Bundle BSW Group Board 5 November 2026

Agenda
Item 1.0 BSW Hospitals Group Board Agenda 5 Nov-26 Public Session v2

1.1 Welcome and apologies

1.2 Declarations of Interest

1.3.1 Minutes of previous meeting on 3 September 2026
Item 1.3.1 - BSW Hospitals Group Board PUBLIC MoM 2026.09.03 (draft) v0.3

1.3.2 Actions log review
Item 1.3.2 - BSW Group Board Action Log Public Board Nov-26

2.1 Patient Story (GWH)
Item 2.1 - Group Board - Patient Story 5th November 2026

3.1 Group Chair's Report
Item 3.1 Group Chair Report Nov-26 Final

3.2 Group Chief Executive's Report
Item 3.2 - CEO Report 5 November 2026 v1.0

4.1 Group Integrated Performance Report
Item 4.1.1 - BSW Group IPR October 2026
Item 4.1.2 - BSW Group IPR October 2026 Final VERSION

4.2.1 Quality & Safety Report
Item 4.2.1 - group qs report Nov board (1)

4.2.2 Thirlwall Inquiry Report

Item 4.2.2.1 - Thirlwall Inquiry Board Front Sheet v1 27.10.2026
Item 4.2.2.2 - Thirlwall Briefing Paper Trust Board final 30 Luisa

4.2.3 Safer Staffing Review (Bi-annual)
Item 4.2.3.1 - Group Board Safer Staffing Six-monthly Review Report Oct 26

4.2.4 Perinatal Workforce Report (Bi-annual)
Item 4.2.4.1 - joint Perinatal workforce cover sheet oct26
Item 4.2.4.2 - Integrated Perinatal Workforce and Capacity Report v2 26.10.2026
Item 4.2.4.3 - Bi-Annual Integrated Workforce Report March 2026– September 2026

4.3.1 Finance Report
Item 4.3 - BSW Group Board Cover Sheet - Month 6 Public Financial Report
Item 4.3.1 - 2026.10.26 BSW Group Financial Report Month 6 - Publicv2

4.3.2 Upward report from Financial Sustainability Committee
Item 4.3.2 - Upward report Financial Sustainability Cee Report to Board 5.11.26

4.3.3 Turnaround Programme (verbal)

4.4.1 People Report
Item 4.4.1.1 - CPO Report Sept 2026 - Group board
Item 4.4.1.2 - Appendix 1 - BSW Workforce Oversight Meeting M05

4.4.2 Corporate Services Transformation
Item 4.4.2 - CST Programme and Temporary Staffing Update - Nov Board

4.4.3 Freedom to Speak Up Annual Report
Item 4.4.3 - BSW Group FTSU Report Bd Nov-26 v3

4.4.4 Equality & Diversity Annual Report
Item 4.4.4.1 - EDI Annual Report Group Board Cover Sheet 26 FINAL

4.4.5 Lord Mann Update

Item 4.4.5.1 - Board Paper Lord Mann Recommendations Update November 2026 v0.2
Item 4.4.5.2 - Appendix 1 - Important Information for NHS employers re Mann Review

5.1 GWH Managing Director's Report

Item 5.1 - GWH MD report

5.2 SFT Managing Director's Report

Item 5.2 - SFT MD Report October

5.3 RUH Managing Director's Report

Item 5.3 - RUH MD Report to Group Board Oct 26 v1.0 - 29.10.26 final

6.1 Group Risk Register

Item 6.1.1 - BSW Group Risk Register October 2026
Item 6.1.2 - GRR Oct26 dashboard
Item 6.1.2 - GRR Oct26 risk register

6.2 Risk & Assurance Committee Escalation Report

Item 6.2 - RAC report to Group Board — 5 November 2026 (v1.9, after the meeting) (1)

6.3 Board Assurance Framework

Item 6.3.1 - BAF Cover Report TB Nov26
Item 6.3.2 - BSW Group Initial BAF Oct 2026

6.4 Audit Committees-in-Common Assurance Report

Item 6.4 - Audit Commmittees-in-Common Chair Report to Group Board Sept 26

7.1 EPR Programme Report

Item 7.1.1 - Group Board EPR Programme Update 05.11.2026
Item 7.1.2 - Appendix A - Why the EPR Programme has moved to Red
Item 7.1.3 - Appendix B - BSW EPR Programme Briefing Note to EPR Assurance Committee

8.1 RUH Unitary Governance
Item 8.1 - RUHX Charity Report to Group Board Oct 26

9.1 Forward look (including items for next agenda)

9.2 Any Other Business

9.3 Written Answers to Public Questions
Item 9.3 Questions from the public Gp Bd Nov-26

9.4 Reflections

9.5 Private Board - Business Summary

9.6 Date and time of next meeting

9.7 Exclusion of the Public and Press

BSW Hospitals Group Board held in Public
5 November 2026 at 9:00 – 15:15 hrs
to be held at Jenner House, Chippenham

AGENDA

Timings		Agenda	Presenter	Purpose
	1.	**Opening Business**		
09:00	**1.1**	Welcome and apologies [Apologies: Jason Lugg, Joy Luxford]	Chair	-
	1.2	Declarations of Interest Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	All	-
	1.3	Minutes of previous meeting on 3 September 2026 Actions log review	Chair	Approval
	2.	**Patient / Staff Story**		
09:10	**2.1**	Patient Story (GWH)	LG	Reflection
	3.	**Chair and Chief Executive Reports**		
09.30	**3.1**	Group Chair's Report	Chair	Note
	3.2	Group Chief Executive's Report	CCB	Assurance
	4	**Group Reports**		
09:45	**4.1**	Group Integrated Performance Report	ME	Note
10:00	**4.2**	Group Quality and Safety • Quality & Safety Report • Thirlwall Inquiry Report • Safer Staffing Review (Bi-annual) • Perinatal Workforce Report (Bi-annual)	LG/JH/JAL	Assurance
11:00		**Break**		
11:10	**4.3**	Group Finance • Month 6 Finance Report • Upward report from Financial Sustainability Committee • Turnaround Programme	SW PvdH/BM SW/SW	Assurance
11:30	**4.4**	Group People • People Report • Corporate Services Transformation • Freedom to Speak Up Annual Report • Equality & Diversity Annual Report • Lord Mann Update	JG	Assurance

12:30 – 1300		**Lunch**		
	5.	**Care Organisation Reports**		
13:00	**5.1**	GWH Managing Director's Report	LT	Assurance
13:20	**5.2**	SFT Managing Director's Report	NJ	
13:40	**5.3**	RUH Managing Director's Report	JP	
	6.	**Risk and Assurance and Governance**		
14:00	**6.1**	Group Risk Register	ME	Assurance
14:10	**6.2**	Risk & Assurance Committee Escalation Report	FC	Assurance
14:20	**6.3**	Board Assurance Framework	ME	Assurance
14:30	**6.4**	Audit Committees-in-Common Assurance Report	JL	Assurance
	7	**Strategic Delivery**		
14:40	**7.1**	EPR Programme Report	SH/JH	Assurance
	8	**Governance**		
14.55	**8.1**	**RUH Unitary Governance** • Charitable Funds Assurance Report	JL	Assurance
	9	**Forward look and closing business**		
15:05	**9.1**	Forward look (including items for next agenda)	Co Sec	Note
	9.2	Any Other Business	Chair	Note
	9.3	Written Answers to Public Questions	Chair	Note
	9.4	Reflections	All	Reflection
	9.5	Private Board – Business Summary	Chair	Note
	9.6	Date and time of next meeting	Chair	Note
	9.7	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"		
15:15	**10**	Close		

MINUTES OF THE BSW HOSPITALS GROUP BOARD MEETING HELD IN PUBLIC
3 SEPTEMBER 2026 AT 9.00AM
DOROTHY HOUSE, WINSLEY, BRADFORD-ON-AVON

Present:

Paul von der Heyde (PVDH)	Chair *(Chair)*
Angie Ansell (AA)	Acting Chief Nursing Officer, SFT
Kathryn Bateman (KB)	Chief Medical Officer, GWH
Bernie Bluhm (BB)	Chief Operating Officer, RUH
Chris Burton (CB)	Non-Executive Director
Paul Cain (PC)	Non-Executive Director
Cara Charles-Barks (CCB)	Chief Executive
Faried Chopdat (FC)	Non-Executive Director
Neil Clark (NC)*	Associate Non-Executive Director
Judy Dyos (JD)	Chief Strategy Officer
Mark Ellis (ME)	Chief Risk Officer
Paul Fairhurst (PF)	Non-Executive Director
Luisa Goddard (LG)	Chief Nursing Officer, GWH
Benny Goodman (BG)	Chief Operating Officer
Jude Gray (JG)	Chief People Officer
Simon Harrod (SH)	Non-Executive Director
Jonathan Hinchliffe (JH)	Chief Digital Officer
Richard Holmes (RH)	Non-Executive Director
Nick Johnson (NJ)	Managing Director, SFT
Peter Knell (PK)	Non-Executive Director
Jason Lugg (JAL)	Chief Nursing Officer, RUH
Joy Luxford (JL)	Non-Executive Director
Rebecca Maxwell (RM)	Chief Medical Officer, RUH
Duncan Murray (DM)	Chief Medical Officer, SFT
John Palmer (JP)	Managing Director, RUH
Niall Prosser (NP)	Chief Operating Officer, SFT
Samaher Sweity (SS)*	Associate Non-Executive Director
Lisa Thomas (LT)	Managing Director, GWH
Simon Wade (SW)	Chief Financial Officer

In attendance:

Ben Irvine (BI)	Programme Director, BSW Hospitals Group
Emma Mooney (EM)	Director of Communications
Deborah Rawlings (DR)	Board Secretary, GWH
Pete Thomond (PT)	Chief Executive, Clever Together
Jodie Da Rosa**	Director of Midwifery, RUH (minute no. 055/26)
Hannah Langford**	Clinical Lead, GWH (minute no. 055/26)
Vicki Marston**	Director of Midwifery & Neonates, SFT (minute no. 055/26)
Kat Simpson**	Director of Midwifery & Neonates, GWH (minute no. 055/26)
Steph Thompson**	Midwife, SFT (minute no. 055/26)

Apologies:

Caroline Coles (CC)	Company Secretary, GWH
Andrew Hollowood (AH)	Strategic Clinical Transformation Director
Bernie Morley (BM)	Non-Executive Director
Richard Samuel (RS)	Non-Executive Director

* non-voting member
** indicates those members attending virtually by MS Teams

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Number of members of the Public: There were 7 members of the public in attendance (Kylie Sanders, SFT Head of Corporate Governance; Tapiwa Songore, SFT Interim Head of Corporate Governance; Jane Podlinski, SFT Governor; Joanna Bennett, SFT Governor; Susan Snoxall, SFT Governor; Frances Owen, SFT Governor; Chris Shepherd, GWH Governor)

Matters Open to the Public and Press

Minute	Description	Action
052/26	**Welcome and apologies** The Chair welcomed all to the meeting of the BSW Group Board meeting to be held in public. Apologies were received as above.	
053/26	**Declarations of Interest** There were no declarations of interest.	
054/26	**Minutes of previous meetings** The minutes of the following meetings were approved as a correct record: a) Group Board meeting on 2 July 2026 b) SFT Trust Board meeting in public on 15 June 2026 c) GWH Trust Board meeting in public on 11 June 2026 **Actions log review** The outstanding actions arising from the following meetings were noted that there were no further matters arising: a) Group Board meeting on 2 July 2026 – it was requested that the Non-Executive Directors be kept aware of the outcome of the work to resolve the Resident Doctors' payroll issues and the anticipated timescale for resolution.	
055/26	**Maternity Stories, GWH, SFT, RUH** The Board received care reflection stories from GWH, SFT and RUH which highlighted experiences from three maternity pathways in relation to maternity, neonatal and bereavement care across the BSW Maternity Group Services. It was noted that these were positive reflections of lived experiences but had also identified some areas where care could be further improved. The feedback and actions reflected improvements already undertaken in line with recommendations from the Ockenden review and Amos independent investigation. The Board reflected on the three patient stories, recognising the compassionate care provided to women and families experiencing bereavement and thanking staff for their support in difficult circumstances. In response to challenge regarding staff wellbeing, the Board was assured that professional midwifery advocates, debriefing, follow-up and psychological support were available across the organisations. The Board questioned how learning from stillbirths and perinatal losses was shared and implemented consistently across the Group. It was advised that maternity leaders met regularly and that a perinatal oversight meeting was being developed to strengthen shared learning, early identification of concerns and dissemination of improvement work. The Board noted that arrangements to systematically identify,	

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implement and track learning across all three organisations were not yet fully established and that this remained an area for further development.

