for Money aspects of their work earlier in the process to ensure adequate time to discuss this fully with ARAC.
- A verbal update was provided by the External Auditors on key activities for 2025/26.
- The Internal Audit Programme for 2025/26 continued to progress well.
- A review of the Trust's DSP Toolkit self-assessment had been undertaken by the Internal Auditors and the assurance level for GWH based on the overall risk across all five objectives was 'significant assurance with minor improvements required'.
- The final internal audit report on Patient Complaints had provided an overall assessment of 'partial assurance with improvements required'. This rating had been driven by the improvements required in the completeness and accuracy of complaint documentation, adherence to extension policies, and the timeliness of complaint resolution.

The Board **noted** the report.

084/25 **Learning from Deaths Annual Report 2024/25**

The Board received and considered the Learning from Deaths Annual Report 2024/25 for the Trust.

Tobenna Onyirioha, Deputy Chief Medical Officer reported that the most recent Trust Level SHMI data for the period January to December 2024 had remained within the expected range. The most recent SHMI publication was released in August 2025. However, interpretation of the data should take into account a five-month lag, as the SHMI figures were subject to a data "cleansing" process conducted by NHSE. It was noted that the Trust had given notice to withdraw from the Telstra contract at the end of September 2025.

It was noted that structured judgement reviews (SJR) undertaken during the reporting period had identified overall Good and/or Excellent care delivered and that processes around SJRs had now been streamlined to focus on mandatory categories for mortality reviews. Documentation remained the biggest opportunity for improvement, together with additional improvement opportunities identified in relation to systems and processes where there were notable delays with some procedures. Good evidence of triangulation and alignment with patient safety reviews could be demonstrated, together with evidence of

Minute	Description	Action

internal mortality monitoring and improved engagement with quarterly Learning from Deaths meetings to ensure that learning was widely shared. Work continued to improve current processes and support provided to departments in relation to internal mortality reviews to inform improvement plans.

Three thematic Trust-wide mortality reviews had been undertaken during 2024/25 following alerts received in relation to inpatient falls, care of patients with a hip fracture, and pneumonia. Outcomes of the reviews would continue to be closely monitored to ensure that identified areas for shared learning and process improvement were effectively implemented.

The Board was also assured that the Quality & Safety Committee had requested oversight of the impact of actions arising from patient safety investigations, as well as Coronial outcomes and recommendations, to ensure that organisational learning was being effectively embedded.

The Board members discussed approaches to capturing EDI data for individual mortality cases; however it was noted that such considerations were already incorporated during the investigation of clinical incidents. It was agreed that the EDI analysis presented on the front sheet of reports should transparently reflect any incomplete EDI data available at this stage. Consideration would also be given to incorporating this data requirement into the EPR dataset to enable more robust analysis in the future.

The Board **noted** the report.

085/25 **Freedom to Speak Up Annual Report 2024/25**

The Board received and considered a report which provided an overview of the work of the Freedom To Speak Up (FTSU) service across the Trust during 2024/25. Key developments in 2024/25 were noted which included the recruitment of additional Guardians and the appointment of a Lead Guardian, development of a communication plan and overarching plan for the year, and identification and implementation of process improvements.

It was noted that the 2024/25 reporting period had seen progress in strengthening the FTSU service across the Trust. The continued rise in concerns raised during the year provided an early indication of growing staff confidence in the service and that this would continue to be monitored in 2025/26 to ensure sustainability. A breakdown of the activity for 2024/25 was noted together with trends and themes that would be used to guide future developments and actions.

. It was also noted that a review of the FTSU across the Group was also to be undertaken to explore opportunities for greater alignment and approach across the organisation and to also share learning around themes and feedback.

The Board **noted** the report on the FTSU service and the actions taken to support management.

086/25 **Improving Together Year 3 Review**

The Board reviewed a paper which detailed the progress of the Trust's 'Improving Together' approach, providing assurance that resources were being utilised effectively and that a plan for long-term sustainability was in place.

It was acknowledged that evaluation against the established model demonstrated good progress in implementing the 'Improving Together' approach, with continuous learning and refinement informed by effective practices. Year 3 adaptations strengthened the focus and consistency of improvement efforts compared to Year 2. Sustaining frontline routines continued to pose challenges, prompting a review of support mechanisms to identify viable solutions within current resource constraints. The Board also recognised the work

Minute	Description	Action

undertaken to date through the Quality Improvement Networks and the associated benefits realised.

The priorities for year 4 deployment were noted which related to strengthening cross-organisational collaboration (Group working and BSW integration), accelerating frontline ownership and sustainability, elevation of the staff and patient/public voice, and to support priority transformation programmes.

Further assurance was provided regarding staff training to support the sustained implementation of the Improving Together methodology across the organisation. Group-level strategic initiatives were also evolving, with a slightly adapted approach to Improving Together to maintain rigour and effective programme management.

Further discussions took place regarding the outcomes of the Go and See Visits conducted at the Trust, focusing on how emerging themes were identified and integrated into an Ideas Collection to inform subsequent actions and be shared with the Board for future Go and See Visits.

The Board noted the report.

087/25 **Inclusion & Health Inequalities Annual Report 2024/25**

Sharon Woma, Head of EDI & Health Inequalities joined the meeting for this item.

The Board received and considered the Inclusion & Health Inequalities Annual Report 2024/25 which provided an overview of the progress against the Equality, Diversity and Inclusion (EDI)/Health Inequalities (HI) objectives, the NHS England six High Impact Actions and our system's Health Inequalities Strategy.

The report summarised the Trust's actions to build an inclusive, safe, and just culture for all stakeholders, supported by initiatives such as staff networks, EDI Champions, and compliance with frameworks like the Workforce Disability and Race Equality Standards, Gender Pay Gap reporting, the Equality Delivery System, and the NHS EDI Improvement Plan.

The new EDI/HI strategy for 2025-2028 sets the direction for the next four years for the organisation. The accompanying action plan sets out the priorities for 2025/26 to support this strategy and would remain flexible to adapt to changing needs, including those arising from new partnership arrangements.

The Board members discussed challenges that were being faced by the Trust to meet EDI strategic objectives from a leadership perspective, which included initiatives to address the gender pay gap and to improve the environment around discrimination and bullying and harassment.

The Board thanked Sharon Woma for the considerable work undertaken to produce a concise and informative report.

RESOLUTION:

The Board approves the Inclusion & Health Inequalities Annual Report 2024/25 for publication.

088/25 **Health, Safety, Fire and Security Annual Report 2024/25**

The Board received and considered the GWH Health & Safety Annual Report for 2024/25 which provided an overview of key health, safety, fire and security incidents that had taken place during the year.

Minute	Description	Action

The Health & Safety Team had commenced site audits during 2024/25 which had provided the Trust with assurance for compliance with key health and safety aspects. Year 2 of the health, safety, fire and security strategy was now operational to provide in-depth scrutiny into key risks identified across workstreams and actions.

There had been a total of 524 staff related incidents reported in 2024/25 with 383 reported under the categories of violence and aggression. The 'Never OK' campaign had been successfully implemented into the organisation to address an increase in behaviours by some patients and that this had been well received by staff.

There had been 15 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable accidents reported to the HSE in 2024/25. The main reporting categories were noted and the actions to drive improvement were outlined.

The Board acknowledged the considerable work undertaken by the Health & Safety Team to continue to drive improvement around key health and safety aspects.

RESOLUTION:

The Board approves the Health, Safety, Fire and Security Annual Report for 2024/25.

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

089/25 **Ratification of Decisions made via Board Circular**
None.

090/25 **Responsible Officer Annual Report**
The Board received and noted the Responsible Officer Annual Report. This report had been reviewed in detail by the Quality & Safety Committee (QSC) at its meeting on 17 July 2025 and recommended approval by the Board for publication.

RESOLUTION:

The Board approves the Responsible Officer Annual Report for publication.

091/25 **Committee Effectiveness Review 2024**
The Board received a paper to consider the annual review for the Board Committee effectiveness and the terms of reference for the Board Committees Remuneration Committee and Charitable Funds Committee. The following was noted:

- Each Board Committee had undertaken an open discussion to consider their effectiveness, including terms of reference.
- There were no issues or concerns to draw to the attention of the Board.
- The terms of reference of the Committees were circulated showing minor amendments.

RESOLUTION:

The Board approves the Terms of Reference for each Committee as circulated within the Board papers.

Minute	Description	Action
092/25	**Urgent Public Business (if any)** None.	
093/25	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 10 November 2025 at 9.30am at the Great Western Hospital, Swindon.	
094/25	**Exclusion of the Public and Press** The Board **resolved** that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity of which would be prejudicial to the public interest.	

The meeting finished at 13.10hrs

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – December 2025				
ARAC – Audit, Risk and Assurance Committee, CFC – Charitable Funds Committee, FIDC – Finance, Infrastructure & Digital Committee, PPPC – Performance, Population and Place Committee, PCC – People & Culture Committee, QSC – Quality & Safety Committee, RemCom – Remuneration Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
None				

Future Actions				
None				

Great Western Hospitals NHS Foundation Trust

Report Title	**Question for the Board**				
Meeting	**Trust Board**				
Date	**11/12/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

Purpose

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

Assurance Level

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

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

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

Assurance in respect of the process of obtaining and gaining response to questions to the Board.

Report

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

This paper reports the question and response asked of the Deputy Chief Operating Officer on 15 October 2025 around signposting/signage.

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

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

Risk + Oversight		Risk Score
Key risks – risk number & description (Link to BAF / Risk Register)	n/a	

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Deputy Chief Operating Officer
Next Steps	Present at Council of Governors meeting 2026

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

Explanation of above analysis:

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is invited to consider the question raised, the response given and agree if any further action is required.

Accountable Lead Signature	Caroline Coles
Date	**03/12/2025**

Questions to the Board				
Topic	**Questioner**	**Question**	**Responder**	**Response**
MAU signposting via Urgent Treatment Centre	Chris Callow, Deputy Lead Governor	The question was around poor signposting for MAU via Urgent Treatment Centre. This is unclear and has led to difficulty locating both the MAU entrance and the exit for patients.	Robert Presland, Deputy Chief Operating Officer, Kevin Clark, General Manager, Urgent & Emergency Care	The IFD project/MAU teams determined the primary entrance to MAU to be the one from the ED side, rather than the main hospital street - this makes sense as it leads directly into Reception. The primary issue was that there was planning for additional signage at the back end of the IFD project, which would have included multiple wall mounted and hanging signs along the entire route. However, there was no IFD budget to cover this, the external provider "dissolved", and there was no department or Trust budget to cover this. Some small works to get the signage fixed have now been approved. Timescales TBC

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**11/12/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 : Summary of Board Safety Walkarounds Appendix 2 : Board Committee Membership – for approval				

Purpose

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

Assurance Level

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

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

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

Due process followed.

Report

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

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

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

- Council of Governors – Key Meeting Dates and update

- Non-Executive Directors Update – including new membership to Board committees for approval
- Strengthening Board Oversight
- Trust Chair - Key Meeting Dates

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

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

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

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

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

Accountable Lead Signature	Liam Coleman, Chair
Date	**03/12/2025**

Chair's Board Report

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

1. Council of Governors

1.1 Governor elections took place over the summer, and the results are as follows:-
Public Northern Wiltshire; Chandra Verma
Public Swindon; Mary Day, Leanne Stevenson, Gordon Wilson , Ashish Channawar (re-elected), Vivien Coppen (re-elected), Lesley Hemingway (re-elected), Raana Bodman (re-elected)
Staff: Administrators, Maintenance, Auxiliary and Volunteers; Chris Shepherd (re-elected)
Staff: Nursing and Therapy; Harrison Darley

Congratulations and welcome to both our new and re-elected governors.

1.2 Chris Callow has been appointed as the new Lead Governor as Natalie Titcombe's term of office came to an end. I would like to thank Natalie for her time and commitment in her role as Lead Governor and congratulations to Chris as he steps back into the role of Lead Governor.

1.3 A Council of Governors meeting was held on 25 November 2025 which included a presentation on CQC visits and PFI expiry.

1.4 The following table outlines the key meetings, training and events during October and November.

October - November 2025 – Council of Governors		
Date	**Event**	**Purpose**
30 September	Engagement & Membership Working Group	To advise and support the Trust in increasing Trust membership and improving membership engagement
1 October	BSW Hospitals Group Council of Governors	Discuss BSW Hospitals 10-year plan / developing BSW Operating model.
7 October	Annual Members Meeting	Annual meeting to present the Annual Report and Accounts and update members and governors on latest issues and achievements
21 November	Group Chair longlisting meeting	To agree Group chair longlisting
25 November	Council of Governors Meeting	Regular meeting to update and discuss Trust issues
2 December	BSW Hospitals Group Council of Governors	To update governors on the development of the Group model which included current context, governance & risk, group narrative & strategy planning and transformation models of care.
3 December	People's Experience & Quality Working Group	To identify key issues in relation to service users and staff experience and the quality of the work of the Trust. An update on Martha's Law and Patient Safety Walks.

2. Non-Executive Directors

2.1 We successfully concluded the recruitment process for Non-Executive Directors and welcome Chris Burton and Sandra Gordon as Non-Executive Directors, and Neil Clark and Samaher Sweity as Associate Non-Executive Directors.

2.2 In terms of Board committee membership it is recommended that the new Non-Executive Directors become members as highlighted in the attached revised Committee Membership table (appendix 1).
The Board is requested to approve the revised membership of Board committees.

3. Strengthening Board Oversight & Development

3.1 *Provider capability self-assessment*

The Trust's provider capability self-assessment, with Board approved evidence, was submitted within the deadline of 22 October 2025. A review period followed where NHSE regional teams had 4 weeks to triangulate data and assign capability ratings. The next step is a national moderation exercise, to ensure a consistent approach across regions to determining ratings. This is due to take place in the first half of December.

3.3 *Safety Visits*

There were 5 Board safety visits during the period covered by this report as follows:-

Date	Area	Board Member
16/10/2025	Dove	Benny Goodman (ED) Claudia Paoloni (NED)
27/10/2025	Theatres	Jude Gray (ED) Faried Chopdat (NED) Helen Spice (NED)
30/10/2025	Trauma	Simon Wade (ED) Bernie Morley (NED)

Date	Area	Board Member
12/11/2025	Occupational Therapy	Luisa Goddard (ED) Visit went ahead with no NED
24/11/2025	Critical Care Unit (ITU)	Luisa Goddard (ED) Helen Spice (NED)

3.4 *Board Safety Visits Bi-annual Summary Report*

A summary of the Board safety visits from January to June 2025 is outlined in appendix 1.

4. Trust Chair Key Meetings during October & November 2025

Meeting
Group Trust Board to Board
BSW Hospitals Group Council of Governors Meeting
BSW Hospitals Group Progress Checkpoint
BSW Recovery Assurance Meeting
Group Chairs / CEO meeting
GWH Annual Members Meeting
GWH NEDs/ANEDs Meeting
Swindon Leadership Forum
GWH Extraordinary Private Board Meeting
NED Recruitment Debrief
BSW Hospitals Group Remuneration Committee in Common
RUH Lead Governors Meeting

Meeting
GWH Finance Infrastructure & Digital Committee
GWH Performance Population & Place Committee
BSW Hospital Group Chairs Meeting
BSW EPR Joint Committee
RUH Subsidiary Oversight Committee
RUH Board of Directors Meeting
RUH Mid Year Review
GWH Board of Directors Meeting
GWH Governors/Company Secretary
BSW Hospitals Group Joint Committee
1:1s with Vice Chairs
1:1s with Managing Directors
1:1s with Chief Executive

Appendix 1 : Board Safety Visit Bi - Annual Summary Report

This report provides a summary of the outcomes from nine Board safety visits. All visits remain positively received, with excellent engagement from all staff involved.

Sharing of positive safety improvements is increasing and those involved in the visits demonstrate proudness of their departments and teams.

Staff are actively sharing areas of concern, supporting constructive conversations with the Executives and Non-Executive members.

Table one provides a summary of the wards/departments where visits have taken place from January to June 2025. All visits are planned and announced. This gives the team time to ensure that any staff member who wishes to be part of the visit can be.

Table one – visit summary

Name of site	Date of Walk Around
Kingfisher	20/01/2025
The Meadows	05/02/2025
Woodpecker	06/03/2025
Ophthalmology	24/03/2025
Ampney	03/04/2025
Medical Assessment Unit/Surgical Assessment Unit	15/04/2025
Maternity Triage	20/05/2025
Neptune	11/06/2025
Linnett	23/06/2025

Concerns or safety points raised on the visit.
Concerns and safety points that are discussed through each visit are recorded in the visit summary.

Some of the concerns or safety points raised included delayed transfers, equipment in extra bed spaces, and respiratory outliers increasing ward rounds.

Some the positive working that is being achieved includes the Advanced Clinical Practitioners (ACP) having a dedicated triage service, the addition of double screens at various stations, excellent relationship with Critical Care Outreach Team (CCOT)

Some of the learning points included proactive reporting of incidents on Datix, morning briefings to discuss all daily hot topics, and development of a handover sheet.

Summary

The feedback from the board safety visits continues to remain very positive, with excellent staff engagement before, during and after the visits.

Staffing, handovers, and space all continue to be areas of concern.

Staff are very proud of the work that do and as such more positive achievements are being discussed as part of the visits.

Appendix 1

Committee Membership

	Audit, Assurance & Risk Committee	Finance & Infrastructure Committee	Performance, Population & Place Committee	Quality & Safety Committee	Mental Health Governance Committee	Remuneration Committee	Charitable Funds Committee	Nomination & Remuneration Committee (Governors)	People & Culture Committee	Trust Management Committee
Non-Executive Directors										
Liam Coleman					Member*	**CHAIR**		**CHAIR**		n/a
Helen Spice	**CHAIR**	Member*		Member		Member		Member		n/a
Faried Chapdat	Member*	**CHAIR**				Member			Member*	n/a
Claudia Paoloni	Member			**CHAIR**	Member	Member				n/a
Will Smart	Member	Member				Member	Member			n/a
Julian Duxfield			Member*			Member	**CHAIR**	Member	**CHAIR**	n/a
Bernie Morley			**CHAIR**	Member		Member	Member			n/a
Christopher Burton			Member	Member		Member				n/a
Sandra Gordon		Member				Member			Member	n/a
Associate NED										
Neil Clark			Member			Member				n/a
Samaher Sueity						Member			Member	n/a

Report Title	**Chief Executive's report**				
Meeting	**Trust Board**				
Date	**11/12/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Cara Charles-Barks, Chief Executive				
Appendices					

Purpose

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

Assurance Level

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

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

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

Report

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

The Chief Executive's report covers:

1. Risks
2. BSW Hospitals Group update
3. National updates
4. Operational position at Great Western Hospital
5. Quality improvements
6. Systems and strategy
7. Workforce, wellbeing and recognition

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

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

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

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

Explanation of above analysis:

The report provides detail on a Government review of anti-semitism and all forms of racism in the NHS, as part of wider efforts to tackle discrimination in the health service.

Our new staff behaviours are covered in the report; these have a focus on being inclusive and respectful to others.

The report features our work to mark Black History Month in October, with celebrations involving staff from across the Trust.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	**04/12/2025**

1. Risks

1.1 Financial position

The financial position across the BSW Hospitals Group has been extremely challenged during the first half of the year, resulting in a £35.5m deficit at month 6. The key drivers of the overspend have consistently been the inability to deliver planned savings due to operational pressures, high cost drugs costs and temporary staffing requirements in excess of planned levels. Following the completion of the first quarter of the year a series of recovery measures were implemented from July onwards, which have demonstrated positive improvements across both the operational and financial positions.

The run rate position at M6 indicated an outturn deficit position in excess of £68m which has been partially mitigated through a comprehensive recovery plan reducing the projected outturn to £10m. Plans have been developed to support this, though there remains a significant element of risk associated with delivering plans at each of the sites. The planned impact of the recovery actions across the sites involve a mix of higher and lower risk schemes, with the high-level RAG categorisation in the table below:

Programme	**Value £m**	**RAG classification**
Optimisation of Temporary staffing usage	8.2	
Elective and Outpatient Productivity (incl Sulis)	9.0	
Non Pay and Drugs	3.2	
Beds/Capacity	1.0	
Commercial and Group opportunities	5.9	
Technical and Other measures	7.7	
Deficit Support Funding	23.4	
TOTAL	**58.1**	

In order to deliver its contribution to the overall system financial position the Hospitals Group has also needed to find an additional £7.4m, along with the planned ICB surplus this would deliver a breakeven position for the BSW system as a whole. Measures identified to address this gap are being fully worked up to ensure there is no impact on the delivery of performance targets. A key element of delivering the operational and financial improvement programme will be through the deployment of a Turnaround team at the RUH. The knowledge gained from this programme will be shared and implementation across both the Salisbury and Great Western sites to enhance delivery of the recovery programme.

1.2 Performance Pressures

Elective Performance

Performance across the BSW Hospitals Group is varied in elective care with the greatest challenges at RUH due to growth in the waiting list over the last 18 months – although since recovery plans were initiated in Q2, waiting list size has reduced and 18 and 52 week performance improved. Salisbury and Great Western Hospitals have started the year with strong performance in RTT and diagnostics although the summer has seen a reduced rate of improvement due to demand pressures.

Key challenges to be aware of from a BSW Hospitals Group perspective are:

- Demand growth in a number of specialties such as Gynaecology and Dermatology for both cancer and elective referrals. The ICB are conducting a review of data to understand drivers of growth and mitigations. Women's Health Hubs closure and reduced scope of service in the Referral Support Service may be contributing to this and further information and mitigations have been requested. The Elective Care Board has developed a proposed transformation programme for dermatology in BSW to manage rising demand and workforce constraints.

- Diagnostic capacity remains challenged particularly in ultrasound across the group where pathway changes in 25/26 have led to increased demand. Plans are in place in all Trusts to deliver increased capacity to sustain 6 week performance. The BSW Diagnostics Group oversees CDC capacity plans and has commissioned a diagnostic workforce plan to understand key constraints and opportunities across the BSW Hospitals Group.

  The planning guidance for 26/27 will require ambitious plans across BSW Hospitals Group as we aim to increase performance and productivity further over the 25/26 position. A Group capacity/demand tool has now been developed and is in use across all three Trusts to ensure a rigorous understanding of the capacity required to deliver this. Effective planning will reduce system reliance on short-term and more expensive means of delivering capacity.

Urgent Care

Urgent Care performance remains challenged across the Hospitals Group although the summer saw improvements in Emergency Department performance and ambulance handovers for BSW. Winter plans have now been developed across the Group and tested via NHSE's Regional team although significant risk remains over winter if demand is higher than plan or Non-Criteria to Reside does not reduce as planned. We are working closely with our system partners particularly local authorities, HCRG and the ICB to ensure we can discharge patients promptly when they are ready to leave and that we increasingly manage patients in the community rather than hospital.

Finally, I particularly wanted to thank all our teams involved in managing the impact of the new SWAST 45 minute handover approach – this has been a significant change across BSW but teams have pulled together to help keep patients safe.

2. Group Update

2.1 Joint Committee

Our latest BSW Hospitals Group Joint Committee meeting was held on 29th September 2025 in Salisbury with focus being on discussion of the Group Leadership Model, Financial Sustainability & Recovery, Care Organisation Risks, and our Group Governance Roadmap. Reports on our Corporate Services Programme, and Group Strategy Development were also introduced. A report from the September Group Joint Committee has been included with November Trust Board papers.

2.2 Leadership Team

Quarter three sees a few developments in the Group leadership team. The three Group Managing Directors joined on 1st September 2025 (Lisa Thomas - GWH, John Palmer – RUH, Nick Johnson - SFT). Andrew Hollowood was appointed as our Group Strategic Clinical Transformation Director. Following approval of the proposed leadership model post-consultation report by the Joint Committee on 29 September 2025, interviews for Group Chief Finance Officer and Group Chief People Officer roles were held in October, with Simon Wade and Jude Gray appointed to these respective roles.

2.3 Group Strategy & 26-27 Planning

The development of our Group Strategy has continued, led by Senior Responsible Officer Joss Foster and coordinated by Trust strategy leads, overseen by our Strategy, Partnership & Planning executive working group. Our Transitional support partner Teneo is also supporting this work. The strategy will create a high-level, long-term vision aligned with the NHS 10-Year Health Plan, acting as a call to action and a clear narrative for staff, partners, and communities. Development is ongoing and will be managed in close coordination with the 26-27 planning round. The draft strategy will be produced by December 2025, with final publication targeted for April 2026.

2.4 Group Governance and Assurance Arrangements and Transition Roadmap

To support safe and effective mobilisation of our new Operating Model by April 2026, a Governance Working Group led by Managing Director, Lisa Thomas, has been established to develop a detailed governance and assurance roadmap. The proposed roadmap was introduced at the Joint Committee on 29 September 2025. The development of BSW Hospitals Group risk approach and assurance arrangements will be integral to this roadmap.

2.5 Councils of Governors Workshop

On the afternoon of 2 October 2025, the three Councils of Governors came together, to discuss the emerging Operating Model, Group Strategy and our developing Group narrative and vision. It was agreed that a series of follow-up meetings would be arranged, so Governors can continue the conversation on Group Governance arrangements and Group Strategy development; the next session was held on 2 December 2025.

2.6 Board to Board Development

We held the latest of our Board-to-Board development sessions on the morning of 2 October 2025. The session focused on our Group Development Roadmap, Strategy and planned Governance and Risk Framework. Our next Board-to-Board session is planned for 12 February 2026. In the meantime, November, December and January will see a series of development workshops focused on our Group operating model, governance and assurance. Further details will be circulated in early November.

3. National Update

3.1 NHS Trust Performance League Tables

In November 2024, the Secretary of State announced that NHS England would assess NHS Trusts against a range of performance criteria and publish the results. This assessment would allow NHS England to determine the support individual NHS Trusts would need to improve: those in the middle of the pack would be supported by NHS England to improve and those demonstrating persistently low performance would receive prompt intervention, while those performing at the top may be rewarded with additional freedoms.

The first league tables were published on 9 September 2025. Ratings for Great Western Hospitals NHS Foundation Trust are outlined below:

The Trust was rated 76th of 132 Trusts across the country.

From an operational perspective GWH has made significant improvements across a number of areas over the last year, whilst recognising key areas that still require further work. In particular, RTT performance has improved by 7% since November 2024 to over 60% as at end Oct 2025, with a similar level of improvement in the wait to first appointment, now at 66% (up from 57% in Dec 2024). The percentage of 52 Week waiters has fallen over that time period from 3.4% to 1.4%. Ambulance handover times have also dramatically improved, such that GWH delivered an average of 33 minutes in October 2025 (versus 97 minutes in Oct 2024). The focus is now firmly on delivering improvements against the 4-hour target for the Emergency Department, with early signs of progress as a result of changes in the UTC and SDEC operational approach among other areas as part of the overall UEC programme in place.

The financial position at GWH over the first half of the year has been extremely challenged, but there have been signs of improvement over the last two months. Key drivers of the overspend include the inability to deliver planned savings due to operational pressures, temporary staffing pressures and drugs costs.

The run rate position at M4 indicated an outturn deficit position in excess of £26m (including Deficit Support Funding) which has now been mitigated through performance in M5 & M6 and a comprehensive Recovery plan, reducing the projected outturn to a risk assessed breakeven. The table below indicates the planned impact of the recovery actions and the risk designation associated with them for the remainder of the year:

Programme	***Value £m***	***RAG classification***
Optimisation of Temporary staffing usage	*3.3*	
Elective and Outpatient Productivity	*2.5*	
Sulis recovery	*1.1*	
Technical measures	*2*	
Non Pay (incl. High Cost Drugs)	*1.8*	
Other	*0.5*	
Deficit Support Funding	*9.6*	
TOTAL	***20.80***	

The operational and financial improvement programme continues to be monitored through the Finance Recovery sub-committee and wider Group recovery forums.

Further information on the leagues tables can be found via https://www.england.nhs.uk/long-read/nhs-oversight-framework-nhs-trust-performance-league-tables-process-and-results/

3.2 NHS Online

The NHS is setting up an 'online hospital' – NHS Online – in a significant reform to the way healthcare is delivered in England.

The innovative new model of care will not have a physical site, instead digitally connecting patients to expert clinicians anywhere in England. The first patients will be able to use the service from 2027.