The Board **noted** the report.

056/26 **Group Chair's Report**

The Board received and considered the Group Chair's Report and noted the Chair's activity and key areas of focus for July and August 2026, which related to governance developments, Non-Executive Directors update, Council of Governors, key meetings for the Chair, and NHSE Board Development Programme participation.

The Board **noted** the report.

057/26 **Group Chief Executive's Report**

The Board received and considered the Group Chief Executive's report, noting that there would be some duplication with the Group Executive Committee Upward Report.

The Board noted the maternity risks highlighted in the Group Executive Committee report and challenged whether further developments should be paused until existing risks were fully understood. It was confirmed that the Chief Nurses, with Chief Medical Officer involvement, would review the Group's maternity ambition and strategy, including inherent risks across services and the needs of the wider population.

The Board **noted** the report.

058/26 **Group Executive Committee Upward Report**

The Board noted sustained operational pressures across the Group, with urgent and emergency care and financial recovery remaining the principal risks, alongside workforce capacity and EPR readiness. Positive progress was reported in elective, diagnostic and cancer performance, including continued RTT improvement at GWH.

Board Members challenged whether workforce capacity should be considered an accepted rather than emerging risk, particularly given the combined demands of operational pressures, financial recovery and EPR. It was acknowledged that pressures continued to increase. Assurance was provided through strengthened turnaround arrangements, additional resource, weekly recovery oversight, site-level UEC recovery plans and work with the ICB. Cara Charles-Barks reported that programmes were being reviewed to cease or reprioritise activity and redirect capacity towards immediate recovery and longer-term transformation priorities.

The Board **noted** the report.

059/26 **Group Integrated Performance Report**

The Board received the Integrated Performance Report (IPR) which provided an overview of the Group's performance for the period up to and including June 2026.

The Board reviewed the IPR, noting alerts relating to RTT, UEC, infection prevention and control, pressure ulcers and workforce. Members welcomed progress in reporting but challenged the lack of timely, consistent Group-level

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metrics, forward trajectories and clear evidence that recovery actions were reducing risk. Executives agreed to strengthen Group reporting while retaining care organisation detail.

The Board challenged the pace of recovery and the Group's capacity to deliver competing priorities. It was confirmed that resources and programmes were being reviewed and reprioritised around EPR readiness, UEC and financial recovery, while continuing essential longer-term transformation.

Board Members sought assurance on system dependencies, particularly reductions in Non Criteria To Reside (NCTR) patients. It was noted that although ICB commitment had been received, detailed delivery plans and timescales remained outstanding. The Board therefore remained concerned about delivery and agreed that recovery plans should quantify dependencies, impacts and mitigations while maximising improvements within the Group's control.

The Board **noted** the report for assurance.

060/26 **Group Quality and Safety**

(1) Maternity & Neonatal 10-point plan development report

GWH

The Board noted the GWH preliminary assessment against the maternity 10-point plan, with nine deliverables compliant, 12 partially compliant, four non-compliant and one non-applicable. Maternity triage remained the principal area of risk, with further assessment and mitigations in progress.

The Board noted that the evidence log, triage risk assessment, accountable lead and timescales for full compliance would be finalised ahead of submission on 30 September 2026. Further scrutiny and assurance would be provided at the extraordinary Board meeting on 21 September 2026.

RUH

The Board noted that the RUH self-assessment against the NHS England 10-point plan had identified no new areas requiring work, with improvement activity already underway. Assurance was provided that key foundations were in place, with further work focused on Martha's Rule, governance and Board oversight, triage, home births, family engagement, equity and culture.

The Board noted that priorities included delivery of the perinatal workforce business case and further development of digital and inequalities intelligence, with existing workstreams to continue to strengthen compliance.

SFT

The Board noted that SFT continued to benchmark its maternity services against the NHSE 10-point plan. Maternity triage was expected to remain an area of significant non-compliance due to the absence of 24-hour telephone and in-person triage services. The Board recognised the extent of the benchmarking required and the opportunity for greater Group collaboration, including the development of consistent metrics and shared BI support. Further assurance would be provided through a detailed review at the extraordinary Board meeting.

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(2) Maternity & Neonatal quarterly safety reports (RUH, SFT, GWH)

GWH

The Board noted risks relating to safe neonatal staffing and workforce capability, with medical and nursing staffing not yet meeting BAPM Neonatal Workforce Standards. Assurance was provided through the comprehensive improvement programme, executive oversight, escalation arrangements and approval to recruit seven additional neonatal nurses. Increased planned caesarean section activity was also placing pressure on theatre capacity, with additional lists introduced and daily monitoring in place.

The Board noted targeted improvement work addressing neonatal hypoglycaemia and hypothermia, alongside strengthened oversight of overdue incidents. Assurance was gained from stable incident reporting, improved incident closure, training compliance above 90% and successful testing of the MOSS signal process, which had provided valuable learning for the service.

RUH

The Board noted that RUH maternity performance remained stable with safe care maintained, but two significant risks required continued oversight: workforce capacity and digital safety, both rated 16. Workforce deficits had been confirmed, with assurance provided through existing mitigations and approval in principle of the perinatal workforce business case, enabling recruitment to priority frontline roles.

The Board noted risks from manual transcription between ultrasound and maternity systems. Assurance was provided that a new digital solution had been approved in principle, with implementation planned for April 2027 and enhanced audit and surveillance continuing in the interim. Further assurance was gained from 100% perinatal mortality review compliance, 96% compliance with the Saving Babies Lives Care Bundle and mandatory training above 90%. The Board would maintain oversight of workforce delivery, digital implementation and further strengthening of safety intelligence.

SFT

The Board noted three key risks at SFT which related to the lack of a dedicated second maternity theatre, non-compliance with BAPM Neonatal Workforce Standards, and the temporary closure of an obstetric outreach clinic. Mitigations were in place, with options for additional theatre capacity, a paediatric workforce review and business case, and alternative community provision being explored.

The Board also noted the elevated stillbirth rate and previous cluster of maternity and neonatal safety investigations. Assurance was provided through full PMRT review, external scrutiny, positive feedback following the MOSS safety signal review, and MNSI's assessment that the cluster appeared isolated with no strong themes identified. Further assurance was provided on midwifery staffing and continued service-user involvement, with the BirthRate+ review to inform a future update.

The Board discussed the increasing national focus on maternity services and the common challenges across the Group relating to workforce, neonatal resilience, triage, theatre capacity, digital infrastructure and increasing complexity of care. Members challenged the sustainability of meeting extensive national requirements

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alongside safe service delivery and questioned whether investment could be prioritised across the Group according to greatest risk and impact.

The Board challenged whether recurring maternity and neonatal risks should be managed through a Group-wide risk framework and dashboard, while avoiding duplication and additional burden. It was agreed that care organisation perinatal risks would be reviewed to determine appropriate escalation to Group level, supported by the developing joint maternity governance arrangements.

Overall, the Board took assurance from strong safety governance, audit, training, incident management and leadership oversight, while recognising that significant risks remained. The Board emphasised that maternity should remain core business within routine performance and risk oversight and approved the papers presented.

(3) Board Assurance Statement - key actions following the Fuller Enquiry

The Board received the Group's response to the NHS England letter of 26 June 2026 and to approve the submission of the Board Assurance Statements. The review has assessed local arrangements against the requirements set out by NHS England, including progress against the Fuller Inquiry recommendations, safeguarding accountability, mortuary governance, estates compliance and wider oversight arrangements.

The Board Assurance Statements demonstrate that the Group has established appropriate systems of governance and oversight and has a clear programme of improvement to ensure the safe, respectful and dignified care of deceased patients. Executive leaders will continue to provide oversight of delivery through Quality and Safety Committee reporting, with progress against outstanding actions reported regularly to the Board.

(4) Directors of Infection Prevention & Control Report

The Board received and considered the Group Director of Infection Prevention and Control Annual Reports 2025/26 and noted ongoing infection prevention risks, including environmental and workforce pressures. Assurance was provided on established IPC governance, surveillance and improvement programmes. The Board approved the annual IPC report and endorsed the priorities for 2026/27.

RESOLUTION:

The Group Board:

- ***a) noted the Maternity & Neonatal 10-point plan development report;***
- ***b) noted the Maternity & Neonatal quarterly safety reports for assurance; and***
- ***c) approved the Board Assurance Statements in response to the Fuller Inquiry.***
- ***d) approved and noted the three BSW Hospitals Group Director of Infection Prevention and Control Annual Reports 2025/26;***
- ***e) noted the BSW Hospitals Group's continued compliance with the ten IPC criteria; and***
- ***f) endorsed the IPC improvement priorities identified for 2026/27.***

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061/26	**Group Finance Report** The Board received and considered the Group Finance report and noted the Month 4 year-to-date adverse variance of £15.6m, comprising £10m at GWH and £5.6m at RUH, with SFT remaining at breakeven. Some improvement was reported, including reduced temporary staffing, stabilising pay costs and increased maturity of efficiency schemes, with approximately 78% implemented or fully developed. The Board remained concerned that improvement was insufficient to recover the year-to-date deficit, particularly given the greater savings required in the second half of the year. Assurance was taken from the improving Month 4 position and progress with efficiency delivery, while recognising that significant financial risk remained and would be considered further in the private session. The Board **noted** the report.	
062/26	**Group People** **(1) Group People Report** The Board received and considered the Group People Report and noted that workforce remained above plan and that, although pay bill savings had improved, delivery remained below target. Further action had been taken to review contracts and recruitment pipelines to reduce costs. It was noted that preparations for the 2026 Staff Survey were underway, alongside development of a Group-wide leadership and management offer. The Board sought assurance regarding temporary staffing arrangements, framework adherence and the implementation of the Bank Partners contract. It was noted that a small number of framework-related matters remained under review and that issues arising during the initial implementation of the Bank Partners contract were being addressed. The Board was assured that performance and financial impact would continue to be monitored and reported through the appropriate governance arrangements. The Board sought assurance that workforce plans appropriately balanced financial recovery requirements with safe staffing, clinical capacity and service delivery. It was noted that workforce levels remained above the planned trajectory, reflecting factors including vacancies, sickness absence, maternity leave, escalation capacity and ongoing service demand. Further consideration of workforce cost-reduction scenarios and associated savings requirements would form part of the private Board discussion on the financial recovery plan. The Board **noted** the report for assurance. **(2) Annual Responsible Officer Report (Medical Revalidation & Appraisal Annual Report)** The Board received the annual Responsible Officer reports and was assured that appropriate arrangements were in place across the three organisations to support medical appraisal, revalidation and professional standards, with increasing collaboration and quality assurance at Group level. The Board discussed the consistency of appraisal and revalidation reporting and sought assurance regarding outstanding appraisals. It was noted that the majority	

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related to approved exceptions, with a small number of unapproved cases being managed through established processes. A more consistent approach to future reporting was agreed.

As one Responsible Officer report had not been included within the Board papers, the Board agreed to defer approval pending receipt of the complete set of reports. The reports, accompanied by a summary to support assurance, would be circulated outside the meeting for approval by correspondence. The Board also noted ongoing work to support greater alignment of appraisal systems as existing contracts reached expiry.

RESOLUTION:

The Group Board agreed that a complete report would be circulated to the Group Board for written approval.

063/26 **Group Digital**

Group Digital Report : Annual Cyber Report & Annual Data Security & Data Protection Report

The Board received the annual Cyber Security and Information Governance reports. The Board noted that cyber security remained a principal digital risk and was assured that appropriate governance, technical controls, staff training and incident response arrangements were in place. The Board noted improvements in DSPT performance across all three organisations, positive external audit findings and the absence of any material cyber incidents resulting in significant patient safety concerns or sustained disruption to services. The Board also noted the approval of additional NHS England funding to support cyber resilience.

The Board sought assurance regarding the adequacy and testing of business continuity arrangements. It was noted that local plans and procedures were in place, supported by collaborative working across the Group and participation in a wider cyber resilience exercise. Further testing would be undertaken through organisational readiness activities associated with the Electronic Patient Record programme.

The Board discussed the evolving cyber threat landscape and requested that future reports include enhanced information on risk measures, trends and performance indicators to support oversight. The Board also noted that a Group Artificial Intelligence policy was in development and progressing through the appropriate review process.

The Board noted the positive Information Governance position, supported by external audit and Data Protection Officer assurance. Ongoing work would continue to strengthen consistency of governance arrangements across the three organisations and maintain oversight of information governance performance and compliance.

The Board **noted** the report.

064/26 **GWH Managing Director's Report**

The committee received and considered the GWH Managing Director's report and it was noted that recovery actions agreed at the extraordinary Board meeting were progressing. Cancer and RTT performance had improved, with reductions in the

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overall waiting list and 52-week waits, although demand in trauma and orthopaedics and gynaecology remained challenging. Urgent and emergency care remained under significant pressure, with record demand, delayed ambulance handovers and corridor care. A six-week improvement sprint was under way, with early positive signs from strengthened ward processes, discharge performance, front-door streaming and admission avoidance initiatives.

The Board discussed progress of the Right Care Programme, performance against the 52-week waiting time standard and the sustainability of interventional radiology services. The Board was advised that Right Care initiatives were delivering improvements, with a reduction in the number of patients waiting over 52 weeks and further improvement anticipated. The Board also noted that interim arrangements had been established to support interventional radiology services while longer-term service models were developed.

The Board sought assurance regarding organisational resilience, actions to reduce the use of corridor care and the effectiveness of revised governance arrangements. It was noted that addressing corridor care would require a combination of additional capacity, system-wide demand management and longer-term investment. The Board was advised that governance arrangements continued to evolve, with increased focus on thematic reviews and organisational learning.

The Board sought assurance that improvements in waiting-list performance reflected genuine reductions in patient waiting times. It was confirmed that routine validation activity had continued but had not been the primary driver of recent improvements. The Board also noted the ongoing financial challenges facing the organisation and the associated constraints on investment and service development.

The Board **noted** the report.

065/26 **SFT Managing Director's Report**

The Board received the SFT Managing Director's report and noted a mixed but improving position, with progress in a number of areas alongside continued operational and financial pressures. Urgent and emergency care remained a key area of focus, with recovery plans in place and the proposed Urgent Treatment Centre expected to support further improvement. The Board noted that the financial position remained on plan, whilst recognising the challenges associated with delivery, cash management and workforce capacity.

The Board noted progress in relation to CQC improvement actions, elective transformation and the ongoing development of Group governance arrangements. The impact of the Corporate Services Review on staff and services continued to be managed.

The Board discussed the funding arrangements for the DASH programme and was advised that work was continuing to identify solutions to address the remaining funding requirement, including consideration of internal capital, charitable funding and other potential sources of support.

The Board sought assurance regarding clinical coding performance and the associated impact on income recovery. It was noted that a clinical coding improvement programme was underway, focusing on capacity, clinical

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documentation and workforce development, and that further work would be required to support longer-term digital improvements.

The Board also received assurance that learning arising from the South Wiltshire integrated discharge review was being progressed with system partners and shared across the Group.

The committee **noted** the report.

066/26 **RUH Managing Director's Report**

The Board received and considered the RUH Managing Director's report and noted that the organisation continued to demonstrate resilience in the context of sustained operational pressures. Demand for services remained high and continued to impact capacity, workforce and financial performance. The Board noted progress in a number of areas, including diagnostics, elective recovery and preparations for the Urgent Treatment Centre.

The Board discussed the alignment of risk management and assurance arrangements across the Group and acknowledged that further work was required to support a consistent approach to risk assessment and escalation. The Board also considered the balance between financial recovery, workforce planning and the maintenance of quality and safety, recognising the importance of clear organisational priorities and effective staff engagement.

The Board sought assurance regarding the ongoing relationship with HCRG and was advised that contractual matters continued to be managed appropriately, alongside constructive operational partnership working. The Board noted continued engagement with system partners to support service delivery and performance improvement.

The Board also noted the focus on reducing healthcare-associated infections and was assured that improvement actions were in place, supported by additional external expertise where appropriate.

The Board noted plans to strengthen executive focus through refreshed turnaround arrangements and a limited number of organisational priorities.

The Board recorded its thanks to Bernie Bluhm, Chief Operating Officer, for her significant contribution to the organisation and welcomed Rebecca Maxwell to the role of Chief Medical Officer.

The Board **noted** the report.

067/26 **Group Risk Register**

The Board received the Group Risk Register which had identified 44 Group risks scoring 12 or above, principally relating to financial sustainability and liquidity, estates and infrastructure, operational flow and access, and workforce capacity. The risks were considered visible and understood with appropriate governance in place; however, evidence of sustained improvement remained limited in several areas.

Board Members noted that financial recovery and UEC would receive further scrutiny through planned Board discussions, while fire safety would be subject to a

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Risk & Assurance Committee deep dive. Full assurance on estates and capital risks was not expected until the next capital planning round was progressed.

The Board highlighted an emerging workforce risk arising from sustained operational pressure and multiple organisational challenges, which was not yet reflected in the Group risk register. It was agreed that this should be considered for inclusion.

The Board **noted** the Group Risk Register.

068/26 **Risk & Assurance Committee Escalation Report**

The Board received the Group Risk Register and noted the principal risks facing the Group, including financial sustainability, estates and infrastructure, operational flow and access, and workforce capacity. The Board was assured that appropriate governance arrangements were in place and that these risks continued to receive focused oversight, whilst recognising that sustained improvement remained challenging in a number of areas.

The Board noted that further consideration of financial recovery and urgent and emergency care risks would be undertaken through future Board discussions, and that estates-related risks would receive additional scrutiny through the Risk and Assurance Committee. Ongoing work to inform longer-term estates and capital planning was also noted.

The Board discussed the impact of sustained operational pressures on the workforce and agreed that the associated risks should continue to be monitored and reflected appropriately within the Group's risk management arrangements.

The Board **noted** the report.

069/26 **Risk & Assurance Committee Terms of Reference**

The Board reviewed the Terms of Reference and agreed an amendment to the Committee membership arrangements, confirming that membership would comprise Non-Executive Directors, with Executive Directors attending as required. The Board noted that this reflected the Committee's assurance role and that Executives could be called to attend where necessary.

RESOLUTION

The Group Board approved the Risk & Assurance Committee Terms of Reference, subject to an amendment to the Committee membership; membership to comprise Non-Executive Directors, with Executive Directors attending as required.

070/26 **Corporate Services Transformation**

The Board received and considered an update on the Corporate Services Redesign Programme and noted improving financial delivery, with savings identified and enhanced monitoring in place to track delivery. Work on the future employer model and a single approach to budget management was progressing. Further opportunities for digital transformation would also be considered, while ensuring that EPR delivery remained a priority.

DRAFT

Minute	Description	Action

Board Members sought greater clarity in the financial reporting, including the RAG ratings, and noted that these would be reviewed and updated where required. The Board also discussed the sustainability of savings, including those associated with vacancy controls, potential resource requirements and the impact of transformation on staff engagement, retention and wider workforce risks. It was acknowledged that these areas would continue to require close oversight, with future reporting providing greater visibility of workforce impacts and mitigating actions.

The Board sought clarification on the future employer model and noted that a range of options remained under consideration, alongside work to develop a more consolidated approach to budget oversight. Members emphasised the importance of ensuring that the emerging model remained aligned with the Group's agreed strategic direction.

The Board **noted** the report.

071/26 **Digital Report: EPR Programme**

The Board received and considered an update on the EPR Programme and noted that delivery remained on track, although risks remained. Testing was progressing well and a five-week adjustment to the data migration timetable was not expected to affect the planned go-live dates. Organisational readiness continued to progress, with capacity, specialist resource and additional funding requirements remaining areas for close oversight.

Board Members sought assurance regarding the assessment and management of programme risks, including vacancies and costs. Jonathan Hinchliffe confirmed that risks were being actively managed, specialist resources were being secured and planning for ongoing support was underway. Further scrutiny of programme risk, workforce capacity, backfill and hardware costs would continue through the EPR Assurance Committee.

The Board **noted** the report and was assured that delivery of the EPR Programme continued to be prioritised across the BSW Hospitals Group.

072/26 **Board Assurance Framework**

The Board received the Board Assurance Framework and noted that it remained under development but had been strengthened through clearer links to the Group Risk Register and the identification of proposed risk owners. Further assurance assessments would be incorporated, together with an additional risk relating to organisational capacity.

Board Members emphasised the importance of establishing a consistent Group risk appetite, noting that a number of principal risks were currently outside the agreed risk appetite or reflected differing existing approaches across the three Trusts. A risk appetite workshop was planned to progress this work.

The Board approved the proposed risk owners and supported the continued development of the Board Assurance Framework, taking assurance from the progress made while recognising that further work was required to fully embed the approach.

DRAFT

Minute	Description	Action

RESOLUTION:

The Group Board:

a) approved and adopted the Initial Group Board Assurance Framework as the Group's baseline strategic risk and assurance framework;
b) approved the three Care Organisation Chief Operating Officers as the senior responsible owners for R6 Reducing Waits;
c) approved the three Care Organisation Chief Nursing Officers as the senior responsible owners for R8 Reducing Avoidable Harm; and
d) noted that BAF links to relevant Group Risk Register risks are complete, that inherited appetite is reproduced at Appendix A, that the Board Workshop on 1 October 2026 will confirm a refreshed Group risk appetite, and that executive proposals on assurance levels will be presented in the next reporting cycle.

073/26 **Board Declaration of Interests Register**

The Board received and noted the Declarations of Interest Register.

The Board **noted** the report.

074/26 **Great Western Hospitals NHS Foundation Trust Governance**

(a) Audit, Risk & Assurance Committee – 24 June 2026

The Board noted the assurance report from the GWH Audit, Risk & Assurance Committee meeting held on 24 June 2026.