This will mean that patients can be seen faster, as teams triage them quickly through the NHS App and let them book in scans at times that suit them at Community Diagnostic Centres closer to home.

NHS Online will provide a huge boost to patient waiting times, delivering the equivalent of up to 8.5 million appointments and assessments in its first three years – four times more than an average Trust – while enhancing patient choice and control over their care.

Initially the focus will be on a small number of planned treatment areas with the longest waits but over time this will be expanded to more treatment areas. Treatment areas will only be offered if the NHS knows it is it is clinically safe to do so remotely.

3.3 10 Year Workforce Plan

The government announced that it is seeking evidence and views primarily from healthcare organisations and those with expertise in workforce planning to inform the development of the 10 Year Workforce Plan.

As part of the 10 Year Health Plan for England: fit for the future, the government conducted the biggest ever public and staff engagement exercise on the future of the NHS. In the 10 Year Health Plan they set out how they will reinvent the healthcare model from:

- hospital to community
- analogue to digital
- sickness to prevention

The 10 Year Workforce Plan will build on the 10 Year Health Plan to set out how the government will deliver a new workforce model with staff who are aligned with the future direction of reform and have real hope for the future.

Rather than a formal consultation on specific proposals, this call for evidence is an opportunity to provide views on the government's plans for the next decade and to share examples and case studies that will support its delivery. The call for evidence closed on 7 November 2025.

Further information regarding the 10 Year Workforce plan can be found via https://www.gov.uk/government/calls-for-evidence/10-year-workforce-plan

3.4 Implementation of Jess's Rule – Three Strikes and we rethink

On 23 September 2025 Jess's Rule: Three Strikes and we rethink was implemented. This initiative is led by the Department of Health and Social Care (DHSC) and NHS England and is supported by the Royal College of General Practitioners.

Jess's Rule is a primary care initiative to encourage GPs teams to rethink a diagnosis if a patient presents three times with the same symptoms or concerns, particularly if symptoms unexpectedly persist, escalate, or remain unexplained.

Jess's Rule asks GP teams to 'reflect, review and rethink' if a patient presents three times with the same or escalating symptoms.

Jess's Rule is named in memory of Jessica Brady who passed away due to cancer in December 2020 at the age of 27. In the five months leading up to her death, Jess had 20 consultations with her GP practice, and her cancer had not been diagnosed. Jess was then admitted to hospital with stage 4 adenocarcinoma and died shortly afterwards. Since then, Jess's family have campaigned for primary care staff to elevate a patient's case for review after their third appointment with their practice about a condition or symptom.

Further information about Jess's Rule can be found via https://www.england.nhs.uk/long-read/jesss-rule-three-strikes-and-we-rethink/

3.5 Government to Tackle Anti-semitism and Other Racism in the NHS

The Prime Minister has ordered an urgent review of anti-semitism and all forms of racism in the NHS, as part of wider efforts to tackle discrimination in the health service. Lord John Mann will lead the review, looking at how to protect patients and staff from racism and hold perpetrators to account.

At the same time, the government announced the immediate rollout of strengthened mandatory anti-semitism and anti-racism training across the health service, and NHS England will review its uniform guidance so patients and staff always feel respected in NHS settings.

BSW Hospitals Group are already looking at how to develop consistent communication materials across the three organisations ahead of the new mandatory training implementation.

3.6 Provider Capability Assessment

As part of the NHS Oversight Framework (NOF), NHS England required all NHS Trusts to complete an annual self-assessment of their organisations capability against the following six areas, derived from the Insightful Provider Board:

1. strategy, leadership and planning
2. quality of care
3. people and culture
4. access and delivery of services
5. productivity and value for money
6. financial performance and oversight

These areas will inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability.

Each organisation within BSW Hospitals Group - Great Western Hospitals, Royal United Hospitals Bath and Salisbury NHS Foundation Trusts submitted their self-assessment and associated evidence by the deadline of 22 October 2025.

3.7 Resident Doctors Industrial Action

The British Medical Association have announced that Resident Doctors in England are set to strike from 7am on 17 December 2025 for five days.

The Trusts within BSW Hospitals Group – Great Western Hospitals, Royal United Hospitals Bath and Salisbury NHS Foundation Trusts will start to look to plan and prepare for the industrial action should it go ahead, adopting similar approaches to previous episodes of strike action.

3.8 Medium Term Planning Framework

On 24 October 2025 NHS England published the Medium Term Planning Framework – delivering change together 2026/27 to 2028/29. This framework is designed to return the NHS to much better health over the next three years with reduced waiting times and access to local care restored to the level patients and communities expect.

Further information on the Medium Term Planning Framework can be found via https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/

Great Western Hospitals NHS Foundation Trust update

4. Operational update

4.1 Latest operational position

Our waiting list has increased and currently exceeds 40,000 people, but the number of patients waiting 52 weeks or more has fallen.

Meeting the four-hour standard in urgent and emergency care remains challenging across the NHS, and in recent weeks we have seen an increase in the number of people accessing these services as we move in to Winter.

We know that longer waiting times for patients presents a clinical risk and are working hard to minimise these as much as we can. Much of our focus has been on reducing the time it takes ambulance crews to hand over their patients to our clinical teams in the Emergency Department, and we have seen a recent improvement in our progress against the 45 minute handover target. This has meant that the hospital has felt at times under greater pressure, we continue to focus on reducing bed occupancy levels through reducing the average length of stay in hospital, and the number of patients in hospital who we have not yet been able to be discharged for onward care.

We have recently been visited by National Director of Urgent and Emergency Care Sarah-Jane Marsh and regional NHS teams, and have taken these opportunities to highlight how we are working to meet the challenges we face.

4.2 New discharge unit

We have opened a new Discharge Unit on Dorcan ward.

This unit combines the existing surgical discharge lounge (Meldon) and medical discharge lounge (Betjeman Centre) into one shared space on the previously vacated Dorcan ward.

The new unit has bed space for up to eight patients and an additional seating area. There is also an accessible kitchen for patients which will be stocked with tea, coffee and breakfast items.

This will enable us to improve our ability to discharge patients, and the vacated space will enable us to provide extra beds should they be needed this winter.

4.3 Industrial action

The British Medical Association (BMA) announced last week that Resident Doctors will hold a five-day strike from 7am on 17 December to 7am on 22 November.

Industrial action is part of the BMA’s ongoing dispute with the Government over pay and conditions, not our Trust as their employer.

Planning for the strike is underway, using our experience and knowledge gained from previous industrial action, including the last five-day strike in November, to inform what we will do.

However, we expect disruption to normal activity, with some appointments, treatments and procedures likely to be unable to go ahead as we prioritise patient safety.

Patients will be contacted directly, at the earliest opportunity, if we need to rearrange their care. Patients should attend appointments as planned if they do not hear from us.

5. Quality

5.1 'Putting the hospital to bed'

Our 'Putting the hospital to bed' initiative returned last month, following the positive impact it had in June.

We know that creating a calmer, quieter, and more respectful night time environment benefits our patients.

We have asked matrons and ward managers to support this project by being present during evening and night shifts throughout November.

Patient feedback from our recent survey shows clear improvements in night time care in June:

- **Better sleep quality**: 45 per cent of patients rated their sleep 4 or 5 out of 5 post-initiative, up from 39 per cent pre-launch.
- **Reduced disturbances**: Reports of being disturbed "very frequently" dropped from 14 per cent to 10 per cent, while "never disturbed" rose from 32 per cent to 38 per cent.
- **Improved compassion**: 84 per cent of patients rated staff compassion at night as 4 or 5 out of 5, up from 81 per cent.

5.2 Improving Together

Last month we held our first BSW Hospitals Group Improving Together Week.

At our Trust, more than 1,500 staff so far have taken part in some form of Improving Together training, with many more embracing its principles.

During the week we celebrated staff from Mercury, Neptune, and Dove wards, along with the Critical Care Unit who have completed their training.

Each day colleagues from our Transformation and Improvement Hub shared how this methodology and way of working is helping teams to solve problems, explore ideas and make improvements in their areas.

Along with tea trolley visits to different parts of the Trust, we also held drop-in sessions every day to help staff find out more about how local and national data and analytic tools can help them make improvements.

5.3 Freedom to Speak Up Awareness Week

We held 'Wear Green Wednesday' as part of our Freedom to Speak Up Awareness Week in October.

The week highlighted how our staff should feel confident to raise concerns when they see them, and are able to make real change happen by acting on what they've heard.

This year's theme, Follow Up In Action, demonstrated how following up on concerns helps create improvements, to ultimately keep bettering the experience for our patients.

6. Systems and strategy

6.1 Finance

Our year-to-date position shows a deficit of £10.6m. This overspend is due to a combination of undelivered efficiencies, high spending on temporary staffing, and removal of deficit funding.

Our clinical divisions, along with corporate teams, have been asked to focus on finding recurrent ways to reduce our deficit positions, rather than one-off savings.

Continued focus on reducing spend on workforce and non-pay will be essential to improving our position in the second half of the year.

Our Financial Recovery Sub-Committee meets fortnightly to monitor our financial position and has oversight of a number of different workstreams.

7. Workforce, wellbeing and recognition

7.1 Our Behaviours

We launched our new set of behaviours in September, having worked with staff and volunteers to develop these over the summer.

How we show up for work and behave towards our colleagues and patients defines our culture and how we deliver excellent care to our patients.

We worked to co-create a new set of behaviours with staff and volunteers, which will replace all previous versions.

The behaviours are grouped around our STAR behaviours:

Service

Be compassionate
Be dependable

Ambition

Be curious
Be courageous

Teamwork

Be inclusive
Be collaborative

Respect

Be thoughtful
Be open

Following the launch of the behaviours, we are now working on helping bring them to life for staff and embedding them in the way the organisation works.

7.2 STAR of the Month awards

The recent winners of our STAR of the Month award are:

Rachana Dalvi, Physiotherapist, who was recognised for outstanding compassion, dedication, and unwavering support to both colleagues and patients. She has a deep understanding and passion for end-of-life care, ensuring patients and their families receive truly compassionate care in their final moments. Her kindness and generosity were described in her nomination as being ‘next level’.

Hayley Palmer, Nutrition Assistant on Trauma Unit, recognised a training opportunity for promoting Safe Swallowing on the Trauma Unit to improve mealtime experiences and safety. She liaised with Speech and Language Therapists and with the Trauma Unit Team to develop a poster presentation, and ensured it was accurate, effective and accessible to all.

Claire Wright, Martha's Rule Specialist Nurse, was recognised for her efforts to introduce the scheme across the organisation, giving patients a voice to escalate any concerns they might have. Claire is very passionate and ambitious about her role, and is working hard to promote inclusivity and accessibility for patients’ cultures and spoken language to ensure all patients are able to access the care they need.

7.3 Black History Month – Standing Firm in Power and Pride

Our Race Equality Network brought colleagues together over a shared lunch which featured insightful discussions and resources highlighting the contributions, history and culture of the Black community.

Our Endoscopy team also hosted a food feast prepared by colleagues – a celebration of their diversity, sharing meals from Guyana, Ghana, Nigeria, Uganda, Malawi, Zimbabwe and Kenya.

7.4 Staff survey

The national NHS staff survey has now closed.

Our response rate was 66 per cent, slightly lower than we have seen in recent years, with 3,639 staff completing the questionnaire.

The results of the survey will be published in March next year and will help form our action plan for engaging with staff for 2026-27.

7.5 Flu vaccination campaign

Our flu vaccination campaign is currently running and we continue to encourage our staff to take up the offer of a vaccine delivered by our Occupational Health team and protect themselves, their family and their patients this winter.

More than half of our workforce have been vaccinated so far.

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	29th October 2025	
Committee Chair	Bernie Morley Non-Executive Director	
Link to Strategic Objective	Pillar 3: Better Together	
Link to Board Assurance Framework	BAF 3: SR 4 – Performance and SR5 - Partnerships	
Improving Together Pillar Metrics	Waiting List – over 52 week waiters	Cancer waiting times
	Emergency Care – demand in area / time in ED	Elective waits – reducing inequality
Improving Together Breakthrough Objective	Non-elective average length of stay	Wait to First outpatient appointment

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Operational Highlight Report (see below)		
2. IPR - DM01	Good	No
3. IPR – RTT	Good	No
4. IPR – Cancer Services	Partial	No
5. IPR – ED / 4 hours	Limited	No
6. IPR – Ambulance Handover	Limited	No
UEC Plan Progress Quarterly Update	Noted	
EPRR Update	Noted	
Quarterly 15+ Risk Report	Good	
Board Assurance Framework	Noted	
Partnership Report	Noted	
Health Inequalities Report	Noted	
Networks 6 monthly update	Noted	

POINTS OF ESCALATION	None.
KEY AREAS TO NOTE	Referral to Treatment – 52 weeks down to 573 and 156 better than plan. Percentage of PTL under 52 weeks at 1.4% which is 0.6% better than plan. On track for 1% by March 2026. RTT <18 weeks is 60.7% but the PTL has grown for four consecutive months. There are now 4,000 more patients than planned for which may impact all measures. 65 week waits was 29 breaches. 78 week wait breaches was 5. Cancer 28 day faster diagnosis was 65.6% which was 15% off plan. Skin represented 34% of the breaches. The cancer PTL is greater than at any point since December 2022. 62 day is 65.6% which is 5.9% off target. Main issues are plastics, urology and breast.

	31 day is 90% and the main issue is capacity in skin pathways. The aim is to invest more in waiting list initiatives in Breast and skin to recover performance. Current expectation is to see improvement by December. Ambulance handover average was 67 minutes in September but October month to date current position is better than the plan trajectory of 33 minutes. This is coupled with an increase in conveyances of 14.5%. The implementation of one directional flow and a reset of the whole hospital approach to continuous flow has supported this. However, this is impacting ED occupancy and Ward occupancy remains high. ED and CEU time in department is 392 minutes and UTC is 171 minutes. The combined ED 4 hour performance is 68.1% in September which is 6.7% below plan. The committee received a recovery plan outlining: • Focus on 3 stream performance (UTC Type 3, Type 1 ED admitted and Type 1 non-admitted) • UTC Type 3 performance improvement is supported by recruitment to 5.4 GP clinicians and 3.4 clinical practitioners with an objective to achieve 98% by February. • Type 1 non-admitted aim to reach 70% by March with counter-measures including recruitment to substantive posts which will improve productivity, reducing waits to be seen and improve effectiveness of dual streaming in ambulatory majors. • Type 1 admitted aim to reach 35% by March with counter-measures outlined in the UEC programme targeting reduced length of stay to increase bed capacity. Non-elective length of stay in September was 0.5 days higher than at the same point last year. Counter-measures were reviewed and the committee received an update on the GIRFT work. The KPMG Discharge Audit was received which stated significant assurance with minor improvements required around better and more frequent reviews of patient discharge plans. EPRR quarterly update was received. Business continuity management is progressing with 10% completion and 80% in progression in clinical divisions. The 2025 assurance report will be received at the next meeting. Partnership Report – risks around housing infrastructure growth in Swindon was discussed; the SBC infrastructure report highlighted the potential impact on acute services as in the range of 100 acute beds (or equivalent) over the next 20 years. It was discussed formalising this as a strategic risk. Health Inequalities quarterly report was received. There is a focus on ED and elective care access for populations in the most deprived areas alongside the Oral health inequalities pilot. There was a discussion about maintaining focus on place-based working in this area. A timeline of end of November was given to comply with national requirements for Board to review health inequalities information. The Never OK campaign was highlighted as action being taken to support staff. Networks 6 monthly update. There is a risk to the South 4 Pathology Partnership due to a need for procurement staff with potential costs of over £0.7m per annum. The diagnostic networks board is working through future delivery models to maintain a Network beyond March 26 when national infrastructure is due to end.

BOARD ASSURANCE FRAMEWORK & RISKS	No change to BAF. One possible new risk relating to the proposed Swindon Borough Council planned housing increases (55k population increase of which half already has planning permission). 15+ risk quarterly report was received showing positive movement in reducing overdue risks by 20% and overdue actions by 35%. Ambulance handover risk was replaced by the risk relating to the use of temporary escalation spaces in ED to support ambulance handovers under 45 minutes.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	Recognising the progress made towards reducing average ambulance handover times with under 33 minutes on target to be achieved in October. DM01 (Diagnostics) – 2% increase in performance at 90.2% seen within 6 weeks and currently better than plan. Elective care access indicators benchmarking mid-table nationally.
REFERRALS TO OTHER BOARD COMMITTEES	None

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

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

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	3rd December 2025	
Committee Chair	Bernie Morley Non-Executive Director	
Link to Strategic Objective	Pillar 3: Better Together	
Link to Board Assurance Framework	BAF 3: SR 4 – Performance and SR5 - Partnerships	
Improving Together Pillar Metrics	Waiting List – over 52 week waiters	Cancer waiting times
	Emergency Care – demand in area / time in ED	Elective waits – reducing inequality
Improving Together Breakthrough Objective	Non-elective average length of stay	Wait to First outpatient appointment

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Operational Highlight Report (see below)		
2. IPR - DM01	Substantial	No
3. IPR – RTT	Good	No
4. IPR – Cancer Services	Limited	No
5. IPR – ED / 4 hours	Limited	No
6. IPR – Ambulance Handover	Good	No
Cancer Services Quarterly Assurance Report	See above	
Board Assurance Framework	Noted	
Partnership Report	Noted	
NHS Performance Assessment Framework (2025/26)	Noted	

POINTS OF ESCALATION	None.
KEY AREAS TO NOTE	**ED 4 hours:** Combined 4 hour performance was 69.9% in Oct, 3.6% below the operational plan. 4.4% increase in attendances versus prior period. Total mean time in ED was 394 mins (up from 392 mins), and mean time in UTC was 159 mins down from 171 mins. To achieve year end target of 78% this represents 15 fewer patients breaching every day across ED and UTC. **Cancer:** 28 day FDS at 61.4% which is 17% off target and down from 65.6% last month. The 62 day standard is at 65.8% which is 7.6% off target. Patients waiting greater than 62 days was 6.8% of PTL in Sept, but has now dropped to below 6%. 28 day capacity issues in skin and breast, and external dermatology clinics are being run for the remainder of the financial year to mitigate the backlog. 31 day is down to 83.6% from 90% and of the 36 pathways breaching, 16 were in skin and 9 in breast.

	Main challenges are around workforce, capacity and financial constraints along with an increase in referrals (9% increase in referrals year on year). **RTT:** Patients waiting over 52 weeks down by 14 to 559 and 98 below plan. Patients on the PTL waiting longer than 52 weeks is down to 1.3%, with year end target of 1.0%. Patients under 18 weeks is similar to prior month, but the total PTL has grown for the 5th consecutive month to 41,621 (5,618 more than anticipated). Patients waiting over 65 weeks, down by 1 to 28, and greater than 78 weeks are down from 5 to 3 (all in plastic surgery). **Partnerships** Contract negotiations are continuing with HCRG. The committee agreed that maintaining visibility of KPIs is important. Wiltshire JSNA (Joint Strategic Needs Assessment): - Ageing population therefore aging well is a key cross cutting theme but there remains a challenge around undiagnosed dementia - Significant disadvantaged areas with specific needs - Higher levels of certain conditions such as adult obesity and type 2 diabetes. The committee received a verbal update on Q2 NHS Performance Assessment Framework (which had been published since paper submission), with the overall position remaining broadly consistent with Q1. Due to the financial over-ride, GWH remains in segment 3.
BOARD ASSURANCE FRAMEWORK & RISKS	One change to the BAF is the increase in population proposed for Swindon – 28,000 homes (56k people), with implications for our expected demand including a requirement for 103 beds over the next 20 years. This has been added to corporate risk 3.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**DM01**: DM01 has reached 92.9% (up from 90.2%) and is the highest since Feb 2020. This means that the year end target has been met 5 months early. MRI, CT and DEXA are all achieving national constitutional standards **Ambulance handovers:** For 2 months we have delivered an average handover time of under 33 minutes, down from 67 mins in Sept, despite an increase in conveyance rate of circa 15 ambulances per day in November.
REFERRALS TO OTHER BOARD COMMITTEES	None

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

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

Board Committee Assurance Report

Committee	**Quality & Safety Committee**	
Meeting Date	18.9.25	
Committee Chair	Claudia Paoloni, Non-Executive Director	
Link to Strategic Objective	Pillar 1 : Outstanding Care	
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality	
Improving Together Pillar Metrics	Reducing Harms	Patient Experience
Improving Together Breakthrough Objective	Falls Harm Prevention	

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Falls (IPR breakthrough objective)	**Partial**	
2. IP&C (IPR breakthrough objective)	**Good**	
3. Complaint Response Rate (breakthrough objective)	**Partial**	
4. IPR Deep Dive: Complaints	**Partial**	
5. IPR Deep Dive: Medicines Safety	**Good**	
6. IPR Maternity	**Good**	
7. Saving Babies Lives Q1 compliance position	**Good**	
8. Patient experience 6 monthly report	**Good**	
9. Sepsis Oversight report	**Limited**	
10. End of Life report	**Good**	
11. Safeguarding Children, Maternity and Adults	**Good**	
12. CQC Inpatient Survey 2024	**Note**	
13. Safe Staffing monthly report	**Note**	
14. Electronic Discharge Summary update	**Note**	

POINTS OF ESCALATION	
KEY AREAS TO NOTE	**IPR: Reduction Total Harms:** • There has been a reduction in total harms from 121 to 114 which continues the current trend in reduction of total harms over last 12 months.
	IPR: Infection Control: • *C diff* cases had reduced slightly into 4 from 5 In July. but GWH still remains above its threshold. • Pseudomonas rates have had an increase and there has been an increase in *E. Coli* rates. Klebsiella rates have seen a notable increase and whilst *Methicillin Sensitive Staphylococcus Aureus* (MSSA) rates have reduced there has been on case on *Methicillin Resistant Staphylococcus Aureus* (MRSA). Cannula care and central line care remains the area of focus for improvement.
	IPR: Breakthrough Objective: Falls • 74 falls in month, with no recorded falls with moderate or higher harm. Overall falls rate is not showing a vast change from trajectory of the previous year. The notable change is in the rate of falls resulting in moderate Harm or Above which is well below trajectory. • A lot of work has been on going in Division of Medicine, where they receive all multiple fallers. • Actions have focused on balance and strength support and environmental factors. • There has been an increase in the number of hospital acquired pressure ulcers, which have been identified to a specific area, where refresher training is now being undertaken. A deep dive into PU is planned for next month.

	Complaints and Concerns Response Rate • The complaint response rate has notably improved from 53% (May) but remains static. A recent KPMG audit has identified improvement opportunities with workstreams around policy tightening, process refinement and cultural development. • Reflecting the on-going work on improvement initiatives, systems are being addressed to identify proactive communication routes and automation for patients around waiting list times and appointments etc, where possible, as a common theme of complaint is around lack of communication from hospital to patients and the fear that patients have been forgotten off lists or lost in the system. • While acknowledging that staff behaviour often features in both praise and concerns, the committee expressed particular interest in the references to clinical care and treatment outcomes, noting that these elements warrant closer scrutiny. The committee requested further detail on the themes and outcomes associated with these complaints with a more comprehensive breakdown. It was agreed that this would be brought back to the committee at a future meeting.
	DEEP DIVE: Medication safety Report • In Q1 84% antimicrobial prescriptions had a review at 24-72 hours, 100% had indication and 98% were according to the guidelines. • Some problems around completion of 'Blueteq' finance forms, critical for ensuring appropriate drug reimbursement costs to the Trust. • Controlled drug audits were all completed in Q1, 24 areas achieved 100% compliance. Documentation errors and poor practice around controlled drug counting have been identified. • Recent audits on medicines storage have initial findings of poorer practice and action plans, to address this, are being prepared. • CQC did not highlight any deficiencies in storage, handling or optimisation of medicines but did note the lack of pharmacy team presence in ED. • Issues that have been highlighted for additional action are around oxygen prescribing and controlled drug documentation. • GWH benchmarks well against other Trusts for all metrics.
	Maternity Integrated Performance Report • Sustained performance in staffing metrics, reflecting the effectiveness of the escalation policy in ensuring safe care,1:1 care had been maintained and no complaints raised related to staffing numbers. • No cases of intrauterine death at more than 24 weeks of pregnancy. • Several cases of OASI, all with no ongoing harm, this is already an area of focus action. • Fetal Surveillance monitoring training compliance has shown a slight dip due to the usual August rotational pressures. • Safeguarding level 3 training has shown some improvement but remains an area of focus. • Significant progress against the CQC action plan, following the September 2023 inspection. • An emerging theme has been identified in maternity which is around missed hip scans for babies due to inconsistency in identifying risk factors at Newborn and Infant Physical Examination (NIPE) after birth by NIPE practitioners, this has resulted in a focus on training and safety processes. All missed scans identified have now been done and all appropriate actions taken, with no harms as a consequence. • The committee received a summary about the introduction of the Perinatal Quality Oversight model.
	Saving babies Lives Q1 • Continued compliance with saving babies lives bundle but this has reduced from 94% to 91% (which is still above target). This reduction has been attributed to two changes in the new version launched earlier this year on fetal growth and gestational diabetes. • Amendments have been made to actions to address these changes. • Where USS capacity was an issue previously, this is no longer an issue.
	Patient Experience Report - 6 monthly • Large volumes of cases managed across Q4 and Q1. • Focusing on internal processes, improving correct capacity planning and identifying sustainable ways of working to improve response times. • PALS continue to support divisional colleagues.

	• The most reported theme is around waiting times and the next most common is around the lack and poor communication. • Large number improvement projects underway across the Trust. • Committee received a summary of the many patient and public engagement initiatives and future development areas.
	Sepsis 6 Oversight Report • This report covered an audit period June 2024 to August 2024, since then improvement actions have been undertaken with good effect. • The report highlighted, during the audit period, a poor compliance rate in completion of sepsis 6 paperwork within the first hour of only 25% and the six components not fully being completed throughout the Trust. • The sepsis management within the golden hour in some components is around 70% but taking blood cultures and measuring urine output are well below standard and requires further action. • Re-education of staff is a key component of the NICE guidelines on sepsis management. • The committee was assured improvement measures now well underway and compliance improved but not yet formally audited. • The committee awaits the next report.
	End Of Life Report • There have been key improvements in the recognition of the dying but key areas for development sit around the lack of 7 day a week face to face palliative care service (doctor or nurse) whilst through mitigated the use of hospice advice this is not the recommended standard. • The other key area for improvement is around the lack of ethnicity data collected to ensure palliative care is equitable, culturally appropriate and legally compliant. To mitigate against this, we have access to interpreters and include EDI champions on the wards and an EDI strategic plan in the Trust.
	Safeguarding Children, maternity & Adults report • Safeguarding activity has continued to be high across paediatrics and maternity. • Marginal (3%) increase in referrals made by GWH for paediatric safeguarding. • A significant proportion of these relate to mental health. • During 2024/25 marked highest recorded safeguarding compliance to date across paediatric services. • Referrals into maternity to Children's social care have decreased by 38% largely due to families already being engaged with services. • Teenage pregnancies have increased by 12% in Swindon and 7.5% regionally, causes unknown. • Children and maternity safeguarding team continue to significantly contribute to multi agency work. • Sustained focus on safeguarding children level 3 and specialist programmes. • In adults, the Trust raised 17.5% less safeguarding concerns than the previous year and the reason for this reduction maybe that local authorities have changed their portals for raising concerns. The Trust is looking at how this impacts our input and population. • Self neglect remains a system and service concern. • The committee was assured by the vast arrange of activities, commitment with multi agencies and internally with the specialist training delivery and completion undertaken over the year.
BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	

REFERRALS TO OTHER BOARD COMMITTEES	

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

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

Board Committee Assurance Report

Committee	**Quality & Safety Committee**	
Meeting Date	23 October 2025	
Committee Chair	Claudia Paoloni, Non-Executive Director	
Link to Strategic Objective	Pillar 1: Outstanding Patient Care	
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality	
Improving Together Pillar Metrics	Reducing Harms	Patient Experience
Improving Together Breakthrough Objective	Falls Harm Prevention	

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Falls (IPR breakthrough objective) – Falls	Partial	
2. IP&C (IPR breakthrough objective)	Good	
3. Complaint Response Rate (breakthrough objective)	Partial	
4. IPR Deep Dive – Pressure Ulcers	Good	
5. IPR Maternity	Good	
6. Quarterly Maternity Safety Report	Good	
7. Perinatal mortality review tool (PMRT) Q2	Substantial	
8. Ockenden report	Good	
9. Board Assurance Framework Q2	Good	
10. 15+ Risk report	Good	
11. In-Patient Survey 2024 – full CQC results	Good	
12. Deteriorating Patients Report	Partial	
13. Stroke Performance Report	Limited	
14. Safe Staffing Monthly Report	Note	
15. Electronic Discharge Summary update	Note	
16. Orthopaedic Mortality Alerts	Note	

POINTS OF ESCALATION	• **IPR: Reduction Total Harms:** have remained static, having reduced over the past 12 months due to reduced infection. Rates, pressure ulcer rates and the removal of Covid from the metrics. • **IPR: Infection Control:** C diff cases have shown a further reduction in August. Which is the fourth consecutive month reduction. e GWH still remains above its threshold. Pseudomonas and E coli rates have shown a reduction in August. Klebsiella rates have seen a notable increase and whilst Methicillin sensitive staphylococcus aureus (MSSA)rates have reduced to one and there has been no case of methicillin resistant staphylococcus aureus. (MRSA). Cannula care and central line care continue to remain the area of focus for improvement • **IPR: Breakthrough Objective: Falls** • This month, there has been an uptick in falls of which suffered moderate harm. • There have also been more incidents of multiple fallers. • Whilst overall falls rate is not showing a vast change from trajectory of the previous year, there has been a notable change in the rate of falls resulting in moderate Harm or Above which is well below trajectory. • Actions have focused on balance and strength support and environmental factors and additional training on the wards for nurses and registered health care support workers. • There has been no change in the number of hospital acquired pressure ulcers.

- **Complaints and Concerns Response Rate**. The complaint response rate has notably improved from 53% (May) to 69% but remains overall static.
- A Trust wide response rate improvement group is being relaunched which will have a broader stakeholder representation to further drive improvement.
- Training on complaint handling continues and a gap analysis planned.
- It is noted that overall concern and complaint rate has been increasing, themes have not changed and relate to wait times and poor communication.

DEEP DIVE: Pressure Ulcers

- The rates for pressure harm for 2024-2025 are significantly reduced compared to 2023-2024 resulting in a 63% reduction in overall harm
- Almost all areas have shown improvement and data collected enables identification of the more challenged areas for additional support measures to be implemented.
- There has also been a reduction in severity of harms and categories acquired.
- The systems and processes introduced are clearly embedded across the Trust.
- The Pressure Ulcer panel has been established 21 months, where all divisions meet weekly to discuss hospital acquired pressure harms.
- Learning points and positive action plans identified and agreed
- Celebration events were held on Dove Ward and ACU where there has been notable improvement with 12 months without any Deep tissue injury or category 2/3/4 pressure harm.

Maternity Integrated Performance Report

- Sustained performance in staffing metrics, reflecting the effectiveness of the escalation policy in ensuring safe care,1:1 care had been maintained
- 12 newly qualified midwives started I September and October, reducing the vacancy rate. Further to come in November and more planned for Jan/Feb 2026
- No cases of stillbirth, non registrable births or neonatal deaths this month§
- Several cases of OASI, all with no ongoing harm, this is already an area of focus action.
- Fetal Surveillance monitoring training compliance has shown a slight dip in medical staff due to August rotational pressures.
- Safeguarding level 3 training has shown some improvement but remains an area of focus. And has now become a conduct matter if persistent non compliance.
- The antenatal screening service has declared partial non submission of Quarter 1 key performance indicators to NHSE, impacted by data capture challenges. The committee received the immediate actions and mitigations taking place.
- The committee received an overview of the Prevention of Future Deaths: Regulation 28, issued to GSW in September 2025.
- The committee received assurance around a position of compliance against all ten safety actions of CNST 6 and are awaiting rebate funding being issued.
- CNST 7 was released in April 2025
- Staff have raised concern around the utilisation of Badgernet, and lack of confidence in its utilisation /using to full advantage, the team successfully secured £20,000 staff retention funding from ICB for training utilisation and provision of a super user for support.
- Implementation of a new digital monitoring tool for consultant ward rooms provides additional evidence of teams working together and presence.
- **Perinatal Mortality Recording Tool Q2**- we are 100% compliant
- **Maternity Safety Report Q2** -All patient safety incidents are being managed appropriately , learnings identified and robust action plans in place, with the use of a dynamic action tracker.
- one theme for improvement was around adequate informed consent and patient information leaflets, which was also found in the coroners regulation 28 report. A review and updating of patient information leaflets is underway.
- 2 new legal cases have been received for the perinatal service relating to allegations of injury and negligence in care
- Post Partum Haemorrhage (PPH) rates at GWH continue as a slight outlier despite mitigation measures which have shown an improvement

	• NICE Guidance promotes the use of Carbetocin in all caesarean sections to reduce PPH which has not been common practice at GWH and will be introduced for standard practice once through November MAG approval. • Achieving required rates of training standards noted in CQC visit has been challenging but slow improvement is being noted. • In Avoiding Term Admission into neonatal unit (ATAIN) metrics have seen an improvement. But one area of note is non compliance around timely CTG review and appropriate peer review, this is being currently addressed through additional learning. • **Ockendon Report** The trust has 17 Amber actions across the Immediate and essential actions. 15 of these are local and have action plans in place, whilst 2 fall outside of our control. • Following the Inquest in August 2025 it was noted that GWH may not be making changes within a reasonable time frame. A comprehensive reassessment has been subsequently done. • **Board Assurance Framework Q2-Outstanding Patient care-**the risk score remains at 16 • 2 new assurance reports: Sepsis deep dives and 30 day readmissions were included • The risk remains outside tolerance • **15+Risk Report-**Quality and safety committee have 3 Trustwide risks accountable to it • All risks are within target Trustwide • The Risk Group reviewed the 15+ risk map and noted concerns over overdue target dates as well as enhanced risk mitigation action from specialists groups. • New standard operating procedures to support with risk management processes was approved. • No new 15+ risks for QSC and none closed • **Patient Survey 2024_CQC Report-**this survey related to patients discharged in November 2024 • There was a reduction in survey response rate noted to only 37% , making action plan decision making more difficult on the back of limited feedback. • White ethnicity over 66 years were the majority contributers • 79% declared physical or mental disabilities or conditions likely tto last over 12 months. • The majority of the questions performed the same (43) as the previous year, three deteriorated and none improved when compared to other Trusts • Within GWH only one question showed significant improvement and one significant deterioration. • Areas where we fall within the bottom quartile against all Trusts benchmarking include: • *Admission to hospital*-around information, contact and waiting times • *delivery basic needs*-around hydration and eating support • *virtual wards*- around information and understanding • *leaving hospital* • An action plan is on place to address highlighted areas and next survey is due November 2025 • **Deteriorating Patient Report-**95% of patients should have an aggregates NEWS 2 score recorded within admission to an inpatient ward. • GWH has improved for achieving this from 53% (April 2025) to 72.4% (July 2025) but the target is 95% • Our response time for escalation of scores of 5 also is below the required 60 mins for all deteriorating cases, at 86%; however, the overall average response time for July was 25 mins (255 patients) suggesting there are extreme ranges. Staffing limitations and occurrence of multiple emergencies at the same time has been reported as impacting this. • Acute care response team are actively delivering support and education to the wards a round NEWS2 scoring.

	• Martha's Rule:A call for concern, where patients, relatives or staff can ask for a review at any time of a patients condition pilot commenced in March and has resulted in 75 referrals (aprox 1 per week) • **Stroke Performance report-**the committee gained limited assurance around The GWH performance related to stroke management. • Declining from a level D to level E on SSNAP performance • Impactors are tighter time frames for time critical interventions and therapies, a reduction in ttherapy provision at the weekends due to financial controls, overall reduction in therapy sessions capacity and their timeliness. An analysis has shown a 77 hr therapy provision gap per week. • Consultant recruitment difficulties and stroke unit access are also contributers. • Some key achievements were also noted around full recruitment into the nursing team, partial consultant recruitment and some strengthened assessments and colloborative working arrangements. • The committee had limited assurance around the delivery of safe care under the current service delivery, with risk to best recovery resulting in increased risk to potential limiting quality of life disability and independent living . • It was noted our mortality rates around Stroke care are in line with national averages. • The Executive committee have asked the performance metrics to become part of the IPR to monitor progress around mitigations and actions. • **Coroner Regulation28 -Report-**the committee received the coroner regulation 28 report on the death of a newborn baby after induction of labour.The incident relates to 2023 but the final coroner findings were presented in September 2025. The Coroners Inquest concluded that failings in care had more than minimally contributed to the baby's death.The initial investigation and MNSI report had been received in April 2024, resulting in a robust action plan being immediately implemented. No additional findings were highlighted by the coroner.The committee received details of the shortcomings and assurance around the actions taken following the MNSI and coroners report.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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

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

Board Committee Assurance Report

Committee	**Quality & Safety Committee**	
Meeting Date	17.11.25	
Committee Chair	Claudia Paoloni, Non-Executive Director	
Link to Strategic Objective	Pillar 1 : Outstanding Care	
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality	
Improving Together Pillar Metrics	Reducing Harms	Patient Experience
Improving Together Breakthrough Objective	Falls Harm Prevention	

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Falls (IPR breakthrough objective). Falls	**partial**	
2. IP&C (IPR breakthrough objective)	**Good**	
3. Complaint Response Rate (Breakthrough Objective)	**partial**	
4. IPR Maternity	**Good**	
5. Safer Staffing 6 monthly report	**Good**	
6. Annual Clinical Audit Report 2024/25	**Good**	
7. Nice Guidelines (assessment & Implementation Report) Q2	**Partial**	
8. CQC prepared ness and progress	**Good**	
9. Integrated Front Door Quality Report	**Partial**	
10. Quality Accounts progress Report	**Good**	

POINTS OF ESCALATION	• **IPR: Reduction Total Harms:** have shown an increase in October of just over 10% (120 from 108 in September) for a variety of causes reflecting the acuity and pressures within the Trust. Some harms resulted in moderate harm. All being reviewed and learnings and actions updated. • **IPR: Infection Control:** • Of particular note are a significant increase in E.Coli infections, half of which were related to urinary sources. Catheter care and hydration has been identified in relation to urinary tract infections An external audit report is awaited around catheter care • C.difficile cases have also risen but remain below the South West Average. • No cases of Methicillin resistant staph aureus (MSRA) or Methicillon sensitive staph aureus (MSSA) • **IPR: Breakthrough Objective: Falls** • This month, there has been a slight uptick in falls, of which 4 suffered moderate harm. However, falls involving repeat fallers remain below trajectory • Actions have focused on balance and strength support, cognitive and motor impairment, medication related factors, environmental factors such as ward moves at night, and additional training on the wards for nurses and registered health care support workers. • There has been no change in the number of hospital acquired pressure ulcers, which remain stable
	• **Complaints and Concerns Response Rate**. The complaint response rate has slightly improved to 72% on a background of increasing concerns which has been an upward trajectory trend observed in recent months. • It is noted that overall concern and complaint themes have not changed and relate to wait times and poor communication.

	Maternity Integrated Performance Report • Sustained performance in staffing metrics, reflecting the effectiveness of the escalation policy in ensuring safe care,1:1 care had been maintained in all but one case • 6 notifiable deaths in October, mostly related to late medical termination and late presentation by mothers for assistance. These did not alert on the new MOSS system and feedback centrally has been sent. • Fetal Surveillance monitoring training compliance has shown a slight dip in medical staff due to August rotational pressures. • Safeguarding level 3 training has shown some improvement but remains an area of focus. And has now become a conduct matter if persistent non compliance. • The antenatal screening service has declared partial non submission of Quarter 1 key performance indicators to NHSE, impacted by data capture challenges. The committee received the immediate actions and mitigations taking place. • The committee received assurance around a position of compliance against all ten safety actions of CNST 6 and are awaiting rebate funding being issued. • CNST 7 was released in April 2025 • Implementation of a new digital monitoring tool for consultant ward rooms provides additional evidence of teams working together and presence. • Audit into Consultant Attendance for events require a Consultant show excellent response with only one event unmet, but resulting in no safety risk. • The committee also received a report on all the claims against maternity services between 2015-2025, which were considered in relation to volume, value and cause. This data successfully triangulated against complaints and safety incidents showing its value as an additional monitoring tool to give aholistic overview of the quality and safety within the perinatal services at GWH.
	• **Clinical Audit and Effectiveness Report Q2** • Q2 sees further audit progress with now only 8 items overdue • There is increased governance around review and sign off by Divisions with action plans in p[ace • 11/39 reports identified limited asurancee with gaps in resources and staffing(stroke services, Falls pathway and Acute Medicine) • 4 reports identified high risks (stroke and heart failure services) • There has been the introduction of links to mortality outcomes to help identify areas of higher mortality than to be expected so that these can be analysed in depth. 8 reports identified links to mortality outcomes. • The committee was assured that the `trust. Demonstrates strong engagement with national audit programmes, however this is a large workload and areas for targeted improvement in data quality have been identified. (240 national audits) 607 audit/improvement projects registered for the year 24/25. The committee posed the question of the impact on resource and whether a consideration into prioritising essential from non essential audits. This will be considered by the team.
	• **Safe Staffing 6 month review for Nursing, Midwifery and AHP** • The committee received assurance that through good oversight of the workforce demands and capacity of service provision. • Some caution was noted around the true reflection of the data presented to the situation on the wards, for example, the September data on the full time equivalent nursing and midwifery workforce places the Trust in quartile 2 suggesting a relatively stable and sustainable staffing position, however local triangulation with quality indicators and professional judgement remains essential to ensure the establishment meets the acuity and dependency needs. • The report highlights that all the wards are funded to be compliant with nurse ratio 1:8 , however over one third of shifts were not fully staffed with the required number of registered nurses and/or healthcare support workers due to short term absence meaning that wards were working to 1:10 ratio. • The Allied Health professional workforce remains in a strong position • Midwifery staffing is challenged , in line with national data, but the Trust's midwifery staffing has continued to improve over the last 6 months by identifying different staffing models ands recruitment

	• The committee were assured there were good oversight of staffing and governance but cautious assurance around the establishment needs being met resulting in suboptimal nursing ratios at times of short term absence. • Establishment reviews are in progress to ensure staffing levels align with patient acuity and service demand
	• **NICE Guidelines. (Assessment & Implementation) Q2** • The committee received a report on the Trust compliance across 1149 Nice guidelines, which was reported as 97% compliant. • The committee felt there was only partial assurance around the consistency and methods used to declare compliance due to the complexity of fully meeting a guideline. In some guidelines only part of the guideline could be within GWH control. • The Team have agree dto consider a reclassification of compliance and an ability to identify those where only part compliance is possible, and to ensure a standardised approach for measuring compliance.
	• **CQC Preparedness and Progress Report** • The Trust continues to demonstrate a strong commitment to CQC compliance through proactive quality improvement initiatives, action planning, and strategic alignment with regulatory expectations. • Despite recent inspections highlighting areas for improvement there has been cl;ear learning and system wide engagement. • Changes within the national setting of CQC leadership will likely result in more change within the CQC domain, which the Trust will need to engage with which may impact in increased workload.
	• **Integrated Front Door Quality report-** • The committee received a comprehensive report on the overview of patient safety,quality and patient experience across the integrated front door, encompassing the Emergency Dept, Urgent Treatment Centre, and Medical Assessment unit, where quality indicators are reviewed in the context of ongoing operational pressures, ambulance off loading delays, overcrowding and in patient flow challenges. • The improvement plan following the recent CQC visit was also reviewed. • Key issues lie around the use of temporary escalation Spaces and Seated areas in Ambulatory measures. Prolonged periods within these areas impact patients in multiple ways from increased risk of harm and poor patient experience • There have been multiple external visits into these areas including by NHSE, GIRFT and CQC. • There has been strengthening in senior staffing governance and oversight of all areas but increasing demand, poor outward flow, and use of areas not fit for purpose (Medical assessment Unit being housed in old building with insufficient facilities for use limit the effectiveness of the mitigations put in place.
	• **Quality Account Priorities Report-** • Significant progress in all 3 priority areas: patient Safety, Patient Experience and Clinical Effectiveness. • **Priority 1: Patient Safety- Sepsis 6 bundle** • There has been a lot of work to improve compliance, with good focus around the speed to adminstation of antibiotics, these have resulted in some improvement although there is still challenge in this area around taking blood cultures and monitoring urine output. This is repeating the audit cycle to ensure more learnings can be found and actions put in place. • **Priority 2: Patient Experience-Putting the Hospital to bed** • This has been a focus of the senior team , including senior staff walk rounds at night • Eye mask and ear plug initiatives have improved conditions and estate works around 'noisy estate'. However night moves remain a significant problem. 30-40% of bed moves happen at night. • **Priority 3: Clinical effectiveness-supporting self administration of Medication** • There has been very positive work in this area with the introduction of a successful standard operating procedure, and new infrasctructure such as introduction patient calibrated lockers to hold. Own medicines with personalised wristbands which activate opening.

KEY AREAS TO NOTE	
BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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

The
only

SUBSTANTIAL GOOD PARTIAL	• **CQC Preparedness and Progress Report** • The Trust continues to demonstrate a strong commitment to CQC compliance through proactive quality improvement initiatives, action planning, and strategic alignment with regulatory expectations. • Despite recent inspections highlighting areas for improvement there has been cl;ear learning and system wide engagement. Changes within the national setting of CQC leadership will likely result in more change within the CQC domain, which the Trust will need to engage with which may impact in increased workload.
	• **Integrated Front Door Quality report-** • The committee received a comprehensive report on the overview of patient safety,quality and patient experience across the integrated front door, encompassing the Emergency Dept, Urgent Treatment Centre, and Medical Assessment unit, where quality indicators are reviewed in the context of ongoing operational pressures, ambulance off loading delays, overcrowding and in patient flow challenges. • The improvement plan following the recent CQC visit was also reviewed. • Key issues lie around the use of temporary escalation Spaces and Seated areas in Ambulatory measures. Prolonged periods within these areas impact patients in multiple ways from increased risk of harm and poor patient experience • There have been multiple external visits into these areas including by NHSE, GIRFT and CQC. There has been strengthening in senior staffing governance and oversight of all areas but increasing demand, poor outward flow, and use of areas not fit for purpose (Medical assessment Unit being housed in old building with insufficient facilities for use limit the effectiveness of the mitigations put in place.
	• **Quality Account Priorities Report-** • Significant progress in all 3 priority areas: patient Safety, Patient Experience and Clinical Effectiveness. • **Priority 1: Patient Safety- Sepsis 6 bundle** • There has been a lot of work to improve compliance, with good focus around the speed to adminstation of antibiotics, these have resulted in some improvement although there is still challenge in this area around taking blood cultures and monitoring urine output. This is repeating the audit cycle to ensure more learnings can be found and actions put in place. • **Priority 2: Patient Experience-Putting the Hospital to bed** • This has been a focus of the senior team , including senior staff walk rounds at night

	• Eye mask and ear plug initiatives have improved conditions and estate works around 'noisy estate'. However night moves remain a significant problem. 30-40% of bed moves happen at night. • **Priority 3: Clinical effectiveness-supporting self administration of Medication** • There has been very positive work in this area with the introduction of a successful standard operating procedure, and new infrasctructure such as introduction patient calibrated lockers to hold. Own medicines with personalised wristbands which activate opening.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Board Committee Assurance Report

Committee	**People & Culture Committee**	
Meeting Date	**30th October 2025**	
Committee Chair	Julian Duxfield, Non-Executive Director	
Link to Strategic Objective	Pillar 2: Valued Teams	
Link to Board Assurance Framework	BAF: SR 2 (Culture), SR 3 (Workforce Planning)	
Improving Together Pillar Metrics	Sickness rates	Staff survey – recommend place to work
	Staff survey – addressing discrimination disparity	
Improving Together Breakthrough Objective	Staff Survey – respect from colleagues	

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Q2 Workforce Report - Corporate Services	Partial	√
2. Q2 Workforce Report – Surgery & Planned Care.	Good	√
3. Q2 Workforce Report – Family & Specialist Services	Good	√
4. Q2 Workforce Report – Medicine	Limited	√
5. GWH Draft People Plan 2025	N/A	x
6. Probationary Policy – Deep Dive	N/A	x
7. Temporary Staffing Project	N/A	x
8. Our Behaviours Update	N/A	x
9. Academy – Mandatory Training Review Report	N/A	x
10. Career Development	N/A	x
11. Annual undergraduate medical education report	Substantial	x
12. Annual postgraduate medical education report	Good	x
13. Integrated Performance Report	N/A	x
14. Risk Register Report	N/A	x
15. Board Assurance Framework	Substantial	x
16. Succession Planning	N/A	x

POINTS OF ESCALATION	During the discussions with divisions to assure progress against workforce recovery targets the Committee recognised the need for the Board to address the issue of the tension between the requirement to meet our workforce recovery targets and the possible quality and safety impacts of these reductions. During the meeting, Medicine Division made it clear that they were unable to deliver the workforce plan due to several factors, including issues with quality and activity. The Chief Nursing Officer (CNO) raised concerns that any further reductions in Medicine would have a significant impact on quality and increase the level of risk currently being managed. The other Division felt more confident in delivery the plan.

KEY AREAS TO NOTE	The initial portion of the meeting was spent in dialogue with each division to assure progress against workforce recovery targets. Each division has some significant risk but it is the Medicine division which is in the most vulnerable position, both with respect to possible risk during the rest of the year and the limited assurance provided by the governance and risk management arrangements being deployed. The Committee approved the proposed People Strategic Plan 2025–2028 which outlines our ambition to create and sustain a thriving, inclusive, and high-performing workforce. It focuses on three key strategic priorities — Great Culture, Great Innovation, and Great Collaboration — which together form the foundation for sustainable improvement in staff experience, engagement, and performance. However, we recognise that, over time, this will be replaced by a Group Strategic People Plan. The Committee noted the work done to investigate the employee relations case review data from June 2025 which highlighted equality concerns with the implementation of Probationary Policy dismissal and the proposed actions to address this issue. The Committee noted the proposal, under review by the Joint Committee, which included an option to an outsourced temporary staffing model subject to consultation and successful procurement tender to give the Group the best opportunity to move from three separate temporary staffing operating models to a single service. Good progress was noted on phase 2 of the work to implement 'Our Behaviours', the Trust's updated framework building on STAR values. A review of the Trust's mandatory training requirements was received. Out of a total of 44 modules this revises nine and removes three modules, leading to a modest but welcome reduction in hours required for training. Although in total this equates to approximately 6 full-time equivalent (FTE) posts per year. The Committee received a report on career development. In comparison to group partners GWH has led in several areas, particularly in T-Levels and leadership development. However, opportunities remain to align approaches and maximise system-wide learning. Our current priorities are: increasing apprenticeship enrolments by 50%; redesigning the Work Experience application process; expanding T-Level placements by 30% and enhancing in-role development resources. Substantial assurance was provided to the Committee on the work done by the Swindon Undergraduate Medical Academy which during the year took 848 undergraduate medical students from the Universities of Oxford (OU) and Bristol (UoB) as well as Kings College Hospital, London (KCL). There is excellent feedback from Students and Universities alike. Good assurance was provided on the Trust's work with postgraduate medical education, although these are significant challenges with high workload in many medical specialties which results in pressurised rotas and some reduced supervision opportunities. Although there are several departments where the

	training is below the standard required it is clear what improvements are required. We have made significant progress in the last year with some areas and there has been a sustained improvement in the feedback we receive from resident doctors in our surgical specialties. The NEDs discussed the succession management report which had been prepared by CPO and the executive team earlier this year. It was agreed that although this work is now quite outdated as a result of the move to a Group structure it was a useful start. It is clear that we need to resolve the future governance process for future succession planning and that in the medium term we should use a pragmatic but evidenced approach to assessments rather than become too fixated on a particular model for succession assessments.
BOARD ASSURANCE FRAMEWORK & RISKS	The October 2025 Risk Report for the People & Culture Committee remains unchanged from the previous report and the BAF was assured at 'significant'.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

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

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

Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**	
Meeting Date	22 September 2025	
Committee Chair	Faried Chopdat, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Financial & Recovery Workstreams Update	Limited	x
2. Month 5 Finance Position	Good	x
3. Improvement & Efficiency Program	Partial	x
4. MARS Update	Note	x
5. Divisional Financial Plans – Progress update	Partial	x
6. Estates & Facilities Risk Report	Good	x
7. PFI Quarterly Report	Good	x
8. 2024/2025 PAM Submission	Good	x
9. Procurement Annual Review & Lessons Learnt	Good	x
10. BAF Strategic Risks – review of emerging risks	Note	x

POINTS OF ESCALATION	**BSW Financial Update:** The financial position of both the Trust and the wider BSW system is significantly challenged in the 2024/25 financial year. Currently, there needs to be greater confidence in the deliverability of efficiency and workforce plans across all BSW organisations before the assurance rating can be improved. Furthermore, the Committee's assurance rating of 'Limited' is based on the scale of the risk, lack of independent challenge at the Group level and immature, albeit evolving, governance processes.
POINTS TO NOTE	**Month 5 Financial Position:** For M05 2025/26, the Trust has an adjusted deficit of £9.0m, representing a £9.0m adverse variance to plan. Income is £1.9m behind plan, the key driver being the loss of deficit funding (£4.0m). Undelivered cash-releasing income efficiencies are £0.3m. Activity reduced by 12% in M05, leading to a £ 0.6 m decrease in ERF income, which is adverse to plan. Note that activity is £2.2m behind the scenario 2a plan and remains broadly in line with the affordability cap. There are favourable positions on high-cost drugs (£0.9m), depreciation income (£0.2m) and vaccination income (£0.2m), which are offset by costs, plus an overperformance on other variable income (RTA, overseas, community de-mobilisation, etc.) of £0.6m. Other income is £1.1m ahead of plan, with an underperformance against private patients offset by gains on education funding. It should be noted that if the Trust were receiving deficit funding, the overall variance to plan would reduce to £5.0m, reflecting the tangible YTD gap the Trust needs to bridge. Whilst the Committee has rated this report as 'Good' assurance due to frequent and regular meetings, specifically Workforce and Financial Recovery Committees, along with relevant workstreams, to monitor spend and associated savings, we are concerned about the increasing risk to achieve breakeven at year's end.
	Improvement and Efficiency Plan: The Trust began 2025/26 with a £27.0m cash-releasing efficiency target, which includes a £2.8m carry forward of undelivered/non-recurrently delivered efficiency from 2024/25. As at Month 5, the programme has delivered £6.62m (excluding £2.43m run rate savings) year to date, which is £6.77m under plan and represents 49% achievement against the £13.39m YTD target. M05 saw significantly improved delivery (£2.36m) compared to M4 (£1.34m), comprising a broad mix of workforce-driven, procurement, and non-pay opportunities. While a substantial delivery gap remains, the inclusion of new schemes, improved BRAG ratings, and continued strong performance in Corporate and Medicine divisions provide a more stable platform. However, significant delivery risk remains with year-to-date delivery at 50%. Therefore, the assurance level is Partial, with a continued focus on delivering against the stretch forecast through Q2.
	Divisional Financial Plans: Whilst there are sound systems in place (corporately and divisionally) that provide a range of financial controls, these balance with the need to always provide safe and effective services. Governance includes Divisional Boards, Workforce recovery (WTE plans), Elective Delivery (Elective care sub-committee), Urgent Care Delivery (Urgent care and flow Subcommittee) and Financial Recovery Sub Committee (FRSC). Divisions have provided summaries to illustrate the current position, risks, mitigations, and plans to address them for this reporting period. The level of financial savings that Divisions have been tasked with finding this year has been particularly challenging, and as a result, the Committee agreed to a partial assurance rating, as the plans presented have yet to be delivered.
	Estate & Facilities Risk Report: The Committee noted that the risk management process and reporting are adequate and effective and is assured that risks are identified, appropriately rated, and mitigation actions are in place. All risks rated 15+ were presented with appropriate mitigation actions.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	N/A
REFERRALS TO OTHER BOARD COMMITTEES	N/A