075/26 **Royal United Hospitals NHS Foundation Trust Governance**

(a) Charities Committee – 18 June 2026

The Board noted the assurance report from the RUH Charities Committee meeting held on 18 June 2026.

(b) Non-Clinical Governance Committee – 17 June 2026

The Board noted the assurance report from the RUH Non-Clinical Governance Committee meeting held on 17 June 2026.

076/26 **Salisbury Hospital NHS Foundation Trust Governance**

(a) Clinical Governance Committee – 30 June 2026

The Board noted the assurance report from the SFT Clinical Governance Committee meeting held on 30 June 2026.

(b) People & Culture Committee – 25 June 2026

The Board noted the assurance report from the SFT People & Culture Committee meeting held on 25 June 2026.

DRAFT

Minute	Description	Action

(c) SFT Constitution Amendment

The Trust Board received a proposed amendment to Salisbury NHS Foundation Trust's (SFT) Constitution to resolve an inconsistency relating to the roles of Senior Independent Director (SID) and Deputy Chair/Vice-Chair. The current Constitution contains conflicting provisions, with one section treating the SID function as part of the Deputy Chair role, while another describes the SID as a separate appointment. This creates ambiguity within the Trust's governance framework.

The proposed amendment clarifies the constitutional position by establishing the SID as a distinct role within the binding body of the Constitution, while providing the flexibility for the SID and Vice-Chair roles to be held either by the same individual or by different Non-Executive Directors. The amendment also aligns terminology throughout the Constitution with the Board Standing Orders.

Approval by both the SFT Council of Governors and SFT Board of Directors would be required under paragraph 43.1 of the Constitution. It was noted that this paper was supported by the SFT Council of Governors on 20 July 2026.

RESOLUTION:

The Salisbury Hospital NHS FT Board approved the proposed amendment to paragraph 26 and the consequential amendment to Annex 8, section 2.2, as set out in section 4 of the report.

077/26 **Forward look (including items for next agenda)**
The Group Board cycle of business had already been reviewed earlier in the agenda and that some items had been identified for future meetings.

078/26 **Any Other Business**
There was no urgent business to report.

The Board wished to record thanks to Bernie Bluhm for her significant contribution to the role of Chief Operating Officer at the RUH and for 47 years in the NHS and wished her well for her retirement.

079/26 **Written Answers to Public Questions**
Question to GWH and Response
The Board received and noted the response to the question from a GWH Trust Member of public on the CQC report stating a rating of overall 'Requires Improvement' and how assurance could be gained in relation to effective quality/patient safety management systems. It was noted that the Trust had moved to 'Good' on 10 July 2026, with maternity and urgent and emergency care rated 'Requires Improvement'. There are specific actions in place to drive improvement in these areas to ensure they achieve good in the next inspection.

The Board **noted** the response and agreed that there was no further action.

080/26 **Reflections**
The committee reflected on the session and any learning taken forward.

DRAFT

Minute	Description	Action
081/26	**Private Board – Business Summary** The Board noted that the private session would consider developing financial and UEC recovery options, strategic matters and commercially sensitive issues not yet appropriate for public discussion. The Board supported the approach and commitment to transparency.	
082/26	**Date of Next Meeting** The date of the next Board meeting held in public is on 5 November 2026 at 10.00am at Jenner House, Chippenham	
083/26	**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.	

DRAFT

BSW Hospitals Group Board | Action Report - Public - October 2026

Date	Ref	Action	Lead	Target Date	Latest progress / update	Current Status
03 September 2026	054/26	**Action Log :** Non-Executive Directors be kept aware of the outcome of the work to resolve the Resident Doctors' payroll issues and the anticipated timescale for resolution.	CMOs	Dec-26	Update in December meeting as part of Maternity & Neonatal 10-Point Plan	Open
03 September 2026	062/26	**Annual Responsible Officer Report (Medical Revalidation & Appraisal Annual Report)** : A complete report would be circulated to the Group Board for written approval.	CMOs	Sep-26	A Board circular was sent 9 Sept-26.	Completed. Closed
03 September 2026	069/26	**Risk & Assurance Committee Terms of Reference** : Amend the terms of reference committee membership as NEDs only.	CoSec	Nov-25	Terms of Reference amended to reflect the change of membership to NEDs.	Completed. Closed
03 September 2026	107/26	**Maternity 10 Point Plans** : An updated position due to be submitted to NHS England by 31 December 2026 and a further report presented to the Board in December 2026	CNOs	Dec-26	On forward Plan	Open
21 September 2026	109/26	**NHSE Provider Capability Assessment** : Final assessments for approval at October Board meeting	CRO	Oct-26	Group Board approved final submission to NHSE prior to deadline of 2 Oct-26	Completed. Closed
01 October 2026	115/26	**MD Reports** : Thirlwell Review : Report on the Thirlwell Inquiry would be presented to the Group Board in November 2026	CNOs	Nov-26	On agenda	Recommended to close
01 October 2026	118/26	**Group EDI Annual Report** : More detailed discussion on EDI to take place in the November Board meeting	CPO	Nov-26	On agenda	Recommended to close
01 October 2026	124/26	**GWH Charitable Funds / HCRG Partnerhsip Agreement** : The approval of the HCRG partnership agreement to be sought outside of the meeting	SW	Oct-26	Email circulated on 2 Oct-26.	Completed. Closed

Great Western Hospitals NHS Foundation Trust

BSW Hospitals Group Board

Report title	Care Reflection – Patient Story	Agenda item	2.1
Date of meeting	5th November 2026		
Sponsor	Luisa Goddard, Chief Nurse		
Prepared by	Tania Currie, Head of Patient Experience and Engagement Georgia Cotton, Videographer		
Approval Process:	*n/a*		

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

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

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

KEY RISKS / BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title		
[e.g. BAF 03]	[Principal risk title from the BAF]		
Key risks (risk number & description	*List only the care organisation risks that the Committee should be aware of linking to the BAF – 12+risk.*	Risk Score	

KEY MESSAGES

This care reflection explores the impact of deconditioning on an older patient following a hip fracture. Deconditioning is a decline in muscle strength, endurance, mobility and functional ability associated with inactivity or prolonged bed rest often exacerbated by a hospital stay. The story highlights the importance of early, regular and sustained mobilisation, tailored to the patient's clinical condition and assessed needs, to maximise the opportunity to regain their pre-fracture level of function and independence.

People living with frailty are particularly vulnerable to deconditioning, and deterioration can occur over a short period of reduced activity. Loss of strength and balance can make everyday activities, such as

transferring from bed to chair, walking, washing and dressing, more difficult. This can contribute to an increased risk of falls, reduced confidence, greater dependence on others, prolonged hospital stays and increased care needs following discharge.

In this story we hear from the daughter of a patient who was previously walking independently around her home but following the fracture and deconditioning process was left with very limited mobility.
The story identifies positive aspects of care alongside opportunities for improvement, reinforcing the need to strengthen staff awareness of deconditioning and its implications for recovery, dignity and patient experience.

The film is already supporting staff training linked to falls prevention and the 'Get up, Get Dressed, Get Moving' campaign. It highlights the importance of integrating safe activity into everyday care, supporting patients to participate in washing, dressing and mobilisation in accordance with their individual care plans.

The project lead will provide further information on the ongoing improvement work and how learning from this experience is being shared to support staff awareness and improvements in patient care.

The film can be viewed at: Deconditioning - Trust Board (youtube.com)

RECOMMENDATION

The Committee is asked to:

1. **To receive the presentation as assurance of patient and family experience along with the developments and improvements identified from this Care Reflection.**

BSW Hospitals Group Board

Agenda item	3.1
Report title	Chair Report
Date of meeting	5 November 2026
Sponsor	Paul Von Der Heyde
Prepared by	Caroline Coles, Director of Corporate Governance & Group Company Secretary
Approval Process:	

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
BAF R1	Becoming an Effective Group

KEY MESSAGES

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

- Development of the Board
- Governance & Assurance
- Non-Executive Directors Update
- Council of Governors – Key Meeting Dates
- Chair - Key Meetings

RECOMMENDATION

The Group Board is asked to:

1. Note the Chair's Report.

Chair's Board Report

1. Introduction

September and October have been an important period for the BSW Hospitals Group, with the Board maintaining a strong focus on operational and financial recovery, urgent and emergency care, maternity services, and the continued development of the Group's governance and assurance arrangements.

On 5 October 2026, the Board held a Board-to-Board session with NHS England, focused on the revised recovery plan and the associated operational and financial delivery plans.

The Board has continued to consider the immediate actions required to strengthen operational and financial performance alongside the longer-term transformation required to improve services and support the Group's future sustainability. This work continues against a challenging backdrop of sustained demand, workforce pressures and capacity constraints across the three Trusts.

2. Development of the Group Board

The Group Board has continued to develop as the joint board for the BSW Hospitals Group, with a particular focus on strengthening collective leadership, clarity of accountability and effective oversight across the Group. At a development session on 1 October 2026, the Board considered the Group's recovery and sustainability programme and began its work to develop a shared approach to risk appetite and how this can support future decision-making and prioritisation.

The BSW Group Board is participating in the first wave of NHS England's Board Development Programme, with the first session taking place on 20 November 2026. This will support the continued development of collective leadership, the role of the Group Board in serving our population, and the governance and assurance arrangements required to deliver the Group's ambitions and strategy.

3. Governance and Assurance

The Group's governance and assurance arrangements continue to develop, supporting oversight of quality, performance, workforce, finance and risk across the three hospitals.

Work continues to strengthen the relationship throughout Group, its governance in common and within the individual care organisations, ensuring that matters are

considered and decisions taken at the appropriate level, with clear routes for assurance and escalation.

4. Non-Executive Directors

The Non-Executive Directors continue to provide independent oversight and constructive challenge across the Group, particularly in relation to recovery, risk, quality and the development of the Group's governance arrangements.

A programme of NED visits and twice-yearly walkarounds has now been developed, with the first visit scheduled to take place at Great Western Hospitals in November 2026.

5. Councils of Governors

The table below summarises the meetings, development sessions and engagement activities undertaken by Governors across Salisbury Hospital, Great Western Hospital and Royal United Hospital during September and October 2026.