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**	
Meeting Date	27 October 2025	
Committee Chair	Faried Chopdat, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Financial & Recovery Workstreams Update	Limited	x
2. Month 6 Finance Position	Partial	x
3. Improvement & Efficiency Program	Partial	x
4. Staff & Student Accommodation Recommendation Report to Board	Good/Approve	x
5. GWH Main Entrance Retail Development – Delivery Options Appraisal	Good/Approve	x
6. Private Healthcare - Feasibility Report	Good/Approve	x
7. Digital Risk Register	Good	x
8. Data Protection, IT Resilience & Cyber Security	Good	x
9. Digital Strategic Plan – Quarterly Update	Good	x
10. Procurement Recommendation Reports • CPR for endoscopy scopes and electrosurgical maintenance • Addendum to CRR for the provision of Cardiac Catheter Lab equipment	Approve	✓
11. BAF Strategic Risks – review of emerging risks	Note	x

POINTS OF ESCALATION	**BSW Financial Update:** The BSW financial position remains adverse to the plan at Month 6. The risk to breakeven after mitigations is £14.3m, split as follows: GWH £4m; SFT £4m; and RUH £6.3m. The individual positions illustrate deteriorating positions at all Provider Trusts, which are partially offset by the ICB improving its favourable position compared to the plan. For all providers, issues persist in delivering efficiency and improvement programs, resulting in run rates that exceed required levels. Mitigating plans are in place to address this to some degree. The financial position of both the Trust and the wider BSW system is significantly challenged in the 2024/25 financial year. Currently, there needs to be greater confidence in the deliverability of efficiency and workforce plans across all BSW organisations before the assurance rating can be improved. Furthermore, the Committee's assurance rating of 'Limited' is based on the significant and escalating risk of the group breaking even.
POINTS TO NOTE	**Month 6 Financial Position:** For M06 2025/26, the Trust has an adjusted deficit position of £10.1m, representing a £10.1m adverse variance to the plan. The overspend is predominantly due to (1) undelivered CIP, (2) high temporary staffing spend, and (3) the removal of deficit funding, which would amount to £4.8m at the month's end. Income is £1.7m behind plan. There are £1.8m in favourable positions offset by costs on high-cost drugs, depreciation income, vaccination income, plus the overperformance of other variable income. The Committee is assured that grip and controls are in place, including regular meetings with the workforce and financial recovery committees to monitor spending and associated savings for the 2025/26 financial year. The Committee has rated the report as 'partial assurance' given the escalation of the risk of not breaking even at year-end.
	Improvement and Efficiency Plan: The efficiency target for 25/26 is £32.4m. As of Month 6, the efficiency programme continues to demonstrate steady progress in delivery, governance and risk management of schemes. While the year-to-date position remains behind plan, the teams have shown a strengthened delivery trajectory, with improved in-month performance, delivering £9.21m YTD of cash and releasing savings representing 58% of the £15.6m YTD target. Several financial controls have been implemented, including tightened expenditure controls, enhanced scrutiny of recruitment and agency use, stricter sign-off procedures for non-essential spending, and robust divisional accountability frameworks. Delivery progress is essential to regain access to deficit funding.
	Digital Risk Report: The Committee noted that the risk management process and reporting are adequate and effective, and is assured that risks are identified, appropriately rated, and mitigation actions are in place. All risks rated 15+ were presented with appropriate mitigation actions. Comprehensive management and documentation of digital risks have been established. The risk oversight review process is ongoing, with CTIO leadership dedicated to ensuring accountability and regular assessment of digital risks to uphold sound governance practices. This report has been harmonised with broader risk reports presented through Trust governance channels. Cyber risk descriptions are now standardised across the ICS. Consequently, assurance regarding these risks will remain at an acceptable level for the present.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	N/A
REFERRALS TO OTHER BOARD COMMITTEES	N/A

Key to lead committee assurance ratings

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

Board Committee Assurance Report

Committee	Finance, Infrastructure & Digital Committee	
Meeting Date	24 November 2025	
Committee Chair	Faried Chopdat, Non-Executive Director	
Link to Strategic Objective	Pillar 4: Use of Resource	
Link to Board Assurance Framework	BAF 4: SR7 (Finance), SR8 (Estates Infrastructure), SR9 (Digital) & SR10 (Cyber/IT System Failure)	
Improving Together Pillar Metrics	GWH Control Total / Improvement & Efficiency	Carbon Footprint / Sustainability
Improving Together Breakthrough Objective	Supporting Financial Recovery	

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Finance (incl. Way Forward Program) Risk Register	Good	x
2. BSW Financial & Recovery Workstreams Update	Limited	x
3. Month 7 Finance Position	Partial	x
4. Improvement & Efficiency Program	Partial	x
5. Debtors Report	Good	x
6. 2026/27 Planning	Partial	x
7. Deconstruction of Income Blocks	Note	x
8. Dorset & Wiltshire Fire & Rescue Service Audit	Partial	x
9. Health & Safety Quality Report	Good/Approve	x
10. Cyber Security Framework – Annual Update	Good	x
11. Update on Procurement	Good	x
12. Procurement Recommendation Reports • Swindon CDC (phase 2) MRI & CT Capital • Swindon CDC (phase 2) Modular Build Contract • Supply of Contrast Media	Approve	✓
13. Preferred options re future of the retained community services	Approve	x
14. BAF Strategic Risks – review of emerging risks	Note	x

POINTS OF ESCALATION	**BSW Financial Update:** The BSW financial position remains adverse to the plan at Month 7. The individual positions illustrate deteriorating positions at all Provider Trusts, which are partially offset by the ICB improving its favourable position compared to the plan. For all providers, issues persist in delivering efficiency and improvement programs, resulting in run rates that exceed required levels. Mitigating plans are in place to address this to some degree. The financial position of both the Trust and the wider BSW system is significantly challenged in the 2024/25 financial year. Currently, there needs to be greater confidence in the deliverability of efficiency and workforce plans across all BSW organisations before the assurance rating can be improved. Furthermore, the Committee's assurance rating of 'Limited' is based on the scale of the risk, lack of independent challenge at the Group level and immature, albeit evolving, governance processes. We have been assured that governance mechanisms at a Group level are under consideration, with a draft TOR being developed.
POINTS TO NOTE	**Month 7 Financial Position:** For M07 2025/26, the Trust has an adjusted deficit position of £10.6m, representing a £10.6m adverse variance to the plan. The overspend is predominantly due to (1) undelivered CIP, (2) high temporary staffing spend, and (3) the removal of deficit funding, which would amount to £5.6m at the month's end. Income is £0.5m behind plan. Commissioner income accounts for a £1.8m adverse position, driven by the removal of deficit funding (£5.6m). There are £1.8m in favourable positions, all offset by costs. The Committee is assured that grip and controls are in place, including regular meetings with the workforce and financial recovery committees to monitor spending and associated savings for the 2025/26 financial year. The Committee has rated the report as 'partial assurance' given the escalation of the risk of not breaking even at year-end.
	Improvement and Efficiency Plan: The efficiency target for 25/26 is £32.4m. As of Month 7, the efficiency programme continues to demonstrate steady progress in delivery and governance. While the year-to-date position remains behind plan, in-month performance has improved, delivering £2.45m against a plan of £2.67m, and overall programme oversight remains strong. Key to breaking even in 2025/26 is delivery against the efficiency savings target of £32.4m. At M07, total recurrent delivery is expected to be £13.1m against a plan to deliver 2/3rds of the target (£21.6m) recurrently. If we cannot improve this delivery, we are carrying an additional £ 8.5 m deficit into our underlying position. Several financial controls have been implemented, including tightened expenditure controls, enhanced scrutiny of recruitment and agency use, stricter sign-off procedures for non-essential spending, and robust divisional accountability frameworks. Delivery progress is essential to regain access to deficit funding.
	2025/26 Planning: The Committee was provided with an update on the 2025/26 Planning activities, for which internal planning processes build on the progress made last year. However, it is also noted that our in-year Trust position, that of BSW Hospitals Group, and that of the wider system are significantly challenged. Because of this, there is significant uncertainty about whether we will meet our system's financial recovery plan. This may impact not only our future deficit position but also potential additional oversight and scrutiny at the national/regional level. On this basis, the assurance level for this element is Partial.
	Dorset & Wiltshire Fire & Rescue Service Audit: During September 2025, Dorset & Wiltshire Fire & Rescue Service attended the site to undertake a routine audit of our fire safety arrangements. The audit identified that some people were at risk in the event of a fire, and improvements are required to enhance safety. A Task & Finish Group has now been set up to oversee the numerous activities identified in the audit. Due to the considerable amount of work required, the 3-month deadline set out in the DWFRS letter is unachievable, and all parties are currently working to secure additional resources to improve the timeline, which presently extends into 2027. Managing these fire safety concerns through a single channel (the Task & Finish Group) is proving effective; however, given some uncertainties around resource levels & timescales, and the potential for the current assessments & works to identify additional activities, only partial assurance can be provided at this time.
	Finance (incl Way Forward Program) Risk Report: The Committee noted that the risk management process and reporting are adequate and effective and is assured that risks are identified, appropriately rated, and mitigation actions are in place. All risks rated 15+ were presented with appropriate mitigation actions. The Committee notes that the Risk & Legal Facilitator continues to support each

	department by facilitating risk management processes and ensuring departments are managing risks in line with theTrust's Risk Policy. Key committees continue to have oversight of high-level risks.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	N/A
REFERRALS TO OTHER BOARD COMMITTEES	N/A

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
SUBSTANTIAL	**Substantial Assurance**: Governance and risk management arrangements provide substantial assurance that the risks/gaps in controls identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas.
GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
PARTIAL	**Partial Assurance**: Governance and risk management arrangements provide reasonable assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance.
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**11/12/2025**	Part 1 - Public	☐	Part 2 - Private	☐
Accountable Lead	Benny Goodman, Chief Operating Officer Luisa Goddard, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Rob Presland – Deputy Chief Operating Officer Ana Gardete – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer Johanna Bogle – Deputy Chief Financial Officer				
Appendices	Use of Resources: • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

Purpose

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

Assurance Level

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

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

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

Report

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

Our Performance

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

STRATEGIC Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

October's performance shows the total number of patients waiting over 52 weeks at 559, a reduction of 14 from the previous month and currently 98 less patients waiting compared to the year-to-date plan. The percentage of the RTT patient tracking list (PTL) over 52 weeks is currently at 1.3% with the Trust remaining on track to meet the 1% target for the end of March.

Overall RTT performance within 18 weeks was 60.6% and whilst this is currently 1.8% ahead of plan the increase in wait list size under 18 weeks will require close monitoring to sustain performance. This is because the PTL has grown for five consecutive months with a further 973 patients added to the wait list at the end of October. Clock starts continue to remain higher than the run rate of clock stops and the RTT PTL now stands at 41,621 patients which is 5,618 (15%) more patients than anticipated at this stage in the year.

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

Patients waiting over 65 weeks at the end of October was 28 and there were 3 x 78-week breaches reported (all within Plastic Surgery and the longest at 86 weeks with next steps booked in December). Plastics remains a key risk due to the impact on RTT and cancer pathways, with two week wait demand being prioritised over long waiting patients. A further review of controls is taking place with the COO team and Surgery Division.

Directives from NHS England outline expectations that all 65 week breaches should be eliminated by 21st December 2025 and to achieve this the Trust is booking all patients into an outpatient slot before the end of October to allow enough time for the next stages of treatment to be completed in time. At the time of writing only 5 patients were not booked and these are being escalated within Clinical Divisions.

- Cancer waiting times

Cancer performance for the 28-day faster diagnosis standard was at 61.4% and therefore 17% below the operating plan trajectory for September, and below the national target of 80%.

Cancer Faster Diagnosis is heavily impacted by the capacity issues seen in the Skin, Colorectal and Breast pathways and counter-measures are in place including additional waiting list initiatives to recover performance by December. The Dermatology waiting list has already seen a significant reduction in the waiting list since this was put in place last month.

The overall Cancer PTL remains elevated and at 38% higher than the same point last year, although 62 day patients are being managed within national tolerances (i.e. under 6% of the overall PTL size).

62-day performance for urgent suspected cancer referral to treatment was similar to last month at 65.6% and is currently 7.6% below operating plan. Tumour site trajectories are most challenged within Urology, Breast and Plastics.

Cancer pathways for Plastic patients remain under review with mutual aid being discussed with Salisbury NHS Foundation Trust. This is becoming more important to resolve because outsourcing arrangements are no longer proving effective at managing the treatment stage of the pathway. Additional Breast weekend Super Saturday radiology clinics have also been secured to support recovery within this tumour site during October and November.

Cancer 31-day performance was at 83.6% in September and was affected by capacity issues in theatres and outpatients. Of the 36 pathways that breached, 16 were in Skin (Outpatient capacity) and 9 were in Breast (Elective capacity).

- Time in Emergency Department

Combined 4-hour performance was 69.9% in October and 3.6% below operating plan trajectory. Counter measures remain in place to support recovery of 4 hour performance including focus on UTC Type 3 (Substantive recruitment of 5.4WTE GP Clinicians & 3.4WTE Clinical Practitioners and review of shift patterns to demand), Type 1 ED non-admitted stream (fast tracking diagnostics and increasing consultant to resident doctor ratios for shift patterns at peak periods in ambulatory majors to improve waits to be seen), and Type 1 admitted stream (additional capacity downstream within Medical Assessment Unit and review of direct to ward admission protocols and escalation processes where professional standards have not been met by receiving specialties).

October showed a 4.4.% increase in attendances compared to the monthly plan, although year to date attendances remain in line with operating plan assumptions. There continues to remain growth in Type 1 ED attendances from both ambulance and non-ambulance arrival methods since the beginning of the year. Mean time in department for Type 1 ED remained at 6.5 hours against the national 4 hour standard and the counter-measures are targeting an improvement in performance so that greater than 53% of patients are seen within 4 hours via these streams.

Ambulance handover performance in October was at an average of 32 minutes and therefore achieving the 33 minute trajectory for the first time. Improved performance has been sustained since May and as at 10th November the month to date was 28 minutes.

Ambulance conveyances continue to show annual growth of c.15%, with an average of 8 additional conveyances per day into the hospital. A review of ambulance conveyance rates and clinical appropriateness has been requested from the ICB and is being reviewed with partners during November.

OPERATIONAL BREAKTHROUGH OBJECTIVES

- Non-Elective Length of Stay

Non-elective length of stay was 6.4 days in October. There has been a 0.4 day reduction since the start of the financial year in April, but the October position remained 0.5 days above

the same point last year. The UEC programme board continues to focus on countermeasures to achieve a 0.5 day reduction on the same point last year, with pre-winter being targeted to maximise bed occupancy to provide headroom in advance of anticipated seasonal pressures. All workstreams have been requested to focus on deliverables pre-December to ensure maximum benefit for the winter period.

Bed occupancy was 99.3% in October which remains higher than levels recommended to sustain good flow out ED, and it is therefore important that cross divisional focus remains on making further improvements to length of stay ahead of the busy winter period.

- Proportion of Outpatient First Appointment Pathways Waiting <18 Weeks

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

Counter-measures within the A3 include the implementation of straight to test appointment notification outcoming in October which will reduce the volume of unnecessary outpatient appointment bookings.

A GIRFT visit also took place in September to inform future counter-measures and this is concentrated on outpatient template reviews with specialty level templates being compared to best practice to inform improvement strategies with clinical leads.

ALERTING WATCH METRICS

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

Diagnostics – October validated DM01 performance was 92.9% which is the highest level since February 2020 (pre-COVID). MRI, CT and Dexa scans are all achieving the national constitutional standard and the Trust is currently achieving the end of year target five months early. Additional Endoscopy capacity from the Community Diagnostics Centre is due to go live on 18th November and focused recovery efforts on Cystoscopy and Audiology are expected to sustain the good performance and mitigate forthcoming risks from seasonal pressures and demand on non-DM01 diagnostic work.

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

Overall no criteria to reside was 21.2% of the bed base and this relates to higher than planned number of days delayed waiting for pathway 2 (inpatient rehabilitation) in Swindon and for Wiltshire Pathway 1 (home without support / restart package of care). Mitigations are in place including resolving Wiltshire brokerage capacity for Pathway 1 and the extension of successful community therapy in-reach in Wiltshire to include Swindon since September. The latter will help to improve referral completion timescales and reduce discharge ready delays for Pathway 2 patients. A BSW System wide recovery plan is also under review during November to support winter resilience.

Our Care

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

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

The total number of harms has increase in month to 120, up from 108 in September.
In October, 86 falls were reported, a slight increase from 84 in September. The level of harm also rose, with 4 harms reported as moderate and above. Falls involving patients who had fallen more than once decreased to eight in October, compared to eleven in September. The percentage of falls involving repeat fallers continues to remain below trajectory.

C. diff cases rose to four in October from two reported in September. The Trust is above internal trajectory but remains below the South West average. The number of E.Coli bacteraemia has risen to 11.

Breakthrough Objectives
The Breakthrough Objective for 2025/26 has changed from reducing harm associated with pressure ulcers to reducing harm from inpatient falls.
Aim for 2025/26
- Reduce inpatient Falls by 10% each year over a 3-year programme
- Reduce inpatient falls resulting in moderate harm by 10% each year
- Reduce inpatient falls resulting in severe harm by 10% each year

The numbers of patients who experienced falls that resulted in moderate harm or above have increased to four in month. The number of patients with two or more falls has decreased to eight in October, compared to eleven in September.

Alerting Watch Metrics
E. coli numbers increased to 11 in October, up from 6 in September. Nearly half were linked to urinary sources, with two patients having catheters. A catheter audit, conducted in partnership with BD, was completed in October to support targeted improvements.
In October, the PALS service received 457 concerns, continuing the upward trajectory observed in recent months.

For ED & UTC key themes for improvement include waiting times, communication during delays, and ensuring patients are kept informed about the next steps in their care.

Non-alerting Watch Metrics

In October, the Trust received 72 new complaints, a similar level to the prior month however response rates improved by 3% to 72%. The number of reopened complaints is 5 this month. Although this is an increase on the prior month, the number remains reassuringly low.

The overall Family and Friends positive response rate for October is 84.3% which is a decreased when compared to the 91.3% in September. Friends and Family Test (FFT) data remains disrupted due to our current external supplier no longer managing card production.

There has been no Methicillin-Sensitive Staphylococcus Aureus (MSSA) or Methicillin-resistant Staphylococcus aureus (MRSA) case reported in month.

The number of hospital-acquired pressure ulcers has remained stable with 11 cases reported.

Further points to note relating to non-alerting watch metrics include:
- Safer staffing fill rates remain above the National target of 85%, although a drop below 90% for the first time.
- No Patient Safety Incident Investigation have been declared in October.

Our People

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

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

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

- **Staff Survey – Recommend as a Place to Work**
  Target: 63%
  2024 Staff Survey score: **59.6%** (no change from the previous year)
  Q2 Pulse Survey: **50.6%** (decline compared to Q1 54.7%)
- **Staff Sickness Absence**
  Target: 3.5%
  September 2025 figure: **4.1%**, (improvement from previous month 4.3%)
- **Equality, Diversity & Inclusion (EDI) – Disparity in Experience**
  Target: 9.4%
  2024 Staff Survey: **11.9%** (improvement from previous year 12.7% last year)
  Q2 pulse survey: **15.6%**, (decline of 10.6% compared to Q1)

Breakthrough Objectives

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

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

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

- The **2025 Annual Staff Survey** launched on 22nd September, and our response rate at week 7 of the campaign is at 57.6%. Support continues in areas of lower response to engage staff on the benefits of completing the survey with COWs available to enable staff to share their views. The survey will close on 28th November, and initial high-level results are expected in mid December.
- The roll out of '**Our Behaviours**' continued in October, with the fortnightly task and finish group working to embed these across the organisation. Our behaviours have been incorporated into Trust induction and our leadership programmes, and the working group is reviewing approaches to socialise our behaviours meaningfully to all staff.
- A monthly Trust-wide **Recognition** initiative is planned to launch in January to celebrate achievements, promote refreshed e-cards aligned with our behaviours, and support a reviewed recognition strategy under Charitable Funds.

Sickness Absence

The Trust's ambition remains to create a healthy, supportive, and inclusive work environment. Sickness absence reduced from 4.3% to 4.1% in September, with the movement attributed to a decreased long-term absence case volume.

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

- Delivery of 65 hours of targeted on-site support from the People Operations team to hotspot areas in October, focusing on absence reduction.
- Piloting of a Burnout Prevention Plan within SAU to address stress, anxiety, and depression-related absence, with a view to wider rollout.
- Distribution of supportive resources across hotspot areas, including going-home checklists, burnout leaflets, and a new MSK video promoting pre-shift wellbeing preparation.
- Implementation of in-month Absence Management policy training for managers and leaders to embed consistent practice across clinical and non-clinical teams.

Vacancy Rate

The overall vacancy rate in October 2025 was 2.40% (121 WTE), our lowest vacancy level YTD.

All Nursing continues to be over-recruited by 44 WTE, broken down with Registered Nursing over-recruited by 53 WTE and Unregistered Nursing holding a vacancy of 9 WTE. This position is due in part to the annual student intake and it is anticipated to change from M8 onwards.

Continued successful Medical recruitment has further improvement the vacancy position, with overall Medical vacancy decreasing further from 19 WTE in September to 1 WTE in October. This is due to Resident Doctor recruitment, and underneath this there is a Consultant vacancy level of 17 WTE. Work is underway to review the establishment position for Medical & Dental staff.

Admin & Clerical vacancies have further increased to 120 WTE due to held posts, and AHP vacancies have improved again to 44 WTE.

Temporary Staffing

At M7, bank usage was 275 WTE (+118 WTE to plan and an increase compared to M6 of 19 WTE) with spend at £14.6M YTD, £2.1M above plan. Agency usage improved compared to last month at 26 WTE (-13 WTE to plan) with spend at £3.7M YTD, £1.9M above plan.

Workforce Recovery
In October, workforce usage rose to 5,236 WTE against a plan of 5,042 WTE, an adverse variance of +194 WTE and an increase of 65 WTE from September, marking the highest usage YTD. Substantive staffing continued to grow above plan (+89 WTE), while temporary staffing remained +105 WTE adverse but showed improvement from last month.

Reviewing current performance against plan at staff group level:

- Nursing: +122 WTE to plan (of which 70 WTE for Unregistered Nursing)
- Medical: +80 WTE to plan
- AHP/STT: +22 WTE to plan

The focus remains on reducing temporary staffing and pulling back to plan. To achieve planned temporary staffing levels in month 8 a total of 99 WTE needs to be reduced from current usage levels:

- Unregistered Nursing: 66 WTE
- Medical: 40 WTE
- AHP/STT: 17 WTE

Use of Resources

For M07 2025/26 the Trust has an adjusted deficit position of £10.6m, which represents a £10.6m adverse variance to plan.

Income is £0.5m behind plan, the key driver being the loss of deficit funding (£5.6m). While activity is in line with M06, ERF income is £0.6m favourable to plan and remains within the affordability cap. The Trust have been asked by the ICB to keep within this for the remainder of the year. There are a further £1.8m of favourable positions on high-cost drugs (£1.0m) and other clinical income (£0.8m), the key contributors being depreciation income and vaccination income. Other operating income is £2.7m ahead of plan, with a £0.5m underperformance against private patients and R&D offset by gains on education funding. It should be noted that if the Trust were receiving deficit funding, the overall variance to plan would reduce to £5.0m, reflecting the tangible YTD gap the Trust needs to bridge.

The pay position is £5.9m adverse to plan, with undelivered cash releasing efficiency savings accounting for £4.4m. The position includes run rate savings of £1.2m driven by prior year gains, the closure of escalation areas and agency framework savings. There is also a £1.8m underspend against Corporate admin lines due to unfilled posts, while the remainder of the variance is due to industrial action costs of £0.2m and £4.3m of agency and locum overspends, the majority against medical and dental staff. Forecast recruitment into both nursing and medical posts over Q2/Q3 is delivering run rate reductions, with M07 seeing the lowest totals for agency and bank spend so far this year.

Non-pay is £4.1m adverse to plan. Undelivered cash-releasing efficiency savings accounts for £2.6m, while additional run rate savings from prior year benefits total £1.6m. Drugs are £1.9m adverse, all passthrough related, £1.0m of which is covered by the favourable income position. Clinical supply costs in the clinical and Corporate divisions are overspent by £1.9m, while there are further benefits of £0.7m driven by education and finance-related costs. Non-pay savings are focussing on areas where run rate is trending upwards, along

with broader grip and control measures such as clinical supplies and drug usage on the wards, as well as reducing discretionary spend.

Key to breaking even in 2025/26 is delivery against the efficiency savings target of £32.4m. At M07 total recurrent delivery is expected to be £13.1m against a plan to deliver 2/3rds of the target (£21.6m) recurrently. If we cannot improve this delivery, we are carrying an additional £8.5m deficit into our underlying position.

Breakthrough Objectives

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

As at M07 the Trust is £10.6m overspent against budget. A key driver of this is an underperformance of £8.0m against the cash releasing efficiency savings programme, delivering £10.0m year-to-date against a target of £18.0m. Of the £10.0m delivered, 58% was recurrent. It should be noted that the Trust has also delivered £5.2m of cost avoidance/run rate reductions due to prior year benefits taken in year and exiting escalation areas. While not removing budget, they are crucial in helping to reduce the overspent position. Our underlying position remains challenging and the objective for all divisions and specialties is to find recurrent saving schemes.

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

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

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

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

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

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

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	✓	☐	☐

Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	✓	☐	☐

Explanation of above analysis:

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

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

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	Benny Goodman, Chief Operating Officer
Date	**05/12/2025**

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

November 2025

October 2025 & September 2025 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

Section & purpose	Slides
Key indicators This is the NHS Oversight Framework indicators for 2025/26 and provides a summary of our performance against national standards	3-4
Executive summary This provides an overview of the targets, performance and countermeasures (remedial actions) for each of our pillar metrics	5-12
Breakthrough objectives This provides a more detailed analysis of performance and risks related to the 4 key metrics for improvement: Patients Developing Pressure Ulcers; Emergency Department - Clinically Ready to Proceed; Implied Productivity and Staff Survey Results	13-17
Our Care This includes key indicators and watch metrics related to our care of patients, as assured by the Quality & Safety Committee	18-20
Our Performance This includes key indicators and watch metrics related to our access performance, as assured by the Performance, Population & Place Committee	21-25
Use of Resources This includes key indicators and watch metrics for finance as assured by the Finance, Infrastructure & Digital Committee, and is also subject to a separate board report	26
Our People This includes key indicators and watch metrics for our workforce, as assured by the People & Culture Committee	27-32
Explaining the IPR This section explains how the work of front line teams to drive improvement connects from 'ward to board' through our operational management system, and the business rules we apply to support that.	33-45

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Target/Thres.	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Percentage of RTT patients treated within 18 weeks		53.1%	54.2%	54.8%	56.9%	58.0%	57.8%	59.6%	60.8%	61.2%	60.5%	60.7%	60.6%
Percentage of RTT patients waiting over one year		4.1%	3.5%	3.2%	3.1%	2.5%	2.2%	2.0%	1.8%	1.8%	1.6%	1.4%	1.3%
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	75% (Nat)	78.9%	79.5%	80.2%	86.2%	83.5%	80.4%	76.8%	79.2%	74.5%	65.6%	61.4%	Reported one month behind
Percentage of patients treated for cancer within 62 days of referral	85% (Nat)	70.4%	73.4%	75.3%	72.7%	82.1%	70.8%	69.7%	78.2%	69.3%	65.6%	65.8%	Reported one month behind
Percentage of Emergency Attendances within Four Hours	95% (Nat)	74.0%	72.1%	73.4%	72.3%	69.9%	69.5%	70.1%	69.1%	69.1%	67.8%	68.1%	69.9%
Percentage of Emergency Attendances over Twelve Hours	2% (Nat)	7.3%	7.9%	10.1%	8.9%	8.3%	9.0%	8.5%	5.6%	5.6%	5.8%	7.4%	7.4%
Planned surplus/deficit		-683	-610	-482	74	690	-2149	-3476	-1173	-801	-1411	-1105	-480
Rate of productivity		-14.0%	-15.0%	-14.0%	-13.0%	-14.0%	-11.0%	-13.0%	-13.0%	-8.1%	-10.0%	-14.0%	Waiting for data
Readmission rate		14.0%	14.5%	15.0%	14.6%	15.4%	15.3%	16.0%	15.3%	17.0%	17.4%	15.5%	15.1%
Summary Hospital Level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months behind	Reported five months behind	Reported five months behind	Reported five months behind	Reported five months behind
Average number of days between planned and actual discharge date		2.2	2.4	2.3	2.7	2.7	2.6	2.4	2.2	2.3	2.7	2.7	2.9
Percentage of inpatients referred to stop smoking services		12.5%	12.5%	11.3%	10.0%	11.1%	11.5%	11.9%	12.0%	12.1%	11.1%	11.3%	12.2%
Percentage of people waiting over six weeks for a diagnostic procedure or test	99% (Nat)	89%	85%	86%	88%	91%	85%	85%	84%	86%	89%	90%	Reported one month behind
Rates of MRSA		0.0	0.0	0.0	0.0	5.5	0.0	0.0	0.0	5.8	0.0	Two month behind	Two month behind
Rates of C-Difficile		17.2	38.8	22.2	24.6	27.7	28.1	48.9	33.7	23.0	11.9	Two month behind	Two month behind
Rates of E-Coli		40.1	33.3	16.6	43.0	33.3	56.1	43.4	39.3	51.8	50.7	Two month behind	Two month behind
Percentage of NHS Trust staff to leave in the last 12 months	14.8% (Int)	9.7%	9.9%	9.0%	10.4%	10.9%	10.3%	11.7%	11.6%	11.9%	13.1%	12.8%	One month behind
Sickness absence rate	3.5% (Int)	4.9%	4.9%	5.1%	4.9%	4.5%	4.1%	4.1%	4.2%	4.4%	4.3%	4.1%	Reported one month behind
Rate of annual growth in under 18s elective activity		32.6%	31.5%	31.9%	30.9%	27.7%	16.4%	11.8%	9.6%	4.9%	4.2%	4.5%	4.1%

Key Indicators

Great Western Hospitals NHS Foundation Trust

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

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

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

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

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

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

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

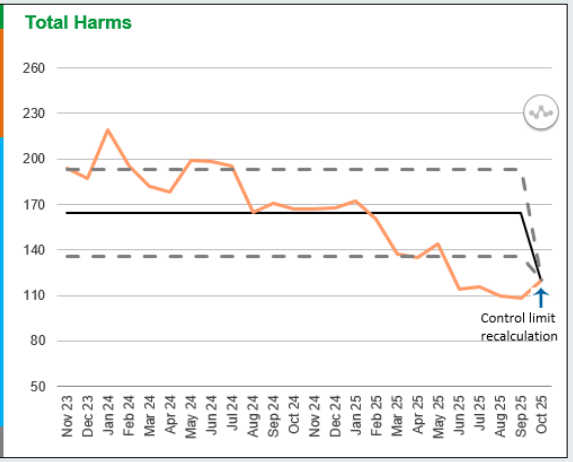
This metric reflects the Trust's commitment to learning from patient feedback and ensuring timely, high-quality responses to concerns raised.

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

Complaints response rate is tracked each month against timescale.

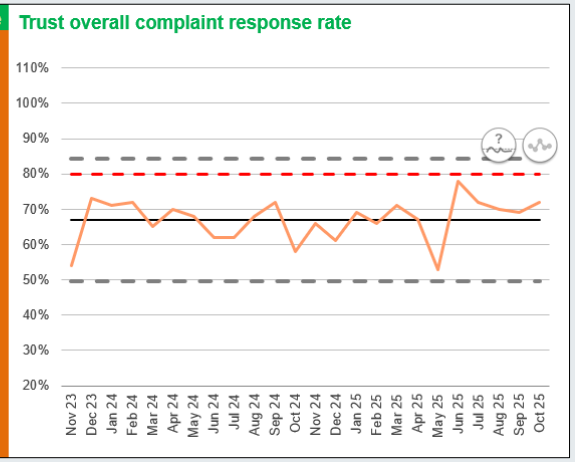
Total Harms
To achieve and sustain zero avoidable harm.

Timescale	Value
Nov 24	167
Dec 24	168
Jan 25	172
Feb 25	160
Mar 25	137
Apr 25	135
May 25	144
Jun 25	114
Jul 25	116
Aug 25	110
Sep 25	108
Oct 25	120



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

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



Counter Measures

The total number of harms has increase in month to 120, up from 108 in September.

C. diff cases rose to four in October from two reported in September. The Trust is above internal trajectory but remains below the South West average. The number of E.Coli bacteraemia has risen to 11.

There has been a small increase in the number of reported Hospital Acquired Pressure Ulcers, with 11 harms reported in October compared to 10 in September. In October, 86 falls were reported with 4 resulting in moderate of above harm.

The Trust's complaint response rate improved to 72% in October, up from 69% in September, reflecting positive progress.

The strengthened A3 working group has driven renewed engagement and focus on improvement initiatives. Benchmarking across the BSW system continues to show that GWH manages consistently high caseloads and contacts, highlighting the need to focus on improvement that reduce concerns and complaints.

To further enhance quality and consistency of responses, dates have been confirmed for two full-day complaint manager training sessions, delivered in partnership with a legal firm. The programme will cover: Causes of conflict, Parliamentary and Health Service Ombudsman (PHSO) standards, Techniques for resolving complaints, Writing effective responses.

Executive Summary

NHS Great Western Hospitals NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance

In September, 81 pathways breached the standard with 66.5 being allocated to GWH resulting in performance of 65.8%. Of these 28% are attributed to the Urology pathway & 17% to the Skin pathways. These pathways are seeing issues with capacity for appointments and diagnostics.

The Plastics service is provided at GWH via an SLA with Oxford. Oxford have been unable to meet this SLA resulting in cancer pathway breaches. In September Plastics was responsible for 11% of breaches, without these performance would have been 69.5%

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

RTT performance decreased by 0.08%, to 60.59%, due to the increasing waiting list size in >18-week patient cohort, compared to a last month's position of 60.67%,. The total number of patients waiting over 52 weeks in October decreased by 14 to 559 compared to the previous month.

There were 28 patients reported at 65 weeks at the end of October, a decrease of 1 from previous month. The majority of breaches were in the plastics pathway. A number of these were due to patient choice and complexity of clinical pathways.

There were 3 x 78-week breaches reported in October 2025 (3 plastics).

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

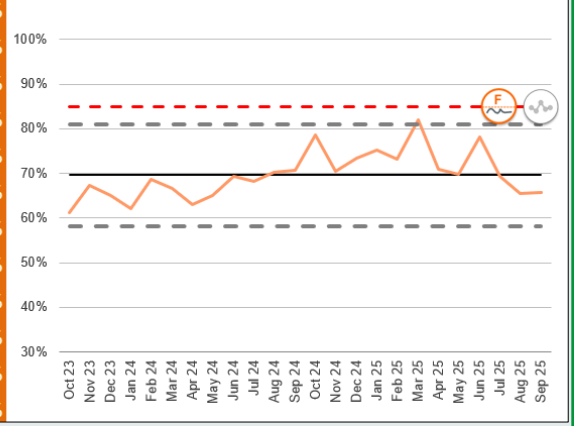
Significant progress is being made to reduce the wait to first appointment through our booking processes, and with clear oversight of the active waiting list across all divisions.

The national ask is that the Trust is reports 0x 65-week breaches by 21st December 2025 and all patients in cohort to have a 1st Outpatient appointment by the end of October 25

Cancer 62 Day

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

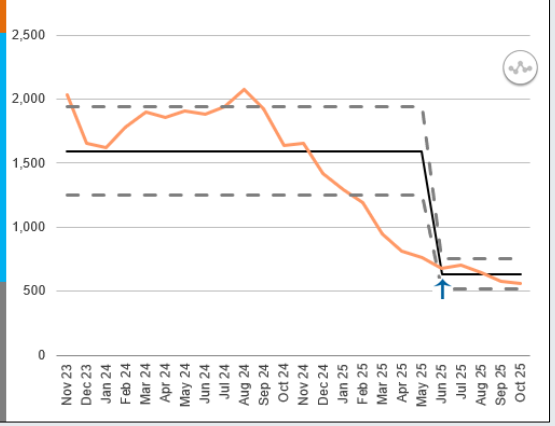
Timescale	Value
Oct 24	78.5%
Nov 24	70.4%
Dec 24	73.4%
Jan 25	75.3%
Feb 25	73.1%
Mar 25	82.1%
Apr 25	70.9%
May 25	69.7%
Jun 25	78.2%
Jul 25	69.3%
Aug 25	65.6%
Sep 25	65.8%



RTT: Number of patients waiting over 52 weeks

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

Timescale	Value
Nov 24	1,657
Dec 24	1,423
Jan 25	1,290
Feb 25	1,195
Mar 25	950
Apr 25	816
May 25	764
Jun 25	679
Jul 25	707
Aug 25	646
Sep 25	573
Oct 25	559



Counter Measures

Risk: Urology Pathways are impacted by delays in Radiology (capacity & vacancies)
Mitigation:
Recruitment of radiology clinical team over summer 25 will improve reporting turn-around times
Risk: Capacity issues for **Dermatology** first and follow up appointments
Mitigation:
Additonal WLI activity provided by external provider (HBS) and via ENT referral
New pathway to assess risk of malignancy before face-to-face appointment in place
Risk: Capacity in **Plastics** for appointments
Mitigation
Additional clinical capacity provided by ENT and by private provider (CSP)

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

- Mutual aid fully utilised as it becomes available
- Unfit patients/patient choice being managed in line with Trust Access Policy.
- Improved clinical review processes introduced with emphasis placed on the use of PIFU if a patient cannot be discharged.
- Validation of waiting lists (Project Verify) being embedded, along with cohorts of patients waiting over 40 weeks being offered alternative health care providers.
- Access team led intensive validation to work through cohort and increase clock stop run rate. Team now commenced extended patient treatment list review sessions.

Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

Executive Summary

Great Western Hospitals NHS Foundation Trust

ED Attendance as a Percentage of Population by Deprivation Quintile

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

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

In October there was a slight decrease on September which was highest on record for NCTR. There has been a system focus on PW3's which can be seen in the improvement below – SBC changes in spot beds have been a contributing factor, coupled with the discussions/escalation process at system level. Countermeasures that have been introduced are:

- Wiltshire In reach results presented at flow board end of October– with positive outcomes for flow and increase in referrals in a timely prior to NCTR. The request has been to expansion of this to be inclusive of Swindon.
- Early escalation of barriers in CTR now on Nerve Centre for monitoring
- Targeted approach to Pw0's on site calls and outcomes (internal delays reduction being monitored)
- Length of Stay reviews twice weekly to continues system wide.
- Introduction of 48 hours.48 hours ,7 days – target dates for partners.
- 21 day LoS panel to commence on the 12/11/25 for CTR & NCTR
- Discharge Lounge move to Dorcan planned first week of Oct – to increase capacity – KPI monitoring and reporting to be undertaken in November.

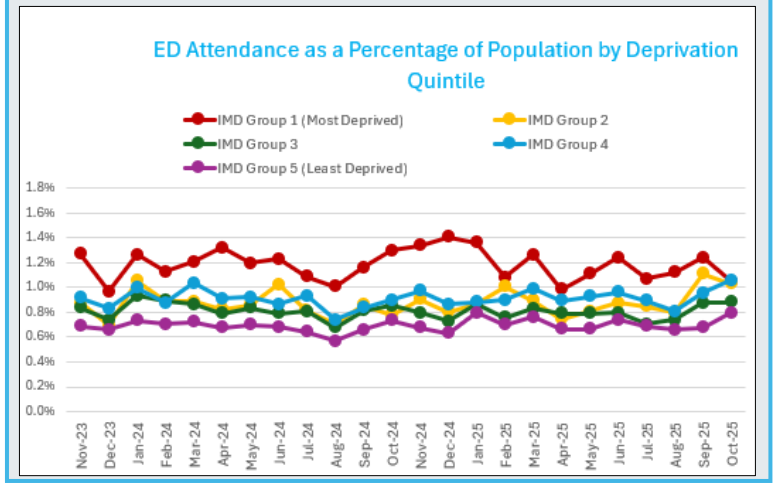
NCTR breakdown/performance:

PW0's - 87% leaving on day 0 – 6% increase on last month.
PW1's – 30% leaving on day 1 –increase of 8% on September performance.
PW2's – 48% leaving on day 2 - 3% increase this continues to increase month on month.
PW3's – 43% discharged on day 3 which is a significant increase of 25% increase (KPI is 7 days locally)

Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect

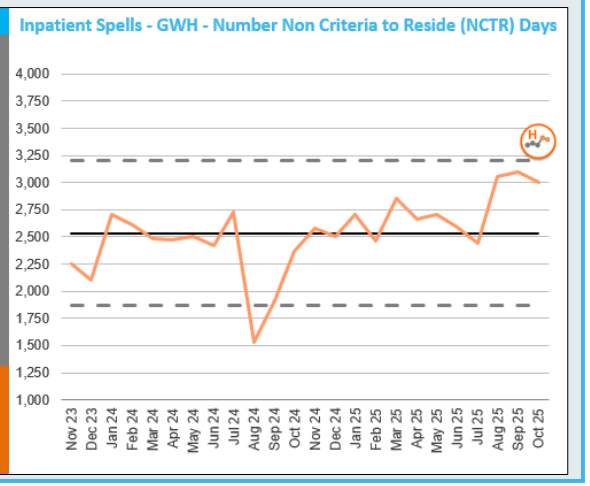
ED Attendance as a Percentage of Population by Deprivation Quintile



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

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

Timescale	Value
Nov 24	2,578
Dec 24	2,500
Jan 25	2,708
Feb 25	2,468
Mar 25	2,851
Apr 25	2,663
May 25	2,710
Jun 25	2,594
Jul 25	2,439
Aug 25	3,054
Sep 25	3,095
Oct 25	3,007



Counter Measures

We are seeking to understand the impact deprivation may have on our population's access to emergency services in order that we can work with people to provide alternative and earlier access to care where appropriate. The difference in access between people from the most deprived quintile and the rest of the population has continued in September with ED attendances also higher in the second most deprived quintile.

We are working with Swindon Integrated Care Alliance and our high intensity user team to develop a dialogue with our population. Reviewing the high intensity user cohort by deprivation quintile is ongoing with a Go & See with the MDT planned. We are also looking to breakdown the data further so that we can understand reasons for different patterns of access to urgent care. We will seek to do this in partnership with people in the most effected populations.

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

Opportunities:

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

Reflections:

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

Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

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

The total meantime (ED & CEU) in October 2025 was 394 minutes against the national standard of 240 minutes, above August. Mean LOS has been affected by continued flow across the organisation throughout July, leading to ED outward flow and capacity to manage incoming patients.

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

Emergency Care – Urgent Treatment Centre - Mean Stay

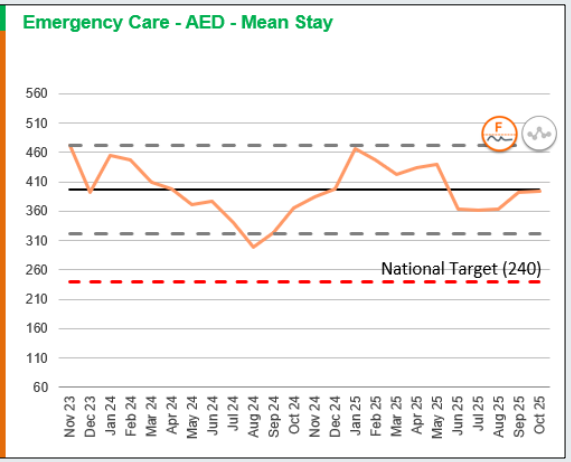
The total attendance mean time wait for a patient in September 2025 was 159 minutes against the national standard of 240 minutes, below the performance in August. Staffing and acuity have continued to be challenging leading to periods with longer LOS, sometimes with 4hrs wait to be seen although discharge has then been prompt.

Benny Goodman | Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

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

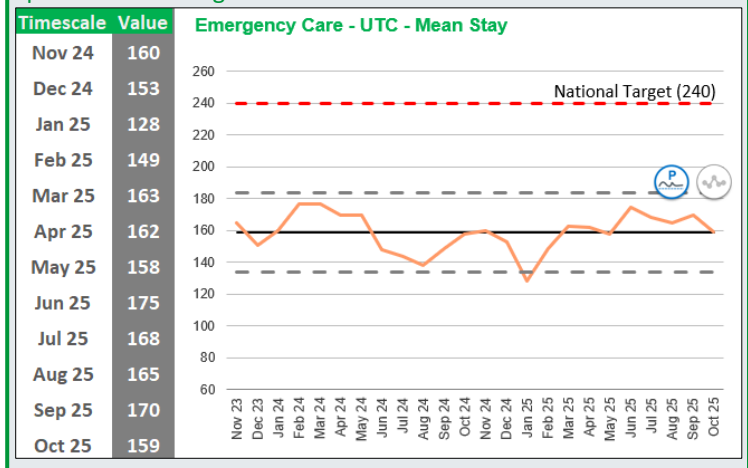
Timescale	Value
Nov 24	384
Dec 24	397
Jan 25	467
Feb 25	447
Mar 25	423
Apr 25	433
May 25	440
Jun 25	364
Jul 25	361
Aug 25	364
Sep 25	392
Oct 25	394



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Nov 24	160
Dec 24	153
Jan 25	128
Feb 25	149
Mar 25	163
Apr 25	162
May 25	158
Jun 25	175
Jul 25	168
Aug 25	165
Sep 25	170
Oct 25	159



Counter Measures

- Recruitment of substantive Registrars in ED – will give increased 'Senior Decision Maker' cover
- Joint approach to IFD 'management' and daily operational oversight – IFD Silver & huddles.
- Rapid Assessment Area process revision – minimise delays and onward movement.
- Process change for patient management in 'Chairs' - identify quick discharges and re-reviews of patients with results -
  - Maximize early discharge for non-admitted cohort
- Review 'Internal Professional Standards' - Early transfer to Specialty Wards
- Recruitment of AMU consultant into ED, to support inter departmental working and continue development of pathways eg. SDEC
- Review/increase alternate capacity
- Review of UTC shift supportive Senior Lead role
- Recruiting into newly budgeted Medical & Practitioner roles, process ongoing near completion – will provide substantive clinical leadership 7/7
- New clinical lead recruitment underway
- ICB support to reduce attendances to UTC - increased community clinic places - Pharmacy 1st, Paediatric Acute Respiratory Hubs.
- Full utilisation of MAU/SDEC pathways
- Drive to maintain early review / maintain UTC 95% performance
  - July UTC Momentum Push (JUMP) - review of issues identified and practice change

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

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

Our target for sickness absence is 3.5%, and performance in September 2025 was 4.1%, a further improvement on the previous month.

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

In 2023 and 2024 the Trust achieved 60% performance.

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

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

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

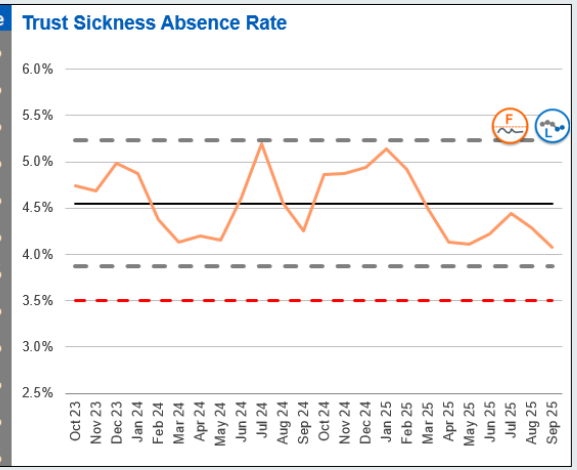
Whilst a small decline was seen in this metric throughout the year, the 2024 Annual Staff Survey results show a sustained result at 59.6%.

Jude Gray
Director of Human Resources (HR)

Trust sickness absence rate

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

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



Staff % recommend the organisation as a place to work

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

Counter Measures

Sickness absence decreased again in September from 4.3% to 4.1%, attributed to a reduction in long term cases (83 to 61 cases).

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

- 65 hours of targeted on-site support from the People Operations team was provided to hotspot areas in October.
- Children's Unit, ED, and SAU continue with enhanced support on absence reduction, with SAU piloting the 'Burnout Prevention Plan' with a view to rolling out further to support levels of Stress/Anxiety/Depression related absence.
- Additional supportive resources are being distributed across hotspot areas including going-home checklists, burnout leaflets, and a MSK video to support staff in appropriately preparing at the start of a shift.

- The annual flu campaign launched on 1st October, and at 10th November 46% of staff have been vaccinated (3,026 people including staff, students, Serco, and volunteers).
- October saw the Trust celebrate Black History Month, focussing on the theme of 'standing firm in power and pride'. The Race Equality Network held a celebration event in the Academy to share, celebrate and understand the impact of Black heritage and culture on our staff, volunteers and patients.
- Enhanced wellbeing support for our staff continues, with activity planned for November including psychological wellbeing support at the End-of-Life champions day and increased drop-ins within the Academy for Medical students.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

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

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

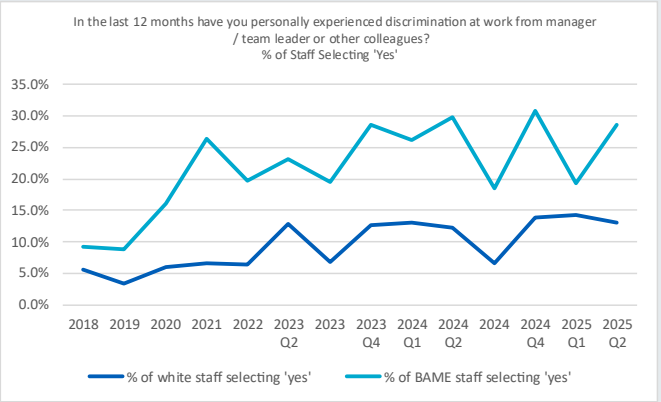
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

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

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

Jude Gray
Director of Human Resources (HR)

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



Counter Measures

- Slice of Life events launched in October 2025, six BME staff attended session one and Jude Gray Group Chief People Officer represented the board. The group focussed on inequalities experienced by internationally educated staff.
- The Guide to addressing racism launched 22 October during Black History Month, alongside this, there is an accompanying workshop that will run in the New Year. Staff were invited to lunch and network and hear more about the guide.
- The Supporting Transgender Employee guide has been updated to reflect the Supreme Court Ruling following engagement with the Joint Network; the policy will be presented at IHISC and EPF before publication. The Equality Human Rights Commission (EHRC) is yet to update its Employment Code of Practice to reflect the clarification between sex and gender which was established by the court case.
- The OD and EDI leads at GWH will undertake Cultural Intelligence (CQ) Certification early December 2025. This will enable the Academy team to offer individual and team-based interventions to support working across cultural boundaries and 'difference' (race, sexual orientation, gender expression, disability etc).

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

For M07 2025/26 the Trust has an adjusted deficit position of £10.6m, which represents a £10.6m adverse variance to plan.

Income is £0.5m behind plan, the key driver being the loss of deficit funding (£5.6m). While activity is in line with M06, ERF income is £0.6m favourable to plan and remains within the affordability cap. The Trust have been asked by the ICB to keep within this for the remainder of the year. There are a further £1.8m of favourable positions on high-cost drugs (£1.0m) and other clinical income (£0.8m), the key contributors being depreciation income and vaccination income. Other operating income is £2.7m ahead of plan, with a £0.5m underperformance against private patients and R&D offset by gains on education funding. It should be noted that if the Trust were receiving deficit funding, the overall variance to plan would reduce to £5.0m, reflecting the tangible YTD gap the Trust needs to bridge.

The pay position is £5.9m adverse to plan, with undelivered cash releasing efficiency savings accounting for £4.4m. The position includes run rate savings of £1.2m driven by prior year gains, the closure of escalation areas and agency framework savings. There is also a £1.8m underspend against Corporate admin lines due to unfilled posts, while the remainder of the variance is due to industrial action costs of £0.2m and £4.3m of agency and locum overspends, the majority against medical and dental staff. Forecast recruitment into both nursing and medical posts over Q2/Q3 is delivering run rate reductions, with M07 seeing the lowest totals for agency and bank spend so far this year.

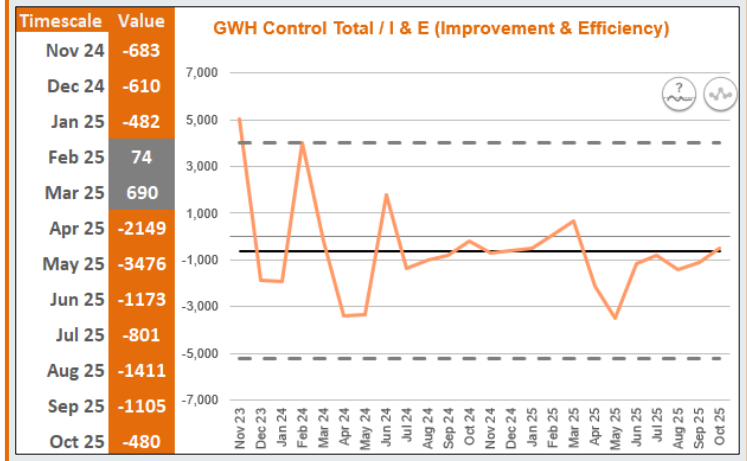
Non-pay is £4.1m adverse to plan. Undelivered cash-releasing efficiency savings accounts for £2.6m, while additional run rate savings from prior year benefits total £1.6m. Drugs are £1.9m adverse, all passthrough related, £1.0m of which is covered by the favourable income position. Clinical supply costs in the clinical and Corporate divisions are overspent by £1.9m, while there are further benefits of £0.7m driven by education and finance-related costs. Non-pay savings are focussing on areas where run rate is trending upwards, along with broader grip and control measures such as clinical supplies and drug usage on the wards, as well as reducing discretionary spend.

Key to breaking even in 2025/26 is delivery against the efficiency savings target of £32.4m. At M07 total recurrent delivery is expected to be £13.1m against a plan to deliver 2/3rds of the target (£21.6m) recurrently. If we cannot improve this delivery, we are carrying an additional £8.5m deficit into our underlying position.

Simon Wade
Chief Financial Officer

GWH Control Total / I & E (Improvement & Efficiency)
To achieve and sustain a break-even financial position.

Timescale	Value
Nov 24	-683
Dec 24	-610
Jan 25	-482
Feb 25	74
Mar 25	690
Apr 25	-2149
May 25	-3476
Jun 25	-1173
Jul 25	-801
Aug 25	-1411
Sep 25	-1105
Oct 25	-480



Counter Measures

Cash releasing efficiency savings were £1.0m below target in month. Actual savings delivered were £1.6m against a plan of £2.6m. Pay was £0.6m under plan and non-pay £0.3m. Recurrent delivery was 60% in month and is 58% year-to-date, in line with M06. Note that the Trust has also made cost avoidance/run rate savings of £5.2m at M07 relating to prior year benefits transacted in-year and the closure of escalation areas. Divisions and services are included in financial recovery workstreams such as substantive workforce, temporary staffing and better buying to focus on delivery recurrent cash out savings.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Carbon Footprint / Sustainability

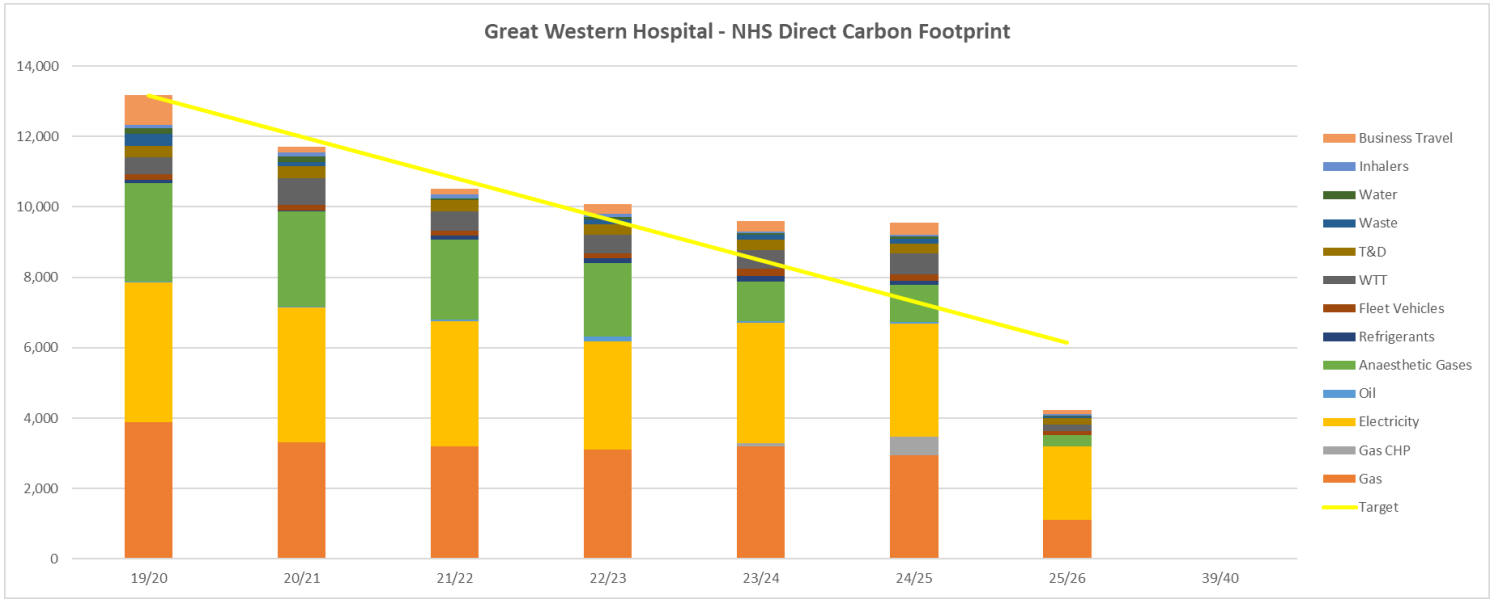
Sustainability is fundamental to maintaining high quality care; to help us meet the needs of today without compromising the needs for future generations.