Event	Purpose/ Primary Content
RUH Lead Governor meeting	Regular meeting to update and discuss any topical issues
RUH Council of Governors meeting	Regular meeting to update and discuss Trust issues
GWH Annual Members Meeting	Attendance to receive the Annual Report and Accounts 2025/26
SFT Annual Members Meeting	Attendance to receive the Annual Report and Accounts 2025/26
RUH Annual Members Meeting	Attendance to receive the Annual Report and Accounts 2025/26
GWH Business & Planning WG	To identify key issues in relation to Trust finances
SFT Governor Development Session and information meeting with NEDs	Regulation developmental session and relationship building with Non-Executive Directors

6. Chair Meetings during September & October 2026

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

Meeting	Purpose
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
Monthly Non-Executive Directors' Meeting	Regular meeting to update and discuss any topical issues
BSW Group Board	Monthly meeting – assurance and accountability & development
Staff & Long Service Awards	Presentation of staff and long service awards
BSW Hospitals Financial Sustainability Committee	To provide overview and scrutiny of Recovery Plan for financial sustainability
Annual Members Meeting	Chair Trust's AMM to present the Annual Report & Accounts 2025/26
NHS SW & GIRFT Improvement Day	Collaborative event to focus on tackling unwarranted clinical variation, reducing elective waiting lists and standarising regional recovery
Visit to Sulis Hospital	To attend Board meeting
GWH ED&I Conference	Attendance at re-imaging EDI
BSW Group Deputies Development Day	An opportunity to bring together developing leaders from across the Group, strengthening collaboration, sharing learning and supporting the development of future leadership capacity.
NHS SW Regional Roadshow and Chairs meeting	Valuable insight into national and regional priorities, offering an opportunity to discuss the challenges facing providers and share learning with colleagues from across the region.
NHS SW / BSW Group Board to Board	Constructive opportunity to discuss the Group's progress, challenges and priorities, whilst strengthening relationships with regional

Meeting	Purpose
	colleagues and supporting shared understanding of the Group's ambitions.
B&NES PLACE Director meeting	Introductory meeting with the PLACE Director of B&NES
UHBW Hospital	Introductory meeting with the Chair

BSW HOSPITALS GROUP BOARD

Agenda item	3.2
Report title	Chief Executive Report
Date of meeting	5 November 2026
Sponsor	Cara Charles-Barks, Group Chief Executive
Prepared by	CEO Office
Approval Process	CEO Approved
Strategic alignment	All five Group priorities
BAF links	R1, R3, R4, R5, R6

☒ FOR ASSURANCE ☐ FOR DECISION ☒ FOR INFORMATION

KEY MESSAGES

BSW Hospitals Group's operational and financial position remains materially off plan and unsustainable; in response the Group has launched a formal turnaround programme.

The principal shared challenges and risks are related to financial recovery, urgent and emergency care recovery, shared EPR implementation, and workforce constraints. These challenges are interdependent and require a coordinated executive response

RECOMMENDATION

The Board is invited to:

- note the performance, risk and regulatory updates; and
- support continued executive focus on safe operational performance and turnaround.

This report provides an update on the most significant strategic, performance, assurance, regulatory and leadership developments across BSW Hospitals Group since the 1 October report. It should be read alongside the Managing Directors' reports and the Group Executive Committee upward report.

1. Strategic priorities and recovery

Board-to-Board with NHS England South West and recovery plan

The Board-to-Board and Mid-Year Review with NHS England South West on 5 October provided firm and constructive challenge to the credibility and deliverability of our plans, the drivers of our operational and financial position, governance and the pace of recovery.

In response, on 14 October we submitted a *Recovery Plan Addendum* and covering letter. We accepted that the Group is materially off plan operationally and financially and that recovery to date has not been sufficiently consistent or rapid. The addendum sets a year-end commitment to contain the Group position at £62m adverse to plan (£78m deficit post-DSF adjustment), while restoring agreed RTT and emergency-care trajectories and protecting quality and safety.

The plan identifies the principal drivers as under-delivery of CIP, excess urgent-care capacity and workforce cost, wider non-pay pressure and delays to clinical and corporate transformation. It also makes explicit the importance of Group-scale change, pathway redesign and service reconfiguration for sustainable recovery.

Turnaround

We have now formally moved BSW Hospitals Group into Turnaround. At the all-staff briefing on 22 October, I was clear that our current position is serious and not sustainable.

At its heart, Turnaround is about making sure we are in the strongest possible position to continue providing safe, high-quality care for our patients and communities now and for the future. That means doing two things at the same time: taking decisive action to improve our position today, while continuing to transform the way we work for the future.

Our immediate focus is on tighter grip and control, including a 12-week pause on external recruitment with an exceptions process, stronger controls over bank, agency, locum and rostering, weekly review of discretionary non-pay expenditure, and re-testing new commitments and business cases.

Five connected delivery workstreams are being established to focus on:

- workforce and temporary staffing;
- elective, theatre and outpatient productivity;
- flow, length of stay and urgent care;
- non-pay, procurement, commercial and corporate services; and
- grip, control, cash and technical items.

Quality and safety of care remain our guardrails. We are not asking colleagues to work harder, but instead to change how we work, recover our performance in the short-term and create the conditions for sustainable long-term transformation of services for the BSW population we serve.

2. Performance across the Group

The October assurance cycle presents a consistent Group picture: areas of progress in elective and cancer pathways sit alongside persistent or deteriorating urgent and emergency care (UEC), flow, workforce and financial pressures.

UEC recovery requires both Care Organisation internal action and collective system working on demand, alternatives to ambulance conveyance, community capacity, discharge and NCTR. A detailed Group-wide UEC improvement work programme and approach to system-wide

oversight are being developed with clear ownership across providers, the ICB and other partners.

Headlines for UEC, RTT and financial performance as well as a summary of executive actions are shown below for each Care Organisation. The Integrated Performance Report and Care Organisation Managing Director reports included with the Board pack provide further detail.

Great Western Hospitals

- GWH continues to show positive assurance in elective volume and cancer recovery: elective activity was 104.5% of plan year to date, the total RTT waiting list remained below planned size and cancer performance improved across the principal standards. However, RTT performance itself remained below operating plan and the overdue follow-up backlog remains material.
- Urgent and emergency care remains persistently challenged, with four-hour performance around 64%, ongoing corridor care and discharge pressure.
- The Month 5 deficit was £17.7m, £13.2m adverse to plan, and forecast in-year efficiency delivery remained below target.
- Stroke is a high risk related to care quality, with Sentinel Stroke National Audit Programme (SSNAP) performance at level E, and further improvement dependent on pathway and therapy capacity.
- ***Executive Actions*** include Right Care and whole-hospital flow work, continued financial and rostering controls, and Group/system escalation. The Group Executive Committee has also commissioned urgent ICB discussion on stroke sustainability and a revised scope for the Group-wide stroke improvement programme.

Royal United Hospitals Bath

- Urgent-care and financial risks have increased in RUH, while elective performance is comparatively stronger.
- UEC remained the principal immediate safety and operational exposure, with demand and admissions above plan, corridor care, delayed assessment and discharge constraints. RUH four-hour performance deteriorated, achieving 68%.
- The submitted financial forecast is £20.4m after further mitigations, with cash expected to become critical in quarter four without recovery, commissioner cash movement or revenue support.
- ***Executive Actions***. RUH has launched Every Minute Matters with quantified daily standards and executive oversight, while elective activity and pathology stabilisation proposals are progressing through governance. Workforce fragility across pathology, cancer, maternity, palliative care and mental-health pathways remains a material dependency.

Salisbury Foundation Trust

- SFT continues to improve in cancer recovery and has strengthened its national oversight position, but urgent care, stroke, workforce and finance have deteriorated.
- Four-hour performance improved only marginally to 67.3% and remains materially below plan; ambulance handovers, 12-hour breaches and occupancy deteriorated, while No Criteria to Reside numbers (NCTR) remain well above target.
- RTT fell below trajectory for the first time in more than a year and diagnostics performance also deteriorated. The October Performance meeting set an expectation of RTT moving back to trajectory. Stroke performance is a significant concern, including in relation to CT timeliness and access to therapy.

- The likely forecast is a £13.1m deficit, with dependencies on completion of the key worker accommodation transaction and improvement in NCTR position.
- ***Executive Actions*** include the UEC recovery plan, stroke therapy recruitment and dashboard, strengthened cash management, Cost Improvement Programme and divisional recovery arrangements.

Monthly Performance review meetings have been established to ensure accountability for delivery of Care Organisation trajectories and Group commitments, in operational performance, finance, workforce, quality and risk.

3. Group risk and assurance

The GEC upward report to the Risk & Assurance Committee identifies the overriding strategic risk as the Group's capacity to deliver financial turnaround, winter, EPR, workforce recovery and transformation concurrently.

The financial outlook has deteriorated and there has not yet been sustained Group-wide improvement in access or patient flow.

Positive assurance remains in mortality, elements of planned care and cancer, developing Group governance and clearer recovery plans. The table below highlights significant risks across each of the three Care Organisations

Care Organisation	Key risk	Why it is being escalated / action
GWH	Stroke pathway quality and timely access to care	SSNAP remains level E; pathway reliability and therapy capacity remain material constraints. Group/ICB stroke sustainability work has been commissioned.
GWH	Failure to deliver planned improvement programme	Recurrent savings, operational demand and constrained delivery capacity continue to threaten delivery of the financial and performance plan.
GWH	High hospital occupancy and impaired patient flow	Persistent high occupancy and corridor care affect safety, access, workforce cost and recovery; actions depend on internal flow and system discharge delivery.
RUH	Financial recovery and delivery of plan	Formal submitted forecast £20.4m after mitigations. Recovery depends on cost control, productivity, structural funding and system action; cash is forecast to become critical in quarter four without mitigation.
RUH	Urgent and emergency care performance and flow	Performance remains off trajectory with corridor care, delayed assessment and discharge constraints; Every Minute Matters is the principal executive reset.
RUH	Shared EPR implementation and readiness	New risk R-3400, score 12. Six-week activity reduction creates activity, income and elective-wait risk; specialty modelling, safety thresholds and recovery plans remain necessary.

SFT	Financial position 2026/27	Break-even is no longer expected; likely £13.1m deficit remains conditional on KWA and NCTR assumptions.
SFT	Failure to reduce NCTR / sustained escalation	NCTR remains materially above target and drives occupancy, escalation care, UEC underperformance, safety exposure and additional workforce cost.
SFT	Stroke performance	CT timeliness, therapy intensity and SSNAP performance remain materially below standard; recruitment, pathway improvement and enhanced oversight are underway.

4. Communications and guidance from NHS England

Thirlwall Inquiry report and required response

The Chief Nursing Officers and Chief Medical Officers are leading the Group's response to the Thirlwall Inquiry report. Focus is on:

- Board-level learning,
- the confidence of staff to speak up and escalate concerns, and
- specific actions relating to sudden and unexpected death in children processes,
- bereavement care,
- insulin security in neonatal services and
- safeguarding training. Note: A Group Board safeguarding training session is being planned for 3rd December 2026.

A wider Group maternity and neonatal risk and investment plan is being developed so that immediate safety and mandatory requirements are prioritised effectively.

Unauthorised access to patient records

We continue to reinforce that confidential patient information must only be accessed for legitimate work purposes. At the 22 October all-staff briefing, colleagues were reminded of their professional, ethical and legal responsibilities: records must not be accessed out of curiosity or for personal reasons; accidental access should be reported promptly; and information-governance training must remain current.

Single-sex services and facilities guidance

NHS England wrote to chief executives and Boards on 15 October following the Equality and Human Rights Commission Code of Practice coming into force on 5 August 2026. Organisations are asked to review local policies, practices and environments at pace and ensure that decisions on patient and staff facilities are lawful, proportionate, evidence-based and clearly documented, while maintaining privacy, dignity, safety and respect for all.

Our review of relevant policies, guidance and facilities has begun; Board-level oversight will need to cover clinical operations, people, estates and facilities, communications, staff support, escalation of complex cases and monitoring of impact.

5. Governance review

Preparation for an external governance review has begun. We are awaiting confirmation of the final scope and in the meantime core documentation is being collated, so that the review can commence promptly.

6. Leadership development and our people

NHSE Board Development Programme

The first session of the NHS England Board Development Programme will take place on 20 November at Jenner House. The programme provides an important opportunity for the Group Board to build on the baseline work already completed and focus collective development on the leadership, oversight and decision-making needed through turnaround and the next phase of BSW Hospitals' Group development.

Leadership team changes

I am pleased to welcome Jo Howarth, who has started in post as Chief Nursing Officer at Salisbury Foundation Trust. I would also like to record my sincere thanks to Angie Ansell for her leadership and support to SFT colleagues and patients prior to Jo taking up the role.