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

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

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

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



Counter Measures

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

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

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

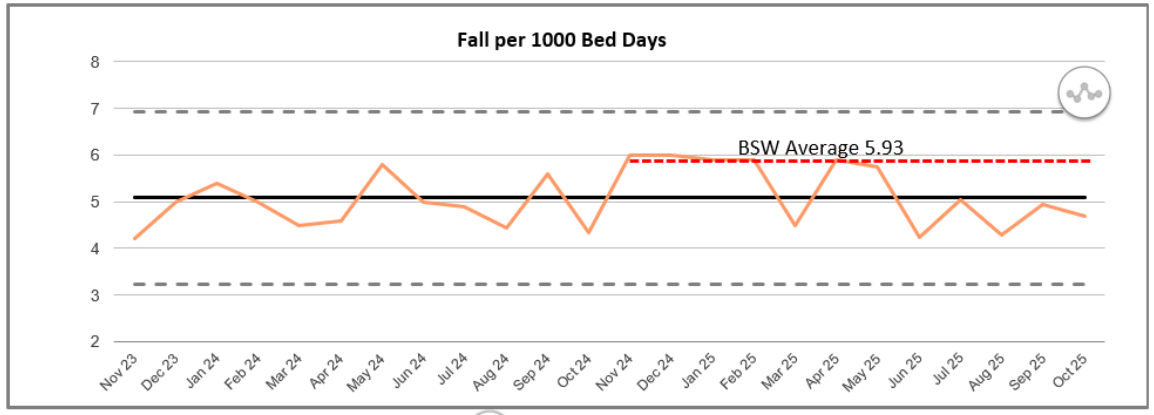
Simon Wade
Chief Financial Officer

2025/26 Breakthrough Objectives

Reducing Falls & Falls With Harm

Great Western Hospitals NHS Foundation Trust

Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25
6.00	6.00	5.90	5.90	4.50	5.91	5.75	4.23	5.03	4.30	4.95	4.70



Common cause - no significant change

Understanding the Data

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

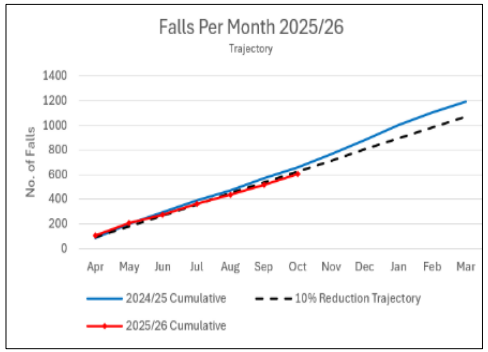
Aim for 2025/26

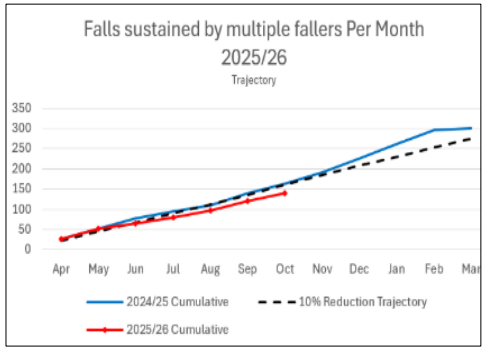
Reduction in the number of Total Falls by 30% over 3 years.
Reduction in the number of patients experiencing moderate harm or above by 10% each year
Reduction in the number of patients that fall more than once by 20%.

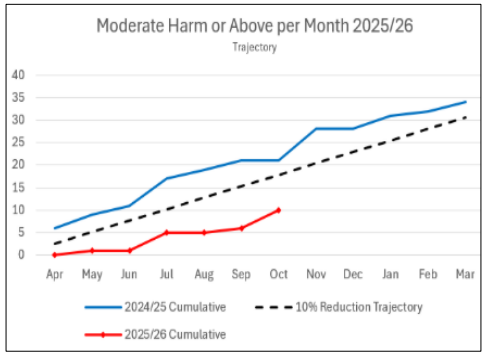
We are driving this measure because…

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

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







Performance

In October, 86 falls were reported, a slight increase from 84 in September. The level of harm also rose, with 4 harms reported as moderate and above. The Trust remains below trajectory for moderate harm reduction.

Falls involving patients who had fallen more than once decreased to eight in October, compared to eleven in September. The percentage of falls involving repeat fallers continues to remain below trajectory.

Improvement Actions considered:

A review took place this month to ensure that appropriate interventions were in place. The Falls Panel examined the data and identified several contributing factors which will form part of the improvement plan:

Cognitive and motor impairment, often worsened by changes in the patient's environment such as ward moves or unfamiliar surroundings, compounded by acute illness.

Medication-related factors, which continue to have a significant impact.

Enhanced care and supervision, remain critical but can be undermined when staff do not consistently stay within the bay or when handover practices vary, particularly during periods of staffing pressure.

The **most common reason for patient falls** was mobilisation related to toileting needs.

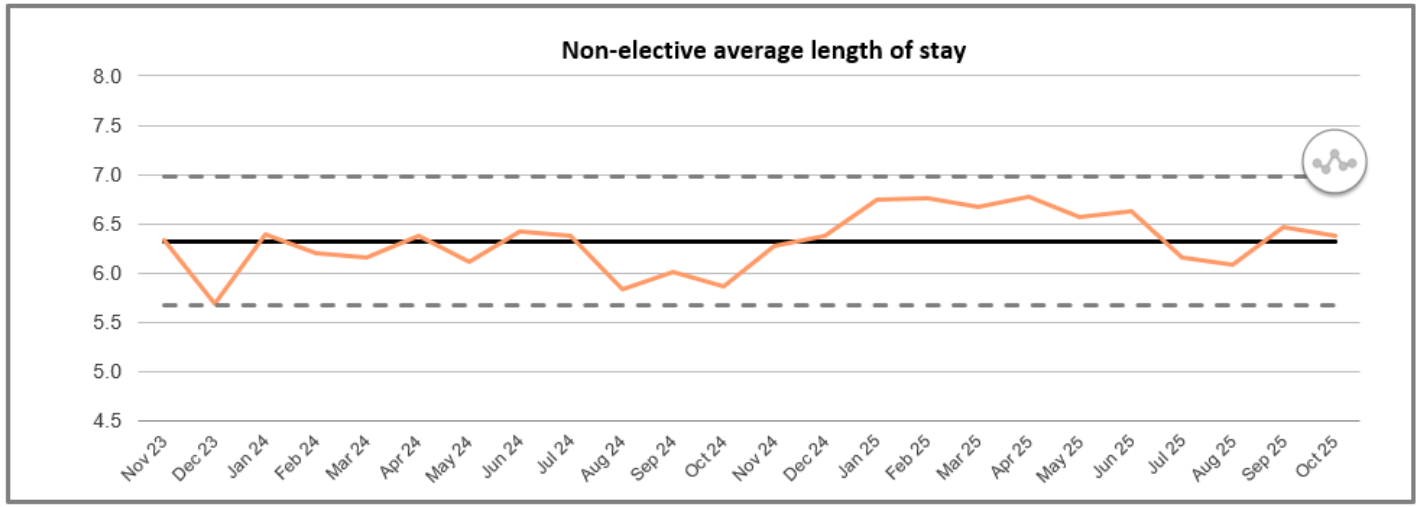
To address these issues, focused work is underway across divisions as part of the deconditioning agenda, specifically reviewing continence management and toileting practices.

2025/26 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Non-elective average length of stay

Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25
6.3	6.4	6.7	6.8	6.7	6.8	6.6	6.6	6.2	6.1	6.5	6.4



Common cause - no significant change

Understanding the Data

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

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

We are driving this measure because...

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

Performance

Non-elective length of stay was 6.4 days in October. There has been a 0.4 day reduction since the start of the financial year in April, but the October position remained 0.5 days above the same point last year. 3 workstreams remain in place:

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

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

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

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

Risks

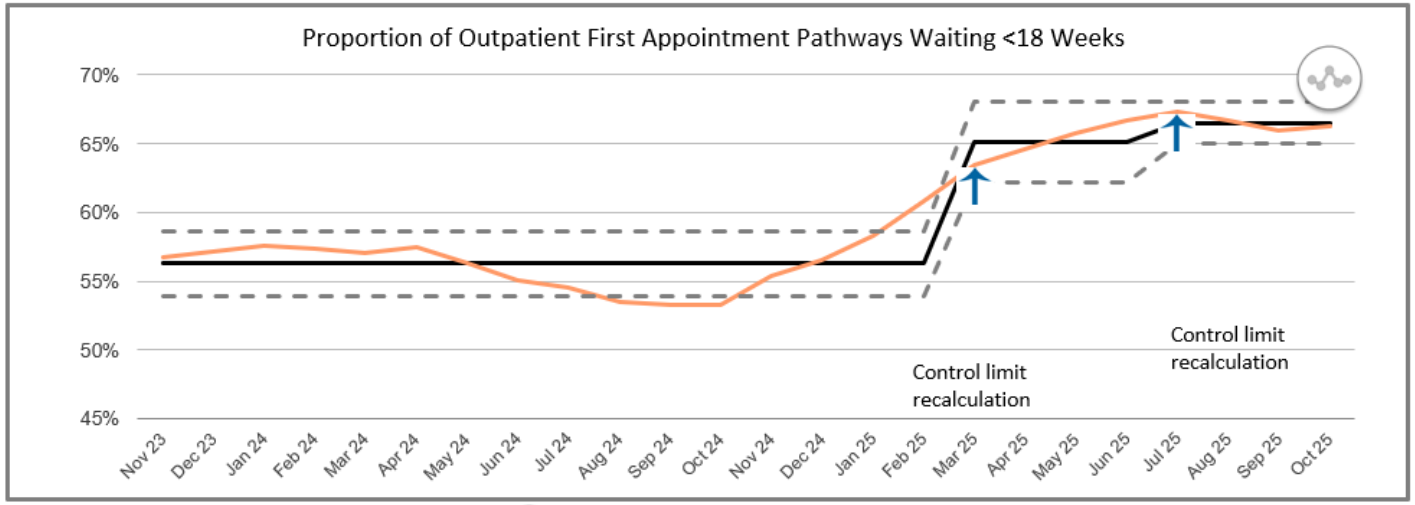
There is a risk that high hospital occupancy leads to poor patient flow through the hospital which impacts on the safe delivery of care. High occupancy resulting in delays to offloading ambulances (risk 731) , overcrowding in ED / ED majors (690) and the use of temporary escalation spaces to deliver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

2025/26 Breakthrough Objectives

Proportion of Outpatient First Appointment Pathways Waiting <18 Weeks

Great Western Hospitals NHS Foundation Trust

Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25
55%	57%	58%	61%	63%	65%	66%	67%	67%	67%	66%	66%



Common cause - no significant change

Understanding the Data

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

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

We are driving this measure because…

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

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

Performance

For the second consecutive month, performance has remained at 66% across the Trust, with no improvement observed. While we have successfully achieved the Trust-wide target outlined in the national guidance, we have not yet reached the national benchmark of 72%, which is required by March 2026. Progress continues in key areas, including the implementation of Straight-to-Test pathways, service development initiatives, and the work of the new clinic templates group.

Straight to test: The automated solutions have been successfully tested and are now live. This enhancement ensures that pathways discharged following a test are validated promptly, preventing them from incorrectly appearing as over 18 weeks. Additionally, pathways flagged for outpatient appointments are now systemically bookable, enabling patients to be scheduled sooner for their first outpatient appointment.

Service Development: Work will focus on optimising ENT and Paediatrics pathways, while Cardiology improvements will be delayed. Initial service mapping has highlighted inefficiencies: ENT currently comprises 10 services but only one assessment service, with eight services directly bookable. Paediatrics has a Referral Assessment Service but only one onward general pathway. Both models are suboptimal and will benefit significantly from redesign.

Clinic Templates: Sarah Knight has identified the specialties with the greatest opportunity for improvement, which will form the new working group. She has begun defining workstream objectives and drafting the A3 plan. The selected specialties include Gynaecology, Cardiology, Respiratory, ENT, Gastroenterology, and Urology.

Risks

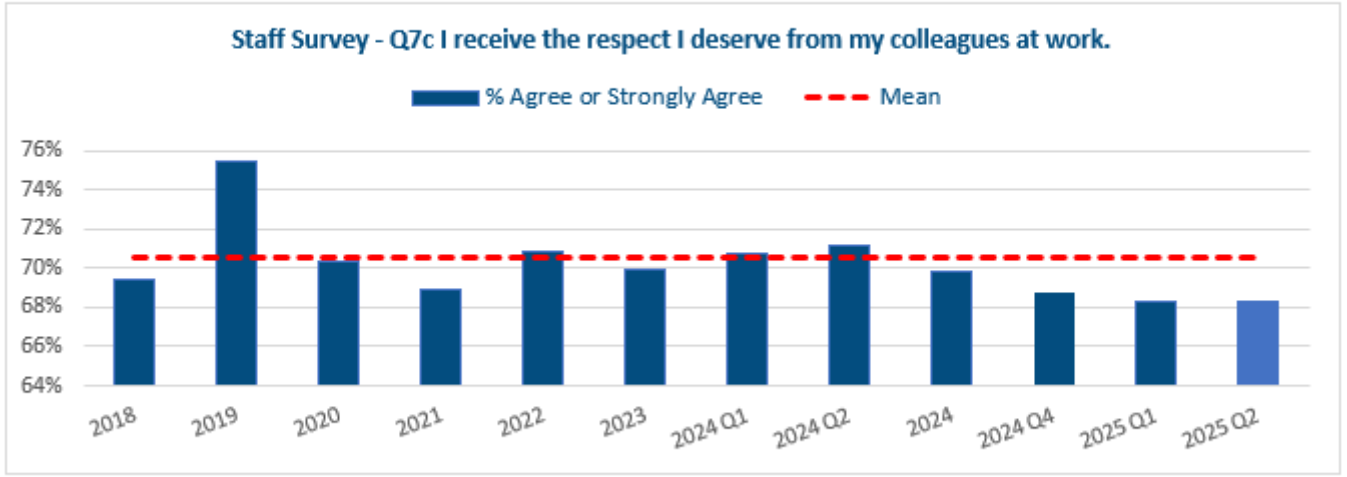
- Administrative capacity to build and support new pathways may result in delays to implementation or pausing of this sub workstream.
- Capacity Constraints: If there is insufficient capacity to handle the increased demand for early appointments, it could delay the overall process and hinder the achievement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

2025/26 Breakthrough Objectives

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

Great Western Hospitals NHS Foundation Trust

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



Understanding the Data

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

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

We are driving this measure because...

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

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

Performance

2025 Staff Survey

The annual staff survey launched on 22nd September and will run until 28th November. The response rate achieved at week 7 of the campaign is 58%, with the current BSW Hospitals Group uptake at 50%. Promotion of the survey continues with GOATs available in areas with lower uptake and walk-arounds being conducted supported by the People Operations team.

Our Behaviours

Following the soft launch of 'Our Behaviours' in September, a fortnightly task and finish group has been established to see through the roll-out across the organisation. Our behaviours have been integrated into Induction and all leadership programmes including Expectations of Line Managers. An engagement group dedicated to testing the initial roll-out and recommending further opportunities to embed has also been established.

Culture of Appreciation and Recognition

A monthly Trust-wide recognition round-up is planned to start in January to celebrate achievements, promote e-cards, and encourage staff to share messages of thanks. Alongside the launch of our behaviours, the current offering of e-cards is being refreshed to include our new behaviours. The recognition strategy is currently under review by Charitable Funds.

Risks

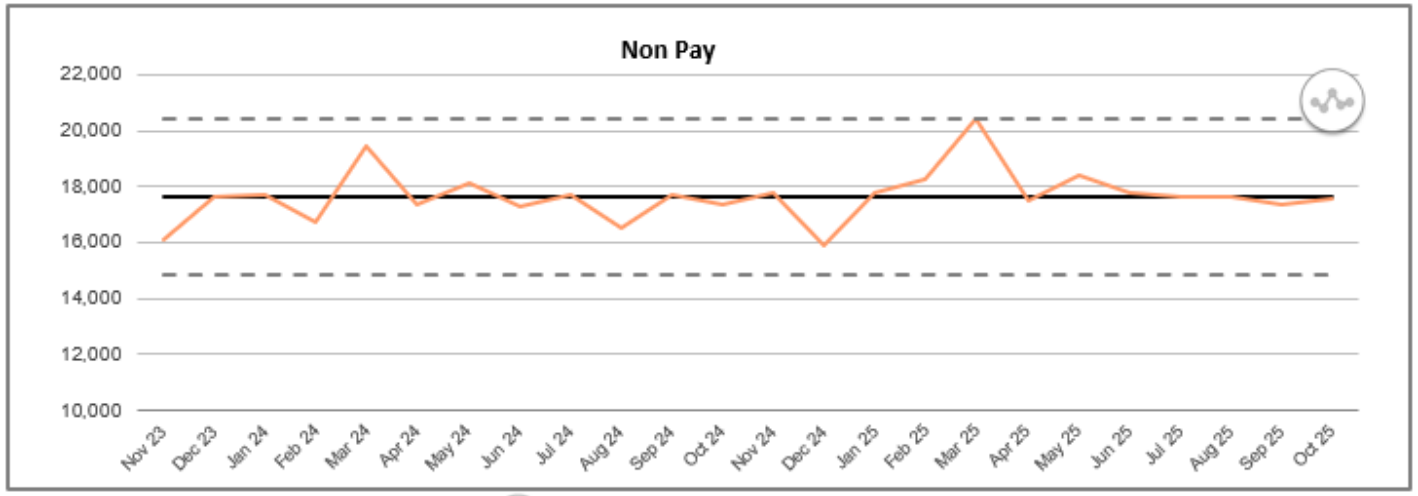
- Significant risk to staff morale and engagement due to current financial challenges, requirement to reduce our workforce, and organisational change.

2025/26 Breakthrough Objectives

Non-Pay run rate stabilisation and reduction

Great Western Hospitals NHS Foundation Trust

Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25
17799	15918	17764	18289	20422	17485	18390	17782	17611	17661	17385	17596



Common cause - no significant change

Understanding the Data

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

We are driving this measure because...

The Trust has a £32.4m efficiency savings target for 25/26, which is £2.7m per month. As at M07 the Trust has delivered £10.0m of actual cash releasing savings, leading to an under delivery of £8.0m. Finding recurrent cash releasing savings is crucial if the Trust is to deliver on its savings programme and achieve a breakeven budget.

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

Performance

M07 costs were £0.6m lower than M06 driven by £0.3m of VAT credits on energy costsand lower pay costs driven by medical agency spend and bank holiday costs in priormonth. Overall, M07 non-pay costs were £0.1m below the YTD run rate.

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

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

Risks

The risks to achievement include:

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

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25	Trend
Concerns and Complaints	No. of concerns received	SPC		431	418	440	457	
IP&C	MSSA	1.92 (Int)		5	2	2	0	
	E.coli	7.50 (Int)		8	9	7	11	
	Pseudomonas	1.75 (Int)		3	4	1	2	
FFT	ED & UTC Positive Responses	79% (Int)		75.6%	78.5%	77.9%	76.7%	

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

Performance & Counter Measure

In October, the PALS service received 457 concerns, continuing the upward trajectory observed in recent months. Case volumes have risen steadily from 346 in June to 457 in October. Turnaround times continue to be challenging, with teams working hard to maintain quality and timeliness despite the growth demand.

Health Care Support Workers (HCSWs) and Clinical Practice Educators (CPEs) have focused recent training on personal care and hygiene, including improvements to patient assessments based on feedback from complaints and concerns. Concerns about appointment delays remain a key theme. Improvement work on improving patient experience and outpatient pathways is delivering results, with 66% of patients now seen within 18 weeks for a first appointment.

E. coli numbers increased to 11 in October, up from 6 in September. Nearly half were linked to urinary sources, with two patients having catheters. A catheter audit, conducted in partnership with BD, was completed in October to support targeted improvements.

For ED & UTC key themes for improvement include waiting times, communication during delays, and ensuring patients are kept informed about the next steps in their care. In October the teams continued to work through initiatives to improve patient experience such as:

- Enhancing communication through digital screens to provide patients in waiting areas with up-to-date information.
- Engaging volunteers to support the collection of real-time patient feedback through questionnaires.
- Implementing enhanced senior nurse quality rounds with a focus on key factors influencing patient experience.

Risks

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

Our Care

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25
Harm	Patient safety incident investigation	SPC		5	0	2	0
	No. of Falls in month	SPC		87	73	83	86
	No. falls with moderate harm or above	SPC		4	0	1	4
	Medication incidents with moderate harm	SPC		1	2	1	4
	Pressure Ulcer (Hospital Acquired)	SPC	L	5	10	10	11
	No. of complaints received	SPC		81	66	75	72
	Number of reopened complaints	SPC		6	3	3	5
IP&C	C.Diff	4.50 (Int)	?	5	4	2	4
	MRSA	0 (Int)	?	0	1	0	0
	Klebsiella	2.17 (Int)	?	1	5	3	2

Performance & Counter Measure

No Patient Safety Incident Investigations (PSII) were reported in October. There are 20 PSII's in progress with 17 overdue against Trust internally set timelines. Progress reports from the Divisions are now discussed and reviewed regularly to ensure timely closure and learning dissemination. A number of investigations are in the final stages, waiting amendments before being presented at the Learning to Improve Group.

The number of falls reported in month is 86 which is an increase from the 83 reported in September.

Hospital-acquired pressure ulcers were stable at 11 in October (10 in September). The rate per 1000 bed days is 0.60. This sits below our reduction trajectory. The improvement focus is on the 2 top contributing areas and elimination of grade 3 harms.

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

In October, the Trust received 72 new complaints, a similar level to the prior month however response rates improved by 3% to 72%. The number of reopened complaints is 5 this month. Although this is an increase on the prior month, the number remains reassuringly low.

The Trust remains above trajectory for all gram-negative bloodstream infections (GNBSI). In October, E. coli and Pseudomonas infections increased, while MSSA cases remained at zero. Klebsiella infections were stable at two cases, consistent with September.
A significant proportion of GNBSI cases were linked to urinary tract infections (UTIs). An external audit of catheter practice was completed in October; results are awaited to inform ward-level improvement plans. Medicine and Surgery and Planned care continue to focus on improving cannula practice. Results from an external hand hygiene audit have been received and will be shared with divisions in November to drive compliance and improvement.

Risks

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

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

Our Care

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25
Safer Staffing	Safer Staffing – average fill rate RN (%)	85.0% (Nat)	P	95.9%	93.1%	91.8%	89.4%
	Safer Staffing – average fill rate HCA (%)	85.0% (Nat)	P	113.0%	112.6%	120.7%	111.2%
FFT	Overall response rate (%)	30.8% (Int)	?	28.2%	34.6%	33.6%	22.0%
	Positive response (%)	90.0% (Int)	?	87.7%	91.6%	91.3%	84.3%
	ED & UTC Response Rate	19.4% (Int)	?	19.3%	19.8%	19.9%	19.8%
	Inpatients Response Rate	29.1% (Int)	?	26.7%	31.4%	30.3%	28.7%
	Inpatients Positive Responses	90.4% (Int)	?	88.4%	92.3%	92.6%	90.6%
	Daycases Response Rate	29.2% (Int)	?	26.7%	30.4%	29.9%	31.2%
	Daycases Positive Responses	94.9% (Int)	?	93.1%	98.7%	96.6%	95.8%
	Outpatients Positive Responses	95.1% (Int)	?	98.9%	98.7%	98.4%	90.0%
	Maternity Response Rate	45.3% (Int)	?	27.1%	28.8%	25.6%	14.8%
	Maternity Positive Responses	92.3% (Int)	?	94.2%	96.0%	95.2%	91.6%

Performance & Counter Measures

Safe Staffing fill rates has remained above the National target and are within safe parameters although a drop below 90% for the first time.

Friends and Family Test (FFT) data remains disrupted due to our current external supplier no longer managing card production. Cards are still available in wards and departments for completion but are not processed and do not currently form part of the national data reporting. Several improvement initiatives are currently underway to positively influence Friends and Family Test (FFT) outcomes.

A consistent theme emerging from feedback relates to communication, particularly during the discharge process. Improvement work is ongoing to clearly define roles and responsibilities, ensure that staff are aware of the terminology used around discharge and that there is clear communication with patients and families. The work is being led by the Matron for Patient flow.

Other improvement work includes: Putting the Hospital to bed project to improve the sleep environment, launch of a new carers support passport, additional clinical practice educators and a focus on Health care support workers training of patient personal care needs along with the launch of our new trust behaviours.

No increase in complaints noted so decreased positive response rate may be linked to lower responses. Patient experience coordinator has resumed daily walk throughs of all areas to promote service and explore increasing accessibility to all service users.

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

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25	Trend
RTT	No. of >=18 weeks waiters		H	15218	15869	15986	16401	
	No. of >=52 weeks waiters		L	707	646	573	559	
DM01	No. of patients on DM01 waitlist		L	8281	7254	7401	One month behind	
	DM01 performance %	99% (Nat)	F	86.4%	89.0%	90.2%	One month behind	
	DM01 6 week wait breaches		L	1123	797	724	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	F	69.3%	65.6%	65.8%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	92.9%	89.8%	83.6%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	45.2%	48.4%	51.3%	One month behind	
	% 28 day faster diagnosis	75% (Nat)	F	74.5%	65.6%	61.4%	One month behind	

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

Performance & Counter Measure

Diagnostics

October's validated DM01 performance showed an increase in performance from 90.2% to 92.86%. The number of patients on the waiting list has decreased by 205 to 7,201. There are now 554 patients waiting over 6 weeks vs 729 last month.

Counter measures: Radiology now have a specialist CT outsourcing provider to support on the mobile pads with complex scans which make up the majority of the long waiters (Cardiacs and Colons). Activity for the imaging vans on the CDC site is now achieving 90% utilisation for MRI and CT. Ultrasound still remains the largest issue with 2,550 on the waiting list and 307 over 6 weeks, but this is recovering well and Audiology represent a risk to YE performance but have recovered to 85.14%. WLIs continue to be in place to support Endoscopy with the Endoscopy CDC due to open on the 18th November.

Cancer

62 Day performance remains heavily impacted by pathway issues in Urology, where diagnostic reporting delays and all options nature of prostate patients means a large number of breaches continue. 28% of the 81 breaches were on a Urology pathway

31D performance fell short in September due to capacity issues in theatres and outpatients. Of the 36 pathways that breaches, 16 were in Skin (Outpatient capacity) and 9 were in Breast (Elective capacity).

Cancer waiting times for first appointment remain below standard. Skin is the largest contributors with 46% of all breaches. Outpatient capacity was the main reason for breaches, being responsible for 82% of breaches.

Cancer Faster Diagnosis is heavily impacted by the capacity issues seen in the Skin, Colorectal and Breast pathways. Skin accounted for 34.1% of breaches, where 91% related to outpatient capacity. 61.5% of all breaches were as a result of outpatient capacity.

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	68.9%	67.8%	68.1%	69.9%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	5.6%	5.7%	7.4%	7.4%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	50.8%	48.3%	48.5%	49.0%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	11.1%	10.6%	14.3%	14.6%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	87.6%	89.6%	88.4%	91.8%	
	Total ED Type 1 Attendances (all arrival methods)	SPC	H	5851	5788	5926	6185	
	Emergency Care - AED - Median Stay	240 (Int)	F	240	290	285	281	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4-hour performance (type 1 and 3) remained consistent at 69.9 (up 1.8%). This is 10.2% below the 25/26 national target. The reduction in overall performance relates to type 3 performance consistently below 90% over last few months (previously sustained at 95% or above) and Type 1 consistent at around 45%.

Total % over 12 hours (Type 1) increased 0.3% from last month at 14.3%. This is over target. Any prolonged length of stay in ED leads to overcrowding and subsequent delays in ambulance offload.

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

Risks

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25
RTT	No. of >=78 weeks waiters	SPC		2	4	5	3
	No. of referrals received	SPC		2186	1885	2181	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.1%	0.2%	0.1%	0.1%
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC		87.8%	88.9%	88.2%	88.3%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		60.7%	64.4%	58.7%	58.2%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		57.1%	60.2%	50.9%	51.6%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	208	210	208	199
	Emergency Care - UTC - Median Stay	240 (Int)	P	158	153	165	153

Performance & Counter Measure

ED, CEU & UTC

ED – 4,947, CEU – 949, UTC – 6,112

Triage performance for ED for 15-minute reduced 0.5% from 58.7 to 58.2%.

For Type 3 (UTC only) triage performance within 15 minutes increased 0.7% from 50.9% to 51.6%.

Risks

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

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25
ED	Total Number of Ambulance Handovers	SPC		2129	2268	2057	2285
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		1422.47	1171.56	1820.91	690.90
	Number of Ambulance Handover Over 15 Minute Waits	SPC		1475	1548	1615	1655
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC		69.3%	68.3%	78.5%	72.4%
	Number of Ambulance Handover 30 Minute Waits	SPC		875	914	1076	916
	Percentage of Ambulance Handover Over 30 Minutes	SPC		41.1%	40.3%	52.3%	40.1%
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		502	459	637	217
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		24%	20%	31%	9%
	Average hours lost to ambulance handover delays per day	SPC		46	38	61	22

Performance & Counter Measure

ED, CEU & UTC

Number of ambulance conveyances increased in October to 2285, an increase of 228 on September. Despite this, average daily hours lost reduced to 22, a decrease of 39 from September.

Risks

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

Our Performance

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		506	505	583	585
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		278	282	291	290
	Elective Patients Average Length of Stay (Days)	SPC		3.9	3.2	3.1	3.6
	Non-Elective Patients Average Length of Stay (Days)	SPC		6.2	6.1	6.5	6.4
	GWH Discharges by Noon (%)	SPC		16.3%	16.5%	16.5%	14.8%
	Number of Stranded Patients (over 14 days)	SPC		110	116	134	141
	Number of Super Stranded Patients (over 21 days)	SPC		61	62	80	86
	Adult general and acute type 1 bed occupancy	SPC		98.6%	98.4%	99.0%	99.3%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	H	19.9%	22.3%	22.9%	21.2%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.90%	95.61%	96.09%	95.76%
	The Number of Patients in Temporary Escalation Spaces within ED	SPC		20	24	27	28
	Total adult general and acute Temporary Escalation Space beds occupied	SPC		3	2	7	9
	Total paediatric general and acute Temporary Escalation Space beds occupied	SPC		0	0	0	0
	Total Temporary Escalation Space beds occupied	SPC		3	2	7	9

Performance & Counter Measure

Patient Flow

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

Risks

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

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

Use of Resources

Great Western Hospitals NHS Foundation Trust

Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25
Use of Resources	Capital Expenditure (£'000)	SPC		901	1085	774	-1723
	Pay (£'000)	SPC		27046	26768	27595	27286
	Non Pay (£'000)	SPC		17611	17661	17385	17596

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

Performance & Counter Measure

Capital spend at M07 is £4.2m against a plan of £12.0m, giving an underspend against plan of £7.8m. The £4.2m includes a £2.6m disposal of community property. Other key underspend drivers are EPR (£1.2m), estates schemes (£0.5m) and equipment replacement (£0.5m) with the remainder due to divisional related CDEL schemes. The Trust was advised to slow its capital schemes due to its revenue position in M02, which has also contributed to the profile of spend being behind plan.

M07 pay costs are £0.3m lower than M06 due to bank holiday costs of £0.2m and lower medical agency spend. Temporary staff costs are expected to reduce over Q3 as substantive staff are fully trained.

Non-Pay costs are £0.2m higher than M06 due to higher clinical supply spend as a result of a 5 week month. VAT credits of £0.3m in prior month were offset by lower estates related accruals.

Risks

The £8.0m shortfall on the Trust's cash releasing efficiency savings programme at M07 is a key driver behind the £10.6m adverse variance to budget. Delivering on the overall efficiency savings target of £32.4m through recurrent cash out schemes, particularly on pay with associated WTE reduction, is vital if the Trust if to achieve its breakeven plan in 25/26.

Our People

NHS
Great Western Hospitals
NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jul-25	Aug-25	Sep-25	Oct-25
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	11.9%	13.1%	12.8%	One month behind

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

Performance & Counter Measure

- Leavers within their 1st year of employment decreased in September to 12.8%. Performance is still below the Trust KPI of 14.8%.
- Staff survey response rates will be available in December once the current annual staff survey has concluded. At present there is no change to this metric.

Risks

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

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

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Trend Vs	
																		Last Month	Oct-24
		Vacancy																	
	W	Vacancy Rate	%	7.00%	3.09%	5.93%	3.51%	2.99%	0.88%	4.29%	4.28%	4.26%	4.18%	4.25%	3.67%	3.04%	2.40%	↓	↓
	W	Vacancy Rate	WTE	-	167.98	331.34	191.83	162.52	46.82	237.77	215.93	215.09	210.64	214.60	185.13	153.23	120.97		
	W	All Nursing Vacancy	%	7.00%	-110.9%	-63.3%	-51.1%	-72.4%	-68.8%	-100.2%	0.1%	0.1%	0.1%	0.0%	-0.7%	-1.4%	-1.8%	↓	↑
	W	All Nursing Vacancy (Reg & Unreg)	WTE	-	-1391.36	-1020.17	-887.72	-1103.75	-1081.84	-1331.81	3.52	1.47	1.23	-1.17	-16.13	-33.00	-43.91		
	W	All Registered Nursing Vacancy	WTE	-	-764.34	-483.87	-411.03	-581.33	-641.89	-784.53	-10.86	-7.52	-9.24	-10.35	-17.41	-37.44	-52.63		
	W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	-817.72	-773.38	-758.91	-804.24	-749.10	-742.52	-41.18	-38.96	-38.48	-40.30	-44.56	-61.01	-71.45		
	W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	-631.02	-538.10	-476.69	-522.42	-439.95	-547.28	14.38	8.99	10.47	9.18	1.28	4.44	8.72		
	W	Medical Vacancy	%	7.00%	28.28%	16.18%	9.71%	21.43%	32.10%	37.27%	8.31%	8.05%	8.10%	8.00%	4.60%	2.55%	0.09%	↓	↓
	W	Medical Vacancy	WTE	-	271.64	134.97	74.37	187.89	322.41	408.25	61.95	59.95	60.35	59.64	34.29	18.97	0.70		
	W	STT/AHP Vacancy	%	7.00%	36.8%	29.4%	20.7%	25.6%	33.8%	42.9%	8.3%	7.7%	7.1%	7.4%	7.5%	6.4%	5.5%	↓	↓
	W	STT/AHP Vacancy	WTE	-	479.37	344.88	219.63	290.59	432.51	635.84	66.18	61.87	56.78	59.15	59.90	51.32	44.34		
	W	SMA Vacancy	%	7.00%	42.2%	44.3%	41.4%	41.4%	25.1%	32.1%	7.5%	8.2%	8.3%	8.7%	9.6%	10.4%	10.7%	↑	↓
	W	SMA Vacancy	WTE	-	808.33	871.66	785.54	787.79	373.74	525.49	84.28	91.80	92.28	96.98	107.07	115.94	119.84		
	W	Recruitment Time to Hire - AFC	Days	46.00	42.80	41.40	39.50	42.19	44.30	33.60	34.80	36.40	39.70	37.70	41.30	40.30	39.10	↓	↓
	W	Recruitment Time to Hire - Bank	Days	46.00	26.70	42.90	37.50	42.90	42.70	38.30	40.00	18.00	40.20	61.10	51.70	28.50	26.50	↓	↓
	W	Recruitment Time to Hire - Medical	Days	46.00	38.40	44.50	36.80	45.02	41.00	36.50	38.00	37.40	40.20	49.00	40.10	39.50	35.50	↓	↓

Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Trend Vs Last Month	Trend Vs Oct-24
		Workforce Utilisation																	
	W	Substantive WTE	WTE	-	5,262.88	5,255.94	5,270.32	5,276.50	5,303.02	5,307.53	4,827.81	4,828.65	4,833.10	4,829.14	4,858.61	4,890.51	4,922.77		
	W	Additional Substantive WTE	WTE	-	9.62	13.99	11.26	12.96	13.66	16.45	11.97	11.84	9.79	9.54	10.88	11.32	11.83		
	W	Bank WTE	WTE	-	270.61	289.89	270.37	325.49	305.77	413.99	311.69	306.31	270.91	287.37	304.15	241.73	274.78		
	W	Agency WTE	WTE	-	23.84	25.72	38.68	39.05	31.77	64.42	48.54	54.27	45.68	44.12	29.32	27.72	26.43		
	W	Total WTE Utilised	WTE	-	**5,566.95**	**5,585.54**	**5,590.63**	**5,654.00**	**5,654.22**	**5,802.39**	**5,200.01**	**5,201.07**	**5,159.48**	**5,170.17**	**5,202.96**	**5,171.28**	**5,235.82**		
	W	Planned Establishment WTE	WTE	-	5,430.86	5,587.28	5,462.15	5,439.02	5,349.84	5,545.30	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74		
	W	Variance to planned est	WTE	-	136.09	-1.74	128.48	214.98	304.38	257.09	156.27	157.33	115.74	126.43	159.22	127.54	192.08		
	W	GL Funded Establishment WTE	WTE	-	5,442.77	5,448.21	5,457.86	5,458.82	5,470.42	5,470.42	5,043.74	5,043.74	5,043.74	5,043.74	5,215.77	5,204.43	5,202.37		
	W	Variance to GL funded	WTE	-	124.18	137.33	132.77	195.18	183.80	331.97	156.27	157.3	115.7	126.4	-12.8	-33.1	33.45		
	W	Planned Est, vs GL Funded	WTE	-	-11.9	139.1	4.3	-19.8	-120.6	74.9	0.0	0.0	0.0	0.0	-172.0	-160.7	-158.63		
	W	Actual Worked vs Planned Establishment	%	-	102.51%	99.97%	102.35%	103.95%	105.69%	104.64%	103.10%	103.12%	102.29%	102.51%	103.16%	102.53%	103.81%		
	W	Total Workforce Cost £	£	-	£36.50M	£26.75M	£28.12M	£27.24M	£27.93M	£28.58M	£26.55M	£26.60M	£26.34M	£25.70M	£30.78M	£27.60M	£27.27M		
	W	Agency Spend as % of Total Spend	%	4.50%	1.23%	1.64%	1.60%	2.52%	1.97%	2.14%	2.26%	2.40%	2.75%	1.82%	1.70%	1.78%	0.97%	↓	↓
	W	Agency Spend £	£	-	£0.45M	£0.44M	£0.45M	£0.69M	£0.55M	£0.61M	£0.60M	£0.64M	£0.72M	£0.47M	£0.52M	£0.49M	£0.26M		
	W	Agency Target £	£		£0.44M	£0.42M	£0.41M	£0.39M	£0.37M	£0.36M	£0.20M	£0.19M	£0.18M	£0.17M	£0.16M	£0.16M	£0.15M		
	W	Agency Spend vs Target £	£ Diff	£0.00M	£0.01M	£0.01M	£0.04M	£0.30M	£0.18M	£0.25M	£0.40M	£0.45M	£0.55M	£0.30M	£0.36M	£0.33M	£0.12M	↓	↑
	W	Bank Spend £	£	-	£2.29M	£2.15M	£2.21M	£1.71M	£2.66M	£2.70M	£2.21M	£2.18M	£2.05M	£1.92M	£2.36M	£1.97M	£1.94M		
	W	Bank Target £	£		£1.73M	£1.65M	£1.57M	£1.50M	£1.42M	£1.34M	£2.90M	£2.56M	£2.22M	£1.88M	£1.53M	£1.19M	£1.31M		
	W	Bank Spend vs Target £	£ Diff	£0.00M	£0.56M	£0.50M	£0.64M	£0.22M	£1.24M	£1.36M	-£0.69M	-£0.38M	-£0.17M	£0.05M	£0.83M	£0.78M	£0.63M	↓	↑
		Retention																	
	W	All Turnover %	%	13.00%	11.08%	11.14%	11.24%	11.08%	11.01%	11.26%	11.31%	11.16%	10.85%	10.74%	10.38%	10.20%	-	↓	↓
	W	Voluntary Turnover %	%	11.00%	8.80%	8.75%	8.78%	8.62%	8.48%	8.55%	8.41%	8.29%	8.13%	7.94%	7.68%	7.49%	-	↓	↓
	W	Number of Leavers	Headcount	-	54	41	45	35	30	70	38	32	43	41	43	50	-		
	W	Number of RN Leavers	Headcount	-	13	13	14	9	8	12	8	8	11	9	9	13	-		
	W	Registered Nursing Vol Turnover	%	-	7.39%	7.32%	7.47%	7.25%	7.28%	6.96%	6.51%	6.16%	6.01%	5.80%	5.46%	5.69%	-		
	W	Number of Unreg Nursing Leavers	Headcount	-	12	8	12	1	5	9	6	10	9	8	8	8	-		
	W	Unregistered Nursing Vol Turnover	%	-	10.87%	10.98%	10.97%	10.27%	9.77%	10.06%	9.45%	9.81%	9.21%	9.38%	9.49%	9.13%	-		
	W	Leavers within 1st Year - Rolling 12 Month	%	-	11.04%	9.68%	9.90%	9.02%	10.37%	10.94%	10.30%	11.68%	0.00%	11.93%	13.09%	12.84%	-		
	W	Number of starters	Headcount	-	52	46	37	55	53	51	36	24	47	39	48	92	-		

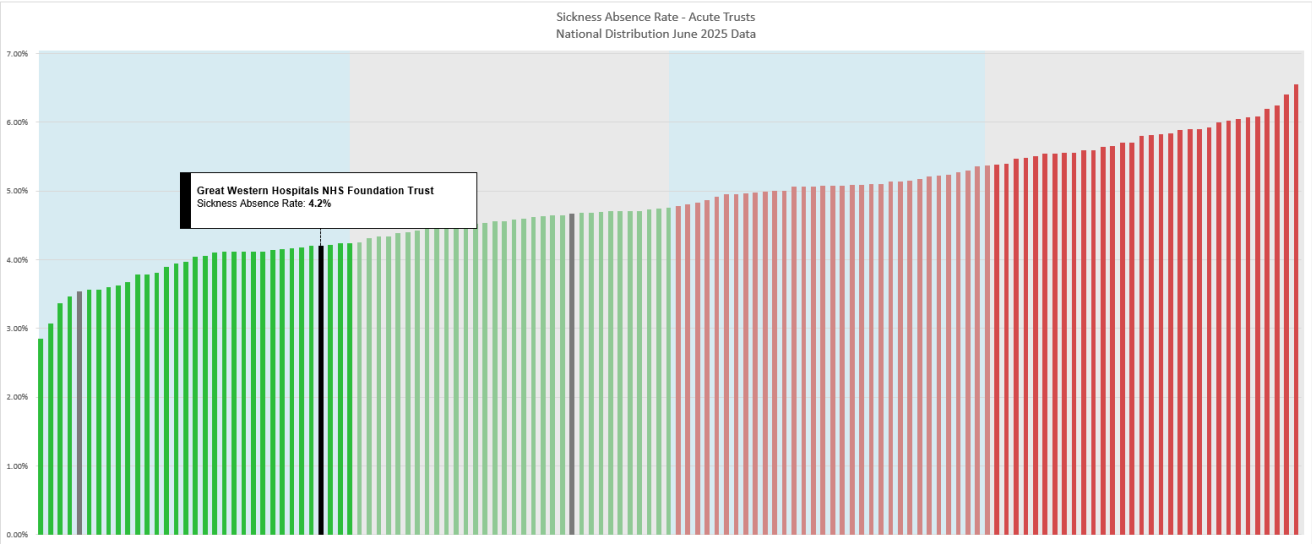
Our People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Pillar	Type	Metric	Unit/Measure	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Trend Vs	
																		Last Month	Oct-24
		Absence																	
	D	Sickness Absence % Rolling 12 Month	%	3.50%	4.57%	4.59%	4.59%	4.61%	4.65%	4.68%	4.68%	4.68%	4.65%	4.59%	4.57%	4.55%	-	↓	↓
	D	Sickness Absence %	%	3.50%	4.87%	4.88%	4.94%	5.14%	4.92%	4.49%	4.13%	4.11%	4.22%	4.44%	4.29%	4.08%	-	↓	↓
	W	Long Term Sickness %	%	2.00%	2.29%	2.26%	2.33%	2.12%	2.49%	2.22%	2.12%	2.09%	2.24%	2.30%	2.40%	2.05%	-	↓	↓
	W	Short Term Sickness %	%	1.50%	2.58%	2.62%	2.60%	3.02%	2.42%	2.26%	2.01%	2.02%	1.98%	2.14%	1.88%	2.03%	-	↑	↓
	W	Sickness Absence Cost £	£	-	£873.5k	£860.3k	£866.9k	£897.5k	£773.1k	£815.5k	£681.0k	£702.2k	£685.5k	£769.3k	£760.1k	£742.3k	-		
	W	WTE Days Lost	WTE	-	7,958.5	7,725.1	8,081.5	8,414.0	7,299.3	7,397.7	5,979.0	6,159.6	6,117.3	6,674.6	6,456.8	5,979.9	-		
		Learning & Development																	
	W	Mandatory Training Compliance %	%	85.00%	90.58%	89.79%	90.06%	90.27%	90.03%	90.03%	90.46%	90.94%	91.66%	91.60%	91.10%	91.38%	91.23%	↓	↑
	W	Role Essential MT %	%	85.00%	90.57%	88.86%	89.37%	89.79%	89.70%	89.86%	90.57%	90.95%	91.77%	91.95%	91.33%	91.70%	91.68%	↓	↑
	W	CQC Safe MT %	%	85.00%	90.58%	90.97%	90.95%	90.89%	90.45%	90.24%	90.33%	90.92%	91.52%	91.15%	90.79%	90.99%	90.67%	↓	↑
	W	Bank-Only Mandatory Training Compliance %	%	85.00%	82.42%	84.73%	85.86%	83.96%	81.72%	80.81%	65.69%	64.67%	64.11%	73.77%	79.71%	77.67%	76.14%	↓	↓
	W	Appraisal Compliance %	%	85.00%	84.90%	84.29%	83.46%	84.51%	84.35%	84.40%	83.88%	81.56%	80.36%	80.08%	80.91%	80.81%	79.02%	↓	↓
	W	Non Medical Appraisal Compliance %	%	85.00%	84.94%	84.60%	83.81%	84.63%	84.44%	84.24%	84.15%	82.14%	81.04%	80.45%	80.90%	80.30%	78.65%	↓	↓
	W	Medical Appraisal Compliance %	%	85.00%	84.58%	82.09%	80.94%	83.68%	83.68%	85.48%	82.08%	77.82%	76.02%	77.75%	80.99%	83.98%	81.21%	↓	↓
		Demographics																	
	W	Staff in Leadership Roles % (B8a+)	%	-	4.28%	4.30%	4.26%	4.29%	4.25%	4.27%	4.30%	4.36%	4.30%	4.20%	4.15%	4.14%	4.20%		
	W	Staff in Leadership Roles WTE (B8a+)	WTE	-	276.00	277.00	275.00	278.00	276.00	277.00	255.00	259.00	256.00	252.00	248.00	249.00	254.00		
	W	% of Leadership Roles who are Female (B8a+)	%	-	70.29%	70.40%	70.18%	70.50%	69.93%	69.68%	68.24%	68.34%	67.58%	67.86%	68.15%	68.67%	69.29%		
	W	% of Leadership Roles who from BME (B8a+)	%	-	6.16%	6.50%	6.55%	6.47%	6.52%	6.50%	5.88%	6.18%	5.47%	5.56%	5.65%	6.02%	6.30%		
	W	Staff in Leadership Roles % (B8c+)	%	-	0.90%	0.93%	0.93%	0.94%	0.94%	0.92%	1.01%	1.03%	1.01%	1.00%	1.00%	1.00%	1.01%		
	W	Staff in Leadership Roles WTE (B8c+)	WTE	-	58.00	60.00	60.00	61.00	61.00	60.00	60.00	61.00	60.00	60.00	60.00	60.00	61.00		
	W	% of Leadership Roles who are Female (B8c+)	%	-	56.90%	55.00%	55.00%	55.74%	54.10%	53.33%	53.33%	52.46%	51.67%	53.33%	53.33%	55.00%	57.38%		
	W	% of Leadership Roles who from BME (B8c+)	%	-	3.45%	5.00%	5.00%	4.92%	4.92%	6.67%	5.00%	4.92%	5.00%	5.00%	5.00%	5.00%	6.56%		
	W	% of Leadership Roles who are disabled (B8c+)	%	-	3.45%	3.33%	3.33%	3.28%	3.28%	3.33%	3.33%	3.28%	3.33%	3.33%	3.33%	3.33%	3.28%		
	W	Male % of Workforce	%	-	18.40%	18.46%	18.51%	18.58%	18.61%	18.67%	19.33%	19.44%	19.51%	19.67%	19.87%	20.00%	19.98%		
	W	Female % of Workforce	%	-	81.60%	81.54%	81.49%	81.42%	81.39%	81.33%	80.67%	80.56%	80.49%	80.33%	80.13%	80.00%	80.02%		
	W	BME % of Workforce	%	-	28.30%	28.40%	28.46%	28.67%	29.29%	29.43%	30.08%	30.30%	30.65%	30.66%	30.71%	31.50%	31.63%		
	W	White % of Workforce	%	-	64.41%	64.30%	64.17%	63.94%	63.48%	63.22%	62.05%	61.76%	61.35%	61.27%	60.43%	59.79%	60.38%		
	W	ER Cases Closed	Number	-	58	48	58	54	33	41	56	46	52	48	48	55	62		

Our People



Performance & Counter Measure

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

Group Sickness Policy for Long-Term Health Conditions:
The BSW Group is committed to development of Managing Long Term Health Conditions guidance by the end November 2025 to support employee retention by demonstrating a commitment to staff well-being and helping the Trust meet legal obligations, under the Equality Act 2010 and UK GDPR, by outlining procedures for managing health data and making reasonable adjustments. The draft guidance will be shared with Staff Side at the monthly EPF in December for further consultation.

Learning From National Best Practice

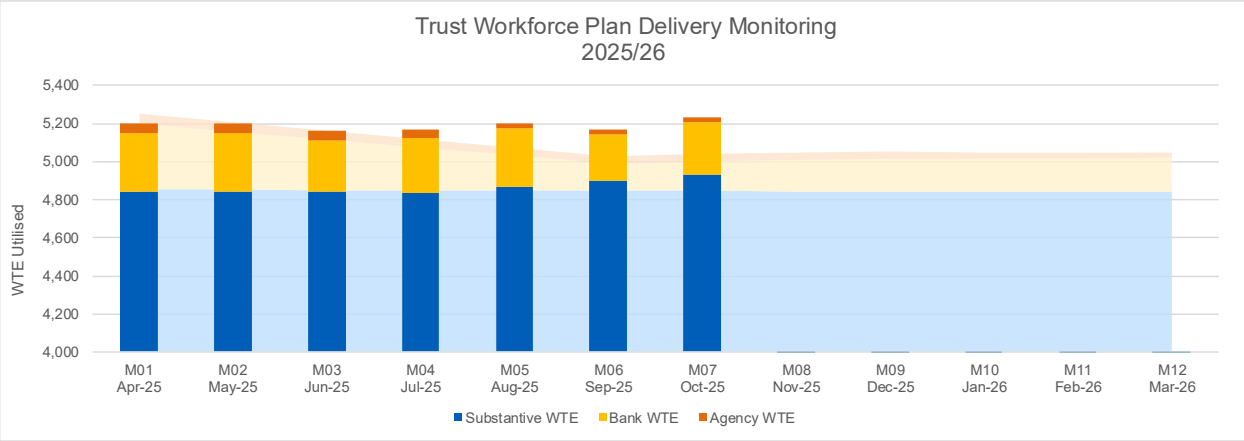
- Benchmarking discussions with the University Hospitals of Morecambe Bay and South Tees Hospitals to review their support packages provided assurance that our Trust offer is closely aligned with their best practice standard. Including health checks, wellbeing apps, recognition schemes, trauma and stress support, mindfulness and CBT courses, menopause support, and bespoke wellbeing talks.

Key highlights from the last working group include:

- Sick call guidance shared within hot spot areas including training to support Rota Coordinators or Nurses in Charge who are answering calls relating to employee absences
- In-month Absence Management (Sickness) policy training sessions held across Trust teams including Clinical Leads Network and the SAU to promote and encourage consistent practice across medical and non-medical workforce.

Our People

Workforce Delivery Plan



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

Performance & Counter Measure

In October we used 5,236 WTE to deliver our services against a planned figure of 5,042 WTE. This was an adverse variance to plan of +194 WTE and an increase compared to September of 65 WTE. Usage in October represented our highest headcount YTD, exceeding levels at M1.

Our substantive staffing position increased further in M7, increasing to 4,935 WTE and above plan by +89 WTE, where planned clinical recruitment continues to outpace reduction requirements. Temporary staffing is +105 WTE adverse to plan, an improvement compared to last month however remaining our primary pressure against our planned position.

Reviewing current performance against plan at staff group level:

- Nursing: +122 WTE to plan (of which 70 WTE for Unregistered Nursing)
- Medical: +80 WTE to plan
- AHP/STT: +22 WTE to plan

The focus remains reducing temporary staffing usage to reduce the gap against plan. To achieve this in month 8, the below reductions to bank and agency will need to be met:

- Unregistered Nursing: 66 WTE (Registered Nursing is below plan)
- Medical: 40 WTE
- AHP/STT: 17 WTE

Impact on Workforce

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

Risks & Mitigations

- There is risk that workforce levels continue above plan in 2025/26 worsening our financial position. The Workforce Recovery Meeting is being reestablished to support and monitor reduction plans.

- At present the Trust does not have material plans on how reductions for 2025/26 will be realised, and with continuing operational pressures there is further risk of growth.