I am also delighted to welcome Dr Emma-Kate Reed as interim Group Chief Clinical Transformation and Innovation Officer. This is an important leadership role as we accelerate clinical transformation, pathway redesign and the strategic shifts required to deliver sustainable improvement across the Group.

7. Care Quality Commission Review

The October Managing Director reports show continued regulatory and CQC-related activity.

- At RUH, the improvement programme arising from the September service inspections continues while the organisation awaits formal inspection reports; workforce sustainability and accessibility of records for vulnerable children and young people were among the areas previously identified for improvement.
- At SFT, published CQC ratings and continuing Regulation 12 warning notices remain significant matters of external scrutiny, reinforcing the need for continued focus on urgent and emergency care, patient flow, workforce sustainability and quality governance.
- GWH reports established CQC preparedness governance, with safe-staffing and wider clinical-governance arrangements under continued scrutiny.

The Group Executive Committee has also commissioned a Group and Care Organisation preparedness for future CQC well-led reviews session, with learning to be shared across the Group.

8. Conclusion

The challenges facing BSW Hospitals Group are significant. We are managing a materially adverse financial position at the same time as persistent urgent-care and flow pressure, workforce constraints, winter readiness, EPR delivery and the need to accelerate transformation. Our move into turnaround reflects the seriousness of that position and the need for greater grip, clearer accountability and faster delivery, with quality and safety protected throughout.

There are also reasons for confidence: teams continue to improve aspects of elective and cancer care, recovery plans are clearer, and our ability to work across the Group is developing.

Most importantly, I want to thank colleagues across GWH, RUH and SFT for the care, professionalism and resilience they continue to show. The months ahead will remain demanding, and their work for patients and support for one another are fundamental to our recovery.

Cara Charles-Barks
Group Chief Executive
BSW Hospitals Group

BSW Hospitals Group Board

Agenda item	4.1
Report title	Group Integrated Performance Report
Date of meeting	5 November 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Spencer Thorn
Approval Process:	Group Executive Committee

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

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

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

BOARD ASSURANCE FRAMEWORK LINK

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

KEY MESSAGES

The October 2026 IPR, principally reflecting August performance, continues to present a mixed and fragile Group position. Mortality remains within the expected range across all three organisations and there are positive in-month signals in falls, pressure-ulcer incidence and selected infection measures. However, the report does not yet demonstrate sustained recovery in the principal access, flow and workforce risks.

Elective performance remains below plan across all three organisations. GWH continues to carry the greatest long-wait risk, despite a reduction in patients waiting over 52 weeks; RUH and SFT both deteriorated against the 18-week standard and SFT's over-65-week waits increased. Diagnostic performance declined at all three organisations, with recovery constrained by workforce, booking,

pathway and non-imaging capacity. Cancer performance remains below standard across the Group, with persistent diagnostic, outpatient, reporting and treatment-capacity pressures.

Urgent and emergency care remains the most significant cross-cutting operational risk. Four-hour and 12-hour performance remain off plan, NCTR and discharge delays continue to restrict flow, and corridor care remains dependent on both internal delivery and system capacity. Recent Board discussion reinforced that the Group must evidence delivery of the actions within its own control, while separately quantifying the patient, capacity and financial consequences of unmet system dependencies.

IPC performance is mixed. E. coli and MSSA remain particular concerns at GWH, although August case numbers reduced for E. coli and C. difficile. The reduction in pressure-ulcer incidence at SFT is positive, but sustained operational pressure, enhanced-care demand and specialist staffing constraints continue to create quality and resilience risks.

The IPR continues to describe substantial improvement activity, but assurance is limited where actions are not linked to quantified trajectories, accountable owners, delivery dates and measurable impact. Consistent with Board challenge, the Group IPR also needs to move beyond presenting three parallel organisational positions by providing a clearer aggregated Group view, while retaining organisation-level exceptions.

RECOMMENDATION

The Group Board is asked to:

- **Receive the October 2026 Group IPR and note the mixed assurance position.**

APPENDICES

BSW Group Integrated Performance Report, October 2026, principally reflecting August 2026 data, with cancer measures reported on the latest validated common-period basis.

Purpose

The purpose of this paper is to provide a triangulated, exception-based assessment of the October 2026 Group IPR, principally reflecting August 2026 performance. It identifies where improvement is sustained, where the position has deteriorated or remains fragile, and where the quality of reporting limits assurance. The assessment also incorporates the principal themes raised through recent Group Executive Committee, Risk and Assurance Committee and Board discussions: the need for a clearer Group-level view, stronger evidence of impact, explicit ownership and trajectories, and a clear distinction between provider-controlled actions and system dependencies.

Executive summary

The October IPR provides positive assurance on mortality, with SHMI remaining statistically within the expected range across all three organisations. Falls and pressure-ulcer performance improved in month, and there were reductions in some infection measures. These improvements are welcome but do not offset the continuing access, flow, workforce and affordability risks.

Elective recovery remains fragile. GWH reduced its over-52-week cohort but remains substantially above plan; RUH and SFT recorded reductions in 18-week performance; and SFT's long-wait position deteriorated. Diagnostic performance declined across all three organisations, with the greatest pressures in non-imaging modalities and continued dependence on additional capacity, workforce and pathway change. Cancer standards remain unmet across the Group.

Urgent and emergency care shows no sustained Group-wide improvement. Flow remains constrained by demand, internal processes, discharge delays, NCTR and insufficient community capacity. The Board has been clear that the Group should not externalise these challenges: provider actions must be delivered and evidenced, while system requirements should be specified through named actions, owners, timescales and quantified impacts.

The IPR gives limited assurance that workforce movement is aligned to safe staffing, recovery plans and affordability. A consistent Group methodology remains necessary to reconcile vacancies, establishment changes, temporary staffing, sickness, turnover, escalation capacity and financial plans.

Alert, advise, assure

Status	Evidence and read-across
ALERT — Elective access	August RTT performance was below plan at all three organisations. GWH remained at 57.7%, 4.3 percentage points below plan, although its waiting list reduced and the over-52-week cohort fell to 1,000. RUH declined to 70.1% amid referral growth of 19% year to date. SFT declined to 69.6%, with over-52-week waits increasing to 126 and eight patients waiting over 65 weeks. Recovery plans require measurable specialty-level trajectories and clearer evidence of capacity, validation and demand-management impact.
ALERT — Diagnostics	Diagnostic performance declined at all three organisations. GWH reduced to 92.0%, with 618 patients waiting over six weeks and significant pressure in respiratory physiology. RUH reported 85.8%, below plan, with the largest breach cohorts in ultrasound, audiology, endoscopy and DEXA. SFT reported 81.6%, below its 88% plan, with continuing cardiac CT, audiology and endoscopy constraints. The current actions are credible, but delivery remains dependent on workforce, approvals, additional capacity and improved utilisation.
ALERT — Cancer	Cancer performance remains below standard across the Group. The latest common-period data show 62-day performance of 66.3% at GWH, 68.0% at RUH and 73.5% at SFT. Faster-diagnosis performance was also below the 80% standard at all three organisations. Recurrent pressures include outpatient access, diagnostic and reporting capacity, Urology, Breast, Colorectal, Lung, Skin and Lower GI pathways. The Committee should seek evidence that funded capacity and pathway actions are translating into sustained improvement.
ALERT — Urgent and emergency care	Four-hour and 12-hour performance remain below plan and there is no sustained improvement in whole-pathway flow. NCTR remains a significant system-wide constraint, discharge-ready delays persist, and corridor care remains an active quality, operational and financial risk. Improved ambulance handover alone has not resolved internal flow or discharge constraints. The Group should demonstrate delivery of internal actions on ward processes, length of stay, discharge timing and front-door models, alongside explicit system commitments and trajectories.
ALERT — Workforce and operational resilience	Operational pressures, escalation capacity, sickness and enhanced-care requirements continue to constrain staffing flexibility. SFT reported increased enhanced therapeutic observation demand and significant unfilled RMN and HCA hours. Vacancy and turnover measures remain difficult to reconcile with funded establishments and recovery plans. Workforce reporting does not yet provide sufficient assurance that staffing is simultaneously safe, affordable and aligned to planned reductions.
ADVISE — Infection prevention and control	IPC performance remains mixed. GWH continues to be the principal exception for E. coli and MSSA and remains above the South West average, although E. coli cases reduced from 14 to eight in August and C. difficile cases reduced from nine to three. RUH reported nine C. difficile cases and one MRSA bacteraemia. Established case review, antimicrobial stewardship and prevention workstreams are in place, but clearer evidence is needed that actions are reducing recurrent infection risk.
ADVISE — Patient safety	Falls performance improved at GWH and SFT, while RUH remained slightly above the national inpatient-falls benchmark but within control limits. Pressure-ulcer incidence reduced materially at SFT and remained low at GWH and RUH. These are positive signals, but operational pressure, trolley and corridor care, acuity and specialist-resource constraints mean the position remains vulnerable and requires continued monitoring.
ASSURE — Mortality	SHMI remains statistically within the expected range at all three organisations. Mortality-review processes, coding improvement, system learning and shared oversight are in place. The first cluster mortality arrangements and continued alignment of coding and review processes should strengthen comparative learning, although changes in reporting geography and methodology should be monitored carefully.

Direction of travel by domain

Domain	Assessment	Latest evidence	Governance read-across
Elective access	**Mixed; below plan across the Group**	GWH held at 57.7% and reduced its over-52-week cohort, but remains materially above plan. RUH and SFT deteriorated against the 18-week standard; SFT long waits increased.	Require specialty-level trajectories, quantified capacity actions and evidence of impact. The emerging Group elective model should demonstrate how mutual aid and Group capacity improve delivery.
Diagnostics	**Deteriorating**	All three organisations deteriorated in August. Workforce, booking, pathway and non-imaging constraints remain material.	Delivery should be tracked through a single Group view of demand, capacity, utilisation, approvals and recovery milestones.
Cancer	**Below standard Group-wide**	The latest common-period 62-day and 28-day data remain below standard at all three organisations.	Capacity schemes and pathway actions require clear delivery dates and measurable effects on breaches and waiting times.
Urgent and emergency care	**No sustained improvement**	Four-hour and 12-hour performance remain off plan; NCTR, discharge delay and corridor care continue to constrain flow.	Internal provider actions and system dependencies should be separately specified, with owners, trajectories and quantified patient, bed and financial impacts.
IPC	**Mixed; GWH remains the principal exception**	Some in-month improvement is evident, but E. coli and MSSA remain elevated at GWH and RUH reported nine C. difficile cases and one MRSA case.	Continue external and peer review, but require evidence that actions are reducing recurrence rather than only demonstrating process compliance.
Patient safety and staffing	**Mixed and fragile**	Falls and pressure ulcers improved, but enhanced-care demand, unfilled specialist staffing and operational pressure remain significant.	Safe-staffing assurance should be triangulated with acuity, escalation capacity, temporary staffing, harm indicators and affordability.
Workforce	**Assurance limited**	Vacancy, turnover and sickness data are not yet consistently aligned to establishment, workforce-reduction trajectories or financial plans.	Implement a common Group methodology and integrated finance-workforce reporting.
Mortality	**Assured**	SHMI remains within the expected range at all three organisations.	Maintain coding alignment, consistent mortality review and cross-organisational learning.