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

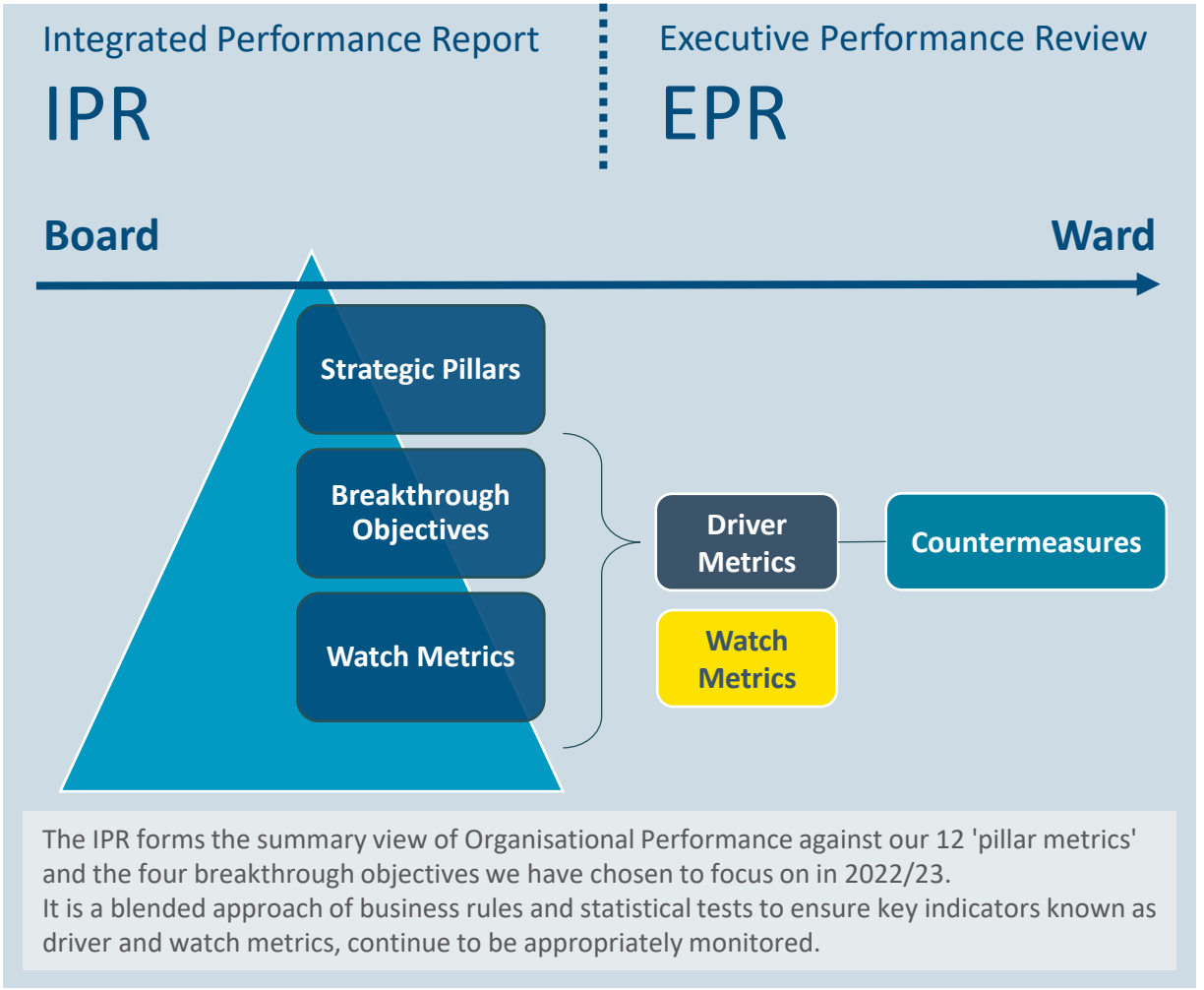
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

NHS
Great Western Hospitals
NHS Foundation Trust

Vision

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

Our four strategic pillars

Outstanding care

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

Valued teams

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

Better together

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

Sustainable future

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

25/26 Strategic Planning Framework

Great Western Hospitals NHS Foundation Trust

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

1 Our four strategic pillars

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

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

Our pillar metrics

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

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

3 Strategic Initiatives

Must do can't fail

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

4 Overlap

Corporate Projects

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

2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

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

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

NHS
Great Western Hospitals
NHS Foundation Trust

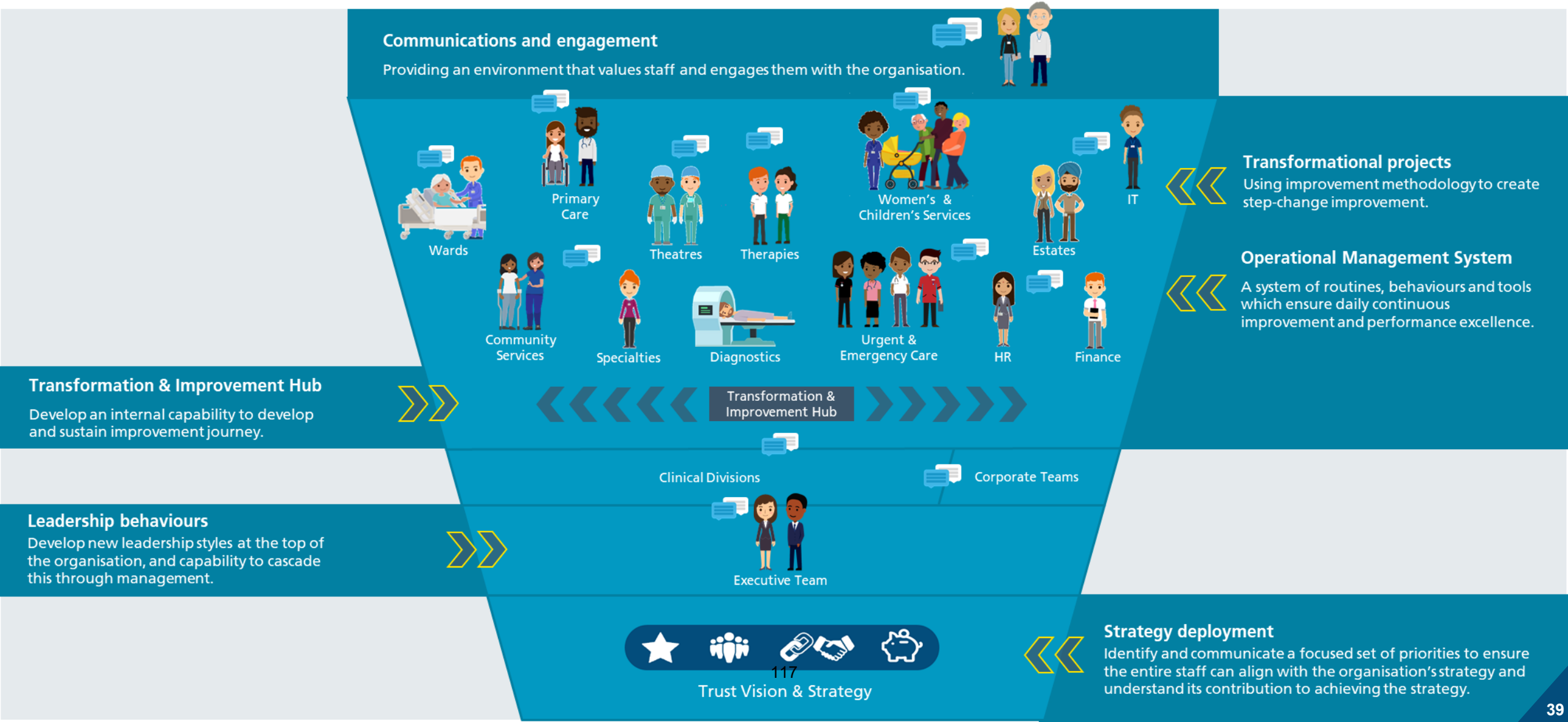
Level	Daily	Weekly	Monthly
	Continuous Improvement on Drivers		Performance Management on Driver & Watch Metrics
Exec			Exec Performance Meeting
Division		Divisional Weekly Driver	Divisional Performance Meeting
Speciality		Speciality Weekly Driver	Speciality Performance Meeting
Frontline	Improvement Huddles		Frontline Performance Meeting

Information Flow

Information Flow

Building a culture of continuous improvement

NHS
Great Western Hospitals
NHS Foundation Trust



SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

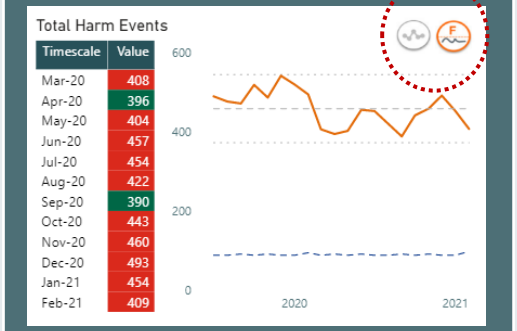
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

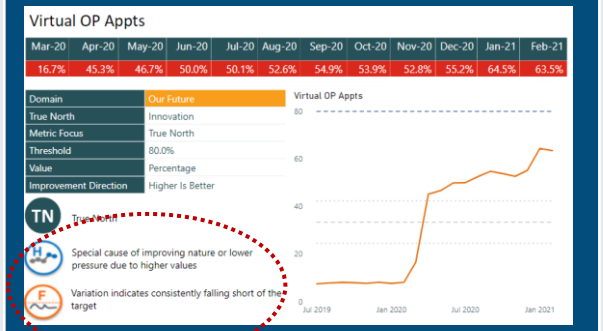
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

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

Agreed Terms

NHS
Great Western Hospitals
NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Board Committee Assurance Report

Committee	**Audit, Risk & Assurance Committee**
Meeting Date	6 November 2025
Committee Chair	Helen Spice, Non-Executive Director

Items received by the Committee	**Level of Assurance** Ratings focus on overall assurance over effectiveness of controls	**Board Action Required? Yes ✓ or No x**
1. Medicine Divisional Risk Register	Good Assurance	
2. Board Assurance Framework	Substantial Assurance	
3. 15+ Risk Register Report	Partial Assurance	
4. External Audit Update	Noted	
5. Internal Audit Progress Report and Action Tracking	Noted	✓
6. Internal Audit – Discharge Final Report	Partial Assurance	
7. Internal Audit – AI Benchmarking Report	Good Assurance	
8. Local Counter Fraud Progress Report	Noted	
9. Local Counter Fraud – Job Planning and Rostering (Radiology and Pathology) Report	Good Assurance	
10. Clinical Negligence Litigation Report Q2 2025/26	Good Assurance	
11. Losses and Compensation Report Q2 2025/26	Noted	

POINTS OF ESCALATION	The Committee reviewed the outstanding actions from the Internal Audit conducted earlier this year on EPR Implementation, which at the time was rated Limited Assurance and required immediate action to provide assurance that the issues raised were being addressed. As the actions remain outstanding and an update was not provided at the meeting, ARAC raised concerns on the lack of engagement to resolve the issues.
KEY AREAS TO NOTE	The Medicine Division updated the Committee on their processes to manage risk and their actions in place to control and mitigate those risks. The Division has made good progress over the last year with a renewed dynamic focus on their risks and have reduced their total risks by 22 overall. The Committee were assured over the processes in place. The Committee raised a concern that the previous year's financial risk had been closed without a new risk being opened. Finance is a significant risk for both the Trust and the Group and divisions need to recognised their responsibilities in taking ownership and leading on work to resolve the challenges. This however needs to be balanced with continuing to ensure a safe and secure environment for our patients and staff. They have had a key focus on mitigating their 15+ risks which have now all been closed or reduced. They have been working through their aged risks on a one to one basis – there is still some work on this that is not yet complete but it is anticipated that work will be complete soon. There has also been a focus on community demobilisation and this will result in eight risks moving out of the risk register. The Committee were assured by the work that has taken place and the progress that has been made across the Division. KPMG presented the final internal audit review on Discharge and this was rated as 'Significant Assurance with minor improvements required'. The Committee were concerned that some of the issues raised could have a significant impact on flow in the hospital which is currently one of the highest risks for the Medicine Division. Although all the actions raised were due to have been completed by 31 October 2025, the timing of the report meant that an update was not available that they had been completed. As a result the Committee agreed to rate the review as Partial assurance and requested an urgent update from management. It was noted that for future internal audit review discussions it would be helpful for the responsible executive to attend ARAC for the discussion. KPMG presented a benchmark report of AI across 22 NHS Trusts and provided a perspective on GWH's approach and current positioning on AI. GWH is only just in the process of developing their AI strategy but it was good to see that this is being aligned with the Trust strategy. There are also some very helpful insights from the KPMG benchmarks that GWH will be able to incorporate into their strategy development. The Committee is keen for the Trust to move forward at pace and referred this as an action to FIDC. November is fraud awareness month and a number of activities are taking place across the Trust to raise awareness. There have been 13 referrals received in the year to date, including one where the Trust controls prevented a potentially significant cyber attack. The Committee asked for confirmation that lessons learned from cases have been implemented. The LCFS conducted a review of job planning and rostering in Radiology and Pathology. A number of actions were raised that are underway. The Committee agree the review was a very helpful insight and provided Assurance on processes and asked that management ensured that these actions are implemented across all specialities as appropriate.

	The Committee received a report on Clinical Negligence Claims activity for Q2 2025/26. The report included benchmarking on the number of claims and related contributions, as well as the Trust's ranking across the country and the Committee welcomed this insight which demonstrated that the Trust is not out of line.
BOARD ASSURANCE FRAMEWORK & RISKS	The Committee reviewed the systems and processes around the Board Assurance Framework and the work undertaken by the Board Committees to review the BAF on a regular basis and confirmed their assurance that the BAF and its processes remain effective. The Committee received an update on the actions and processes being undertaken by management to review risk across the organisation and were assured that the processes are in place and effective although continue to raise concerns about risks with no actions. This included three high rated risks and the Committee requested urgent assurance to ensure that these risks are being appropriately managed. The Committee welcomed the actions that are being taken to ensure that project risks, including Group project risks, are being included in the overall Trust risk processes and escalated to Trust Board as appropriate. It was also noted that following the discussion at an earlier meeting on Corporate Risks that a detailed mapping has been completed and will be shared with the Committee to provide assurance that all risks are mapped into the appropriate governance routes with an ultimate route to Trust Board if required.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	The AI Benchmarking report was referred for further consideration and action to FIDC. The challenge of managing financial and safety risks with staff capacity risks in the Medicine division is being considered by the Quality and Safety Committee in conjunction with Trust management.

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

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

Board Committee Assurance Report

Committee	**Charitable Funds Committee**
Meeting Date	18th November 2025
Committee Chair	Julian Duxfield, Non-Executive Director

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Financial reporting	Good	
2. Fundraising	Partial	
3. Cases of need	Good	
4. Divisional spending plans	Good	
5. GWH Arts Programme update	N/A	
6. Charity Annual Trustee Report & Accounts 2024-25	N/A	
7. External review action plan	Partial	

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	The total value of the Trust's overall charitable funds on 30th September 2025 were £792k of which £580k is restricted and £212k is unrestricted. Prior to the meeting the general fund's uncommitted balance stood at £107k, above our agreed minimum threshold of £57,000. The disappointing level of income generation has been caused by a significantly depleted charity team. This situation has been largely rectified with staff appointments and moves, as a result the income position should see improvement over the next 3-6 months. Cases of need: It was agreed to provide £30k as initial 'pump priming' funding for the Chemotherapy Appeal. The recent relocation of SACT (systemic anti-cancer treatment) services means there is an opportunity to renovate an unused area (hydrotherapy pool) to expand our health/wellbeing offer and estate to patients and their families. This will involve codesigning the space with patients, relatives and staff following a period of fundraising with our Trust Charity. As in previous years it was agreed, in principle at this stage, to support a range of staff recognition events. Funding will be released for these as funds become available. The committee agreed that arts should be become a core part of the GWH charity strategy and that the focus should be on leveraging corporate partnerships and utilising existing relationships with other charities that provide arts services. Each Fundraising Manager will be briefed on how to incorporate creative concepts into projects, staff requests and donor approaches. The committee approved the Charity Annual Trustee Report & Accounts 2024-25. Deloitte have completed an independent examination and raised no material concerns as part of their review. Online submission to Charities Commission is due by 31 January 2026.

BOARD ASSURANCE FRAMEWORK & RISKS	Each of the divisions presented a summary of their charitable funds. In all three cases the sum of the committed and new project spends was between 65-70% of available funds. As previously, the external review action plan was assessed at 'partial' pending approval of the funds rationalisation project. This is due to be delivered at the start of the new financial year and will substantially reduce the number of charitable funds across the Trust which will help move from a restrictive model of fund management to a more strategic and flexible approach to deliver the best for the hospital and its patients. Divisions are being engaged with the preparations for this move.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	None

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

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

Report Title	**Perinatal Services Six Month Summary (Q1 & Q2 2025/26)**				
Meeting	**Trust Board**				
Date	**11/12/2025**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Luisa Goddard				
Report Author	Kat Simpson (Director of Midwifery & Neonatal Services) Laura Little (Project Coordinator)				
Appendices	N/A				

Purpose

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

Assurance Level

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

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

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

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

Report

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

This six-month update on perinatal services provides a comprehensive overview of progress mapped against key priorities, including CQC must-do and should-do actions and the Three-year Plan for Maternity and Neonatal Services. This review demonstrates the commitment to strengthening perinatal care through improved staffing, addressing health inequalities, and fostering a positive culture within our workforce.

Our roadmap for the coming months includes maximising the use of our digital systems, engagement in the NHS England led review and improvements in maternity and neonatal services and further embedding co-production for all aspects of the service.

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

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

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

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

Explanation of above analysis:

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the progress within the service against the Three-Year Maternity & Neonatal Delivery Plan and the impact on the development of the perinatal services to make care safer, more personalised and more equitable.

Accountable Lead Signature	Luisa Goddard.
Date	**07/11/2025**

Perinatal Service Summary

April - September 2025 (Q1 & Q2)

Overview of Perinatal Service Summary

- This presentation provides an update on perinatal services with a comprehensive overview of progress
- Progress across the service has been mapped against key national and local priorities including:
  - CQC must-do and should-do actions for Great Western Hospital
  - Three-year Delivery Plan for Maternity & Neonatal Services
- All CQC Must Do and Should Do actions are underpinned by detailed improvement action plans with dedicated senior management ownership. An action summary position mapped against the service priorities is included throughout this perinatal review.
- Ongoing focus on improving footprint and estate to futureproof services.
- This review demonstrates the commitment to strengthening perinatal care through improved staffing, addressing health inequalities, and fostering a positive culture within our workforce
- Our roadmap for the coming months includes maximising the use of our digital systems, engagement in the NHS England led review and improvements in maternity and neonatal services and further embedding co-production for all aspects of the service.

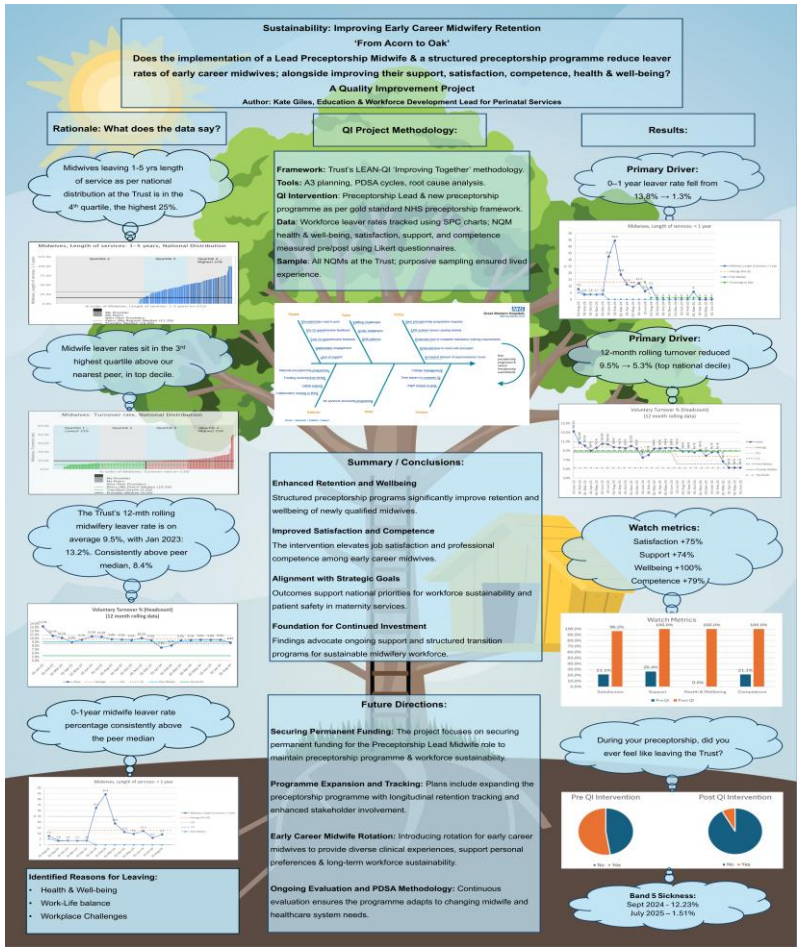
MD1	•The service must ensure staff are up to date with maternity mandatory training modules.
MD2	•The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night.
MD3	•The service must ensure non-compliant audits are acted upon and improvement plans put in place
MD4	•The service must ensure incidents are managed well, including but not limited to effective sharing of learning, using learning to effect change and improvement in practice.
MD5	•The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, consistent use of SBAR, consistency and accuracy over several record-keeping systems
SD1	•The service should ensure that staff are compliant with MEOWS and ensure effective audit programme is in place
SD2	•The service should ensure all incidents are monitored by ethnicity. In order to identify potential health inequalities

Workforce & Training

- The service has implemented a successful preceptorship programme to support early career midwives throughout their first year of practice. The quality improvement initiative has demonstrated:
  - A significant reduction in turnover within their first year of practice
  - A reduction in sickness rates
  - A positive improvement in self reported role satisfaction and overall wellbeing

- Following workforce investment and a successful recruitment programme the Paediatric and Neonatal consultant roster are now operating independently. This has enabled the service to support a fully operational Transitional Care. There is continued investment in development opportunities which is enabling more staff to achieve the Qualified in Speciality (QIS) certificate for intensive care and access to Advanced Neonatal Nursing training.

- System wide approach to succession planning in development across the three Trusts to support career progression opportunities, operational and leadership resilience within the service, and provide a framework to align within a group model



- The service has an ongoing focus for expanding and developing the Band 3 workforce. This includes improving pathways for career progression and supporting the development of skills and abilities.

Three Year Delivery Plan

CQC GWH Actions

Objective 4 Grow Our Workforce

Objective 5 Value & Retain Our Workforce

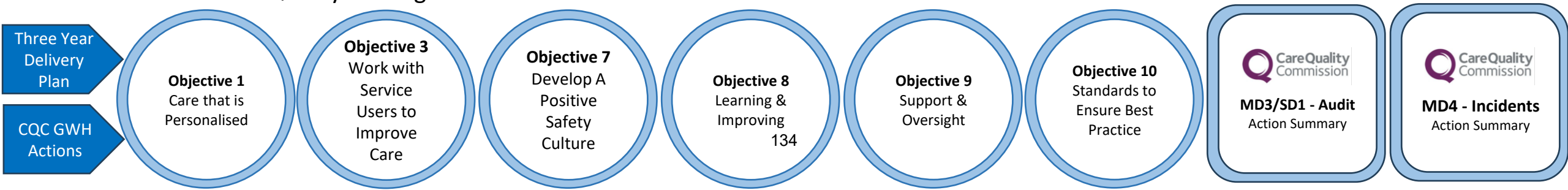
Objective 6 Invest In Skills

Care Quality Commission

MD1 - Training Action Summary

Quality & Safety

- A Regulation 28 Prevention of Future Deaths report was issued by HM Coroner following the inquest into the death of Mabel Olivia Williams. We extend our sincere condolences to her family and reaffirm our commitment to learning and improving care in response to this report.
- In response, the Trust has undertaken a comprehensive review of patient information materials, particularly around VBAC and uterine rupture, and has implemented improvements to ensure informed consent is enabled facilitated by accessible pathways for communication.
- Governance processes have been strengthened to ensure timely implementation of learning from serious incidents, with enhanced oversight, accountability, and a centralised tracking system to support sustainable change.
- Nationally the maternity governance pathways are undergoing a period of change led by NHS England with the introduction of new reporting frameworks and supporting processes.
    - **Introduction of the Perinatal Quality Oversight Model (PQOM):** The PQOM replaces the previous surveillance model to provide a proactive, structured approach to identifying and addressing risks in maternity and neonatal services. It establishes clear responsibilities across trusts, ICBs, regions, and national bodies, with a focus on improving safety, equity, and quality through shared intelligence, service user voice, and collaborative governance.
    - **MOSS (Maternity Outcomes Signal System)**: A new NHS England safety surveillance tool using near real-time data to detect early signals of risk, such as term stillbirths, neonatal deaths, and brain injuries, enabling rapid response and governance escalation under the Perinatal Quality Oversight Model.



Digitalisation of Services

- Following implementation of the new electronic documentation system in January, all women currently receiving maternity care from the service have utilised BadgerNET from booking as their maternity care record.
- BadgerNET is now live across all three organisations within the BSW System which is providing the opportunity for an aligned approach to maternity documentation and reporting
- The Trust have made available BadgerNotes to all women accessing maternity care at GWH, this enables women to have access to their own care records without the need for handheld maternity notes. Currently there has only been a small number of patients who have chosen not to utilise the app; these individuals have been provided with printed records and traditional handheld “orange” notes.

- Following feedback from staff a period of focussed support to maximise effective use of the electronic system is underway to ensure all reporting capabilities are achieved
- As part of ongoing commitment to supporting staff and enhancing digital engagement across the service, this year our mandatory education programme for clinical staff includes allocated time to share best practice around the use of BadgerNet.
- Preparations for the release of NEWTT2 within BadgerNet remain a key focus for the Digital Maternity team, with the system due to go live across the unit on 18 November.

Three Year Delivery Plan

CQC GWH Actions

Objective 2 Improve Equity for Mothers & Babies

Objective 10 Standards to Ensure Best Practice

Objective 11 Data To Inform Learning

Objective 12 Make better use of digital technology

CareQuality Commission

MD5 - Digital Action Summary

Continued Service Improvements from Service User Feedback

- Coproduction with our Maternity & Neonatal Voice Partnership (MNVP) of a patient focussed infographic to support informed choice for women about place of birth

- Following feedback from service users, the Trust have introduced a dedicated feeding support space with drop-in education sessions which are held daily on Hazel Ward. These have been positively received by service users and are being accessed by inpatients during both the antenatal and postnatal periods.
- Door signage has been developed and introduced for use on Hazel Ward to indicate if a baby is being cared for on the Neonatal Unit as a visual reminder for all staff to be aware of the impact of separation for parents and baby

- In response to a drop-in rates of breastfeeding babies born before 34 weeks gestation our infant feeding team have focussed improvements on providing feeding support for parents on the unit. A dedicated nursery nurse with extensive knowledge on infant feeding was available for parents on LNU and a range of positive benefits have been reported.
  - An increase in the breastfeeding rates at discharge
  - Improved staff morale
  - Significant improvement in parent satisfaction supported by written feedback

Three Year Delivery Plan

CQC GWH Actions

Objective 1 Care that is Personalised

Objective 2 Improve Equity for Mothers & Babies

Objective 3 Work with Service Users to Improve Care

Objective 5 Value & Retain Our Workforce

Objective 8 Learning & Improving

Objective 11 Data to Inform Learning

CareQuality Commission

SD2 - Inequality Action Summary

Ongoing Focus

- A coproduced strategic plan for perinatal services is under development with key performance metrics which will inform Board updates looking forward into 2026/27. This is fully aligned to the Trust vision, strategy and priorities.
- Following the Secretary of State's announcement of a rapid independent investigation into maternity and neonatal services, NHS England have outlined key initiatives to accelerate improvements in care quality, equity, and safety which will guide local ongoing focus.
  - NHS England has launched a national programme to tackle inequalities in maternity and neonatal care, focusing on anti-discrimination, cultural competence, and trauma-informed support.
  - Engagement with a new digital portal (SPEN) which is now live for streamlined reporting of perinatal safety events, improving data sharing and early risk identification.
  - Trusts will use a refreshed NHSE led performance dashboard and receive tailored support from a new improvement team to accelerate safety and quality improvements.
- Divisional driver metric focus on staff survey question "I receive the respect I deserve from colleagues at work" in line with Trust breakthrough objective.
- Estates improvement work including the outpatient services and maternity theatres
- Service led driver metric focus on discharge process and length of stay in the postnatal period.
- Plans are being prepared by Trust Estates team to revise footprint through Day Assessment Unit and Triage area to improve environment and flow for ongoing care.
- Continued progress to establishing transitional care supporting babies from 34 weeks gestation at birth.
- The Trust anticipates the release of national reports from the Thirlwall inquiry and Nottingham hospital review and will undertake action as appropriate to meet the recommendations

Any questions?