HOSPITALS GROUP

BSW Group Integrated Performance Report

October 2026 (August 2026 data)

NHS
Great Western Hospitals
NHS Foundation Trust

NHS
Royal United Hospitals Bath
NHS Foundation Trust

NHS
Salisbury
NHS Foundation Trust

Interpreting summary icons

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

	Variation / performance Icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
MSSA	Group			Aug-26	8				Common Cause Variation
MSSA	GWH			Aug-26	7				Common Cause Variation
MSSA	RUH			Aug-26	1				Common Cause Variation
MSSA	SFT			Aug-26	0				Common Cause Variation
MRSA	Group			Aug-26	1				Common Cause Variation
MRSA	GWH			Aug-26	1				Common Cause Variation
MRSA	RUH			Aug-26	0				Special Cause Improving - Below Lower Control Limit
MRSA	SFT			Aug-26	0				Common Cause Variation
Ecoli	Group			Aug-26	13				Common Cause Variation
Ecoli	GWH			Aug-26	8				Common Cause Variation
Ecoli	RUH			Aug-26	4				Common Cause Variation
Ecoli	SFT			Aug-26	1				Common Cause Variation
Cdiff	Group			Aug-26	13				Common Cause Variation
Cdiff	GWH			Aug-26	3				Common Cause Variation
Cdiff	RUH			Aug-26	9				Common Cause Variation
Cdiff	SFT			Aug-26	1				Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
ED 4 Hour Performance	Group	All Types		Aug-26	62.2%				Special Cause Concerning - Decreasing Run
ED 4 Hour Performance	GWH	All Types	78.0%	Aug-26	63.6%	✗			Special Cause Concerning - Decreasing Run
ED 4 Hour Performance	RUH	All Types	77.2%	Aug-26	56.1%	✗			Common Cause Variation
ED 4 Hour Performance	SFT	All Types	82.0%	Aug-26	67.3%	✗			Common Cause Variation
ED 12 Hour Performance	Group	Type 1 and Type 2 attendances		Aug-26	14.4%				Special Cause Concerning - Above Upper Control Limit
ED 12 Hour Performance	GWH	Type 1 and Type 2 attendances	12.0%	Aug-26	15.7%	✗			Common Cause Variation
ED 12 Hour Performance	RUH	Type 1 and Type 2 attendances	0.0%	Aug-26	11.4%	✗			Common Cause Variation
ED 12 Hour Performance	SFT	Type 1 and Type 2 attendances	6.2%	Aug-26	17.9%	✗			Special Cause Concerning - Above Upper Control Limit
Cancer 62 Day Performance	Group			Jul-26	69.0%				Common Cause Variation
Cancer 62 Day Performance	GWH		76.0%	Jul-26	66.3%	✗			Common Cause Variation
Cancer 62 Day Performance	RUH		80.5%	Jul-26	68.2%	✗			Common Cause Variation
Cancer 62 Day Performance	SFT		80.4%	Jul-26	73.5%	✗			Common Cause Variation
Cancer 28 Day Performance	Group			Jul-26	75.7%				Common Cause Variation
Cancer 28 Day Performance	GWH		80.0%	Jul-26	76.9%	✗			Common Cause Variation
Cancer 28 Day Performance	RUH		81.5%	Jul-26	72.1%	✗			Special Cause Improving - Run Above Mean
Cancer 28 Day Performance	SFT		82.1%	Jul-26	79.5%	✗			Special Cause Improving - Run Above Mean

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
RTT wait times top versus bottom quintile of social deprivation	GWH			Aug-26	-1.0%				Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	RUH		0.0%	Aug-26	-0.9%	✗			Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	SFT		0.0%	Aug-26	-3.8%	✗			Common Cause Variation
RTT 18 week %	Group			Aug-26	65.4%				Special Cause Improving - Above Upper Control Limit
RTT 18 week %	GWH		60.0%	Aug-26	57.7%	✗			Special Cause Concerning - Run Below Mean
RTT 18 week %	RUH		74.7%	Aug-26	70.1%	✗			Special Cause Improving - Above Upper Control Limit
RTT 18 week %	SFT		72.4%	Aug-26	69.5%	✗			Special Cause Improving - Run Above Mean
RTT % Over 52 Weeks	Group			Aug-26	1.1%				Special Cause Improving - Run Below Mean
RTT % Over 52 Weeks	GWH		1.0%	Aug-26	2.3%	✗			Special Cause Concerning - Two Out of Three High
RTT % Over 52 Weeks	RUH		1.0%	Aug-26	0.4%	✓			Special Cause Improving - Below Lower Control Limit
RTT % Over 52 Weeks	SFT		0.0%	Aug-26	0.4%	✗			Special Cause Concerning - Increasing Run
DM01 Performance	Group			Aug-26	86.8%				Special Cause Improving - Above Upper Control Limit
DM01 Performance	GWH		99.0%	Aug-26	92.0%	✗			Common Cause Variation
DM01 Performance	RUH		87.5%	Aug-26	85.5%	✗			Special Cause Improving - Above Upper Control Limit
DM01 Performance	SFT		90.0%	Aug-26	81.6%	✗			Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
% of NCTR	Group			Aug-26	20.9%				Common Cause Variation
% of NCTR	GWH			Aug-26	21.0%				Common Cause Variation
% of NCTR	RUH			Aug-26	23.3%			H	Special Cause Concerning - Two Out of Three High
% of NCTR	SFT			Aug-26	18.2%				Common Cause Variation
Average days between discharge ready date and discharge date	Group			Aug-26	1.4			H	Special Cause Concerning - Run Above Mean
Average days between discharge ready date and discharge date	GWH			Aug-26	2.1				Common Cause Variation
Average days between discharge ready date and discharge date	RUH			Aug-26	2.7				Common Cause Variation
Average days between discharge ready date and discharge date	SFT			Aug-26	0.5			H	Special Cause Concerning - Above Upper Control Limit
Average handover time	Group	Minutes		Aug-26	45				Common Cause Variation
Average handover time	GWH	Minutes		Aug-26	41			L	Special Cause Improving - Run Below Mean
Average handover time	RUH	Minutes	30	Aug-26	52	X	?		Common Cause Variation
Average handover time	SFT	Minutes	20	Aug-26	37	X	?	H	Special Cause Concerning - Two Out of Three High
Average LoS	Group			Aug-26	7.6				Common Cause Variation
Average LoS	GWH			Aug-26	6.9				Common Cause Variation
Average LoS	RUH			Aug-26	8.6				Common Cause Variation
Average LoS	SFT			Aug-26	7.7				Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
SHMI	GWH	Summary Hospital-level Mortality Indicator		Apr-26	99.2%				Special Cause Improving - Run Below Mean
SHMI	RUH	Summary Hospital-level Mortality Indicator		Apr-26	87.3%				Special Cause Improving - Below Lower Control Limit
SHMI	SFT	Summary Hospital-level Mortality Indicator		Apr-26	94.5%				Common Cause Variation
Pressure Ulcers per 1000 beddays	Group	Category 2/3/4, excluding specialist areas		Aug-26	1.0				Common Cause Variation
Pressure Ulcers per 1000 beddays	GWH	Category 2/3/4, excluding specialist areas		Aug-26	0.5				Common Cause Variation
Pressure Ulcers per 1000 beddays	RUH	Category 2/3/4, excluding specialist areas		Aug-26	0.4				Common Cause Variation
Pressure Ulcers per 1000 beddays	SFT	Category 2/3/4, excluding specialist areas		Aug-26	2.7				Common Cause Variation
Care Hours per Patient Day (CHPPD)	Group			Aug-26	8.6				Common Cause Variation
Care Hours per Patient Day (CHPPD)	GWH			Aug-26	8.9				Common Cause Variation
Care Hours per Patient Day (CHPPD)	RUH			Aug-26	8.3				Common Cause Variation
Care Hours per Patient Day (CHPPD)	SFT			Aug-26	7.5				Common Cause Variation
Falls per 1000 bed days	Group			Aug-26	4.2				Special Cause Improving - Below Lower Control Limit
Falls per 1000 bed days	GWH			Aug-26	1.0				Special Cause Improving - Below Lower Control Limit
Falls per 1000 bed days	RUH			Aug-26	7.0				Common Cause Variation
Falls per 1000 bed days	SFT		7.0	Aug-26	5.8	✓			Common Cause Variation

BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Vacancy Rate	GWH		7.0%	Aug-26	3.4%	✓			Common Cause Variation
Vacancy Rate	RUH		4.0%	Aug-26	-1.3%	✓			Special Cause Improving - Below Lower Control Limit
Vacancy Rate	SFT		5.0%	Aug-26	-1.3%	✓			Common Cause Variation
% Voluntary Turnover	Group			Jul-26	6.89%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	GWH		13.00%	Jul-26	6.46%	✓			Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	RUH			Jul-26	5.47%				Special Cause Improving - Run Below Mean
% Voluntary Turnover	SFT			Jul-26	9.37%				Special Cause Improving - Decreasing Run
% Sickness	Group			Jul-26	4.84%				Common Cause Variation
% Sickness	GWH		4.00%	Jul-26	4.24%	✗			Special Cause Improving - Run Below Mean
% Sickness	RUH		4.70%	Jul-26	5.29%	✗			Common Cause Variation
% Sickness	SFT		4.80%	Jul-26	4.96%	✗			Special Cause Concerning - Above Upper Control Limit

BSW Group Scorecard

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

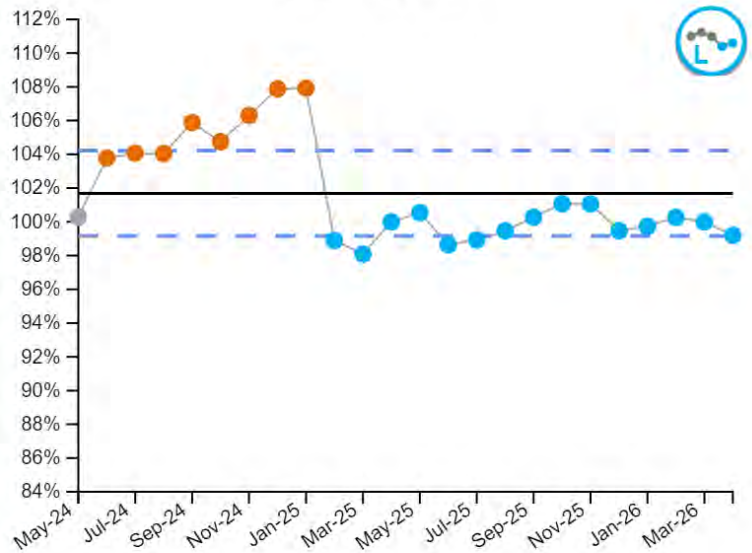
BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	Group			Aug-26	11.49				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	GWH			Aug-26	6.42				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	RUH			Aug-26	0.00				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	SFT		0.00	Aug-26	5.07	X			
Average Daily Number of Patients in Corridor Care within ED	Group			Aug-26	45.09				
Average Daily Number of Patients in Corridor Care within ED	GWH			Aug-26	23.19				
Average Daily Number of Patients in Corridor Care within ED	RUH			Aug-26	17.10				
Average Daily Number of Patients in Corridor Care within ED	SFT		0.00	Aug-26	4.80	X			

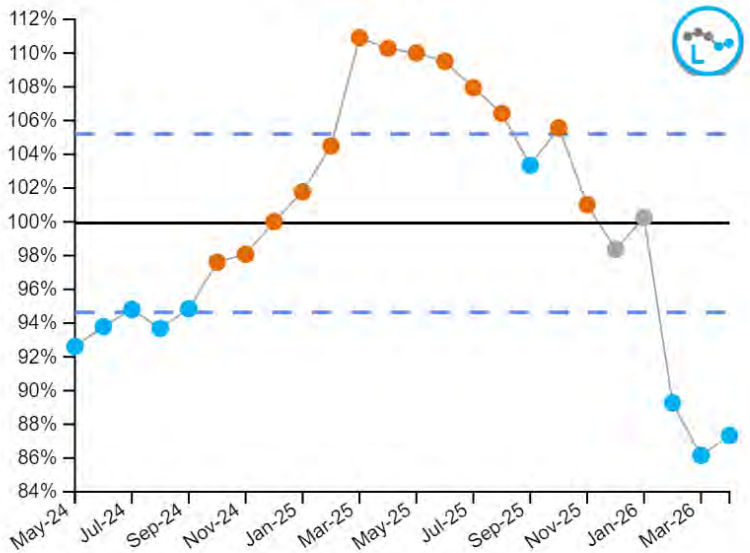
SHMI

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

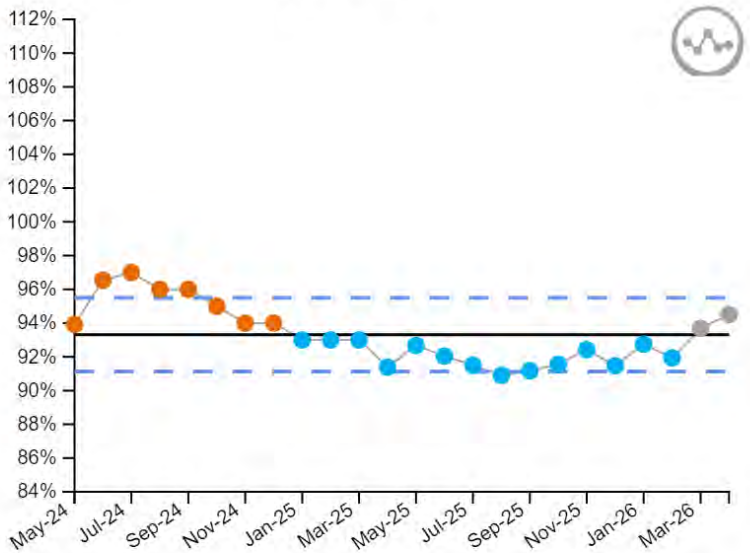
SHMI - GWH



SHMI - RUH



SHMI - SFT



SHMI

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
SHMI	GWH	Summary Hospital-level Mortality Indicator		Apr-26	99.2%				Special Cause Improving - Run Below Mean
SHMI	RUH	Summary Hospital-level Mortality Indicator		Apr-26	87.3%				Special Cause Improving - Below Lower Control Limit
SHMI	SFT	Summary Hospital-level Mortality Indicator		Apr-26	94.5%				Common Cause Variation

Understanding Performance

Each of the 3 Acute Trust's SHMI remain statistically within the expected range according to data published by NHSE. The latest SHMI data publication covers the period from 1st May 2025 to 30th April 2026.

RUH – The SHMI shows a much improved position and is now below the lower control limit. Improvement work recently focused on resolution of a coding backlog. The data shows the mortality position to be statistically 'As Expected.'

GWH - This shows the Trust to be 'As Expected'.

SFT – This shows the Trust to be 'As Expected'.

Countermeasures

The first cluster mortality group meeting is due to take place on 7th October 2026.

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

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

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

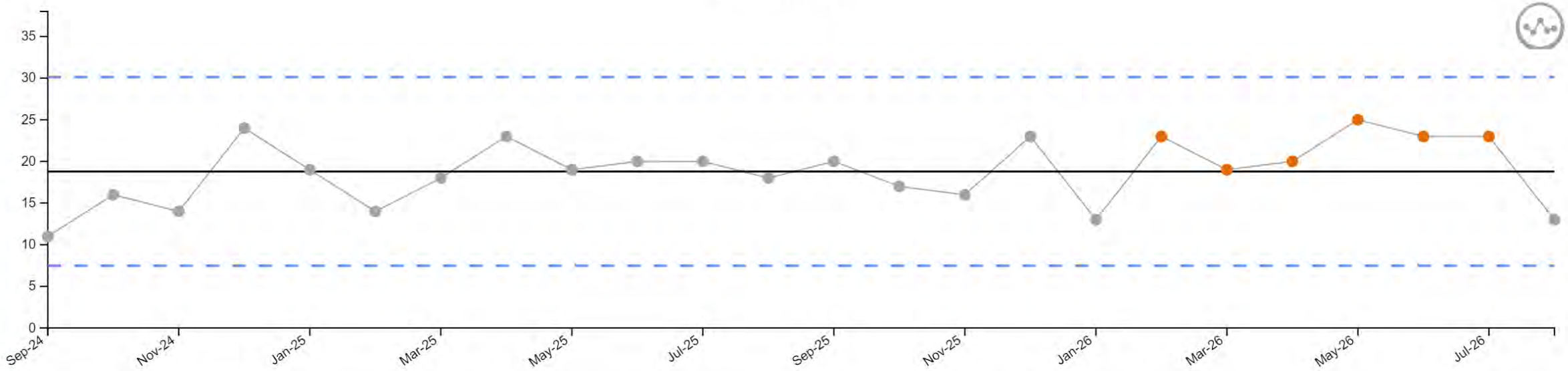
Risks and Mitigation

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

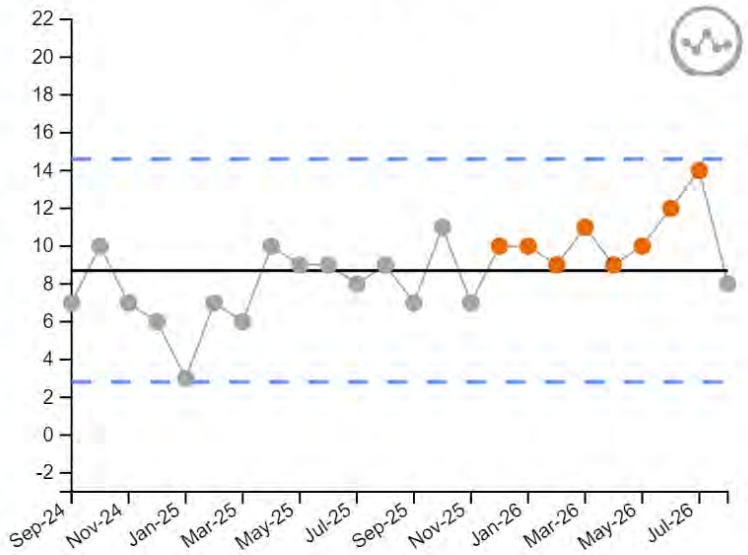
The SHMI data published by NHS Digital continues to be reviewed regularly by each of the hospital mortality teams. The combination of improving our internal reporting, development of the Power-BI toolkit, use of the NHS Digital SHMI dashboard, and adherence to each acute Trust's internal learning from death processes, collectively ensures that learning is identified at the earliest opportunity.

Ecoli

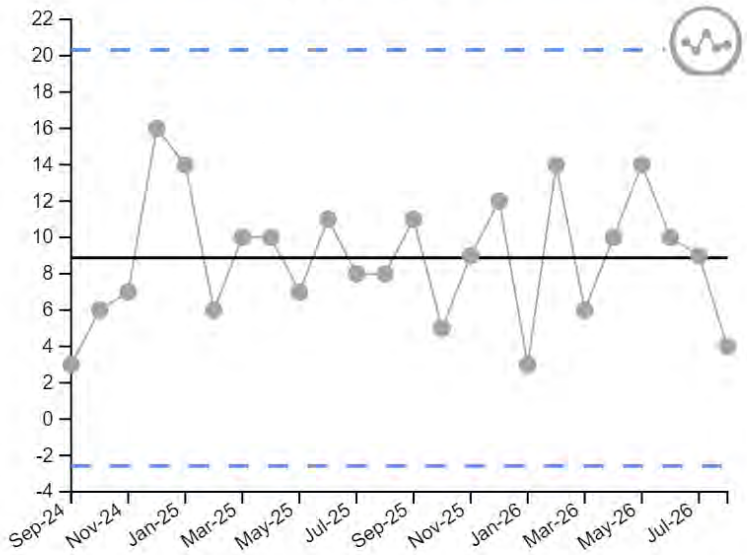
Ecoli - Group



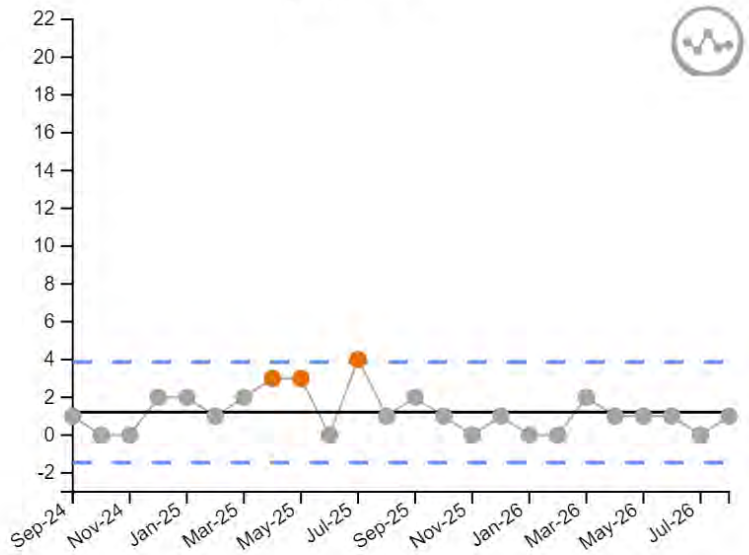
Ecoli - GWH



Ecoli - RUH



Ecoli - SFT



Ecoli

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Ecoli	Group			Aug-26	13				Common Cause Variation
Ecoli	GWH			Aug-26	8				Common Cause Variation
Ecoli	RUH			Aug-26	4				Common Cause Variation
Ecoli	SFT			Aug-26	1				Common Cause Variation

Understanding Performance

Group: E. coli bloodstream infection performance remains within expected control limits. However, the aggregate position continues to demonstrate special cause variation above the mean, predominantly driven by higher case numbers reported at GWH. Variation between organisations reflects differences in patient case mix and infection sources, but overall performance remains stable with no evidence of sustained deterioration across the Group.
GWH: Cases reduced in August, with 8 reported compared to 14 in July. The primary source of infection for the E-Coli BSI remains lower urinary tract infections, there has been no change in this and continues with similar themes to the previous months, however throughout quarter two we have seen a rise in hepatobiliary and skin and soft tissue infections as a primary source.
SFT: There has been no Hospital Onset Healthcare Associated (HOHA) reportable *E.coli* BSIs in month.
RUH: Numbers continue to fluctuate; however, the 4 cases in August remained within common-cause variation. Urinary tract infections remain the leading contributor to E. coli bloodstream infections.

Countermeasures

Group: BSW IPC Leads continue to work collaboratively to reduce variation. Key areas of focus include catheter care, antimicrobial stewardship, hand hygiene, hydration, and the prevention and management of urinary tract infections.
GWH: Review of cases has identified opportunities to strengthen fundamental care and infection prevention practices. A Trust-wide improvement programme is being implemented to support consistent safe practice, reduce avoidable infections, and improve patient outcomes.
SFT: Catheter care remains a priority, supported by targeted education from the Urology Nurse Specialist and Infection Prevention and Control teams.
RUH: Targeted quality improvement workstreams are in place focussed on preventing urinary tract infections and increasing hydration. The NHSE Regional Infection Prevention and Control Team has undertakenm a peer review visit in September to provide external assurance on case management and the delivery of improvement workstreams.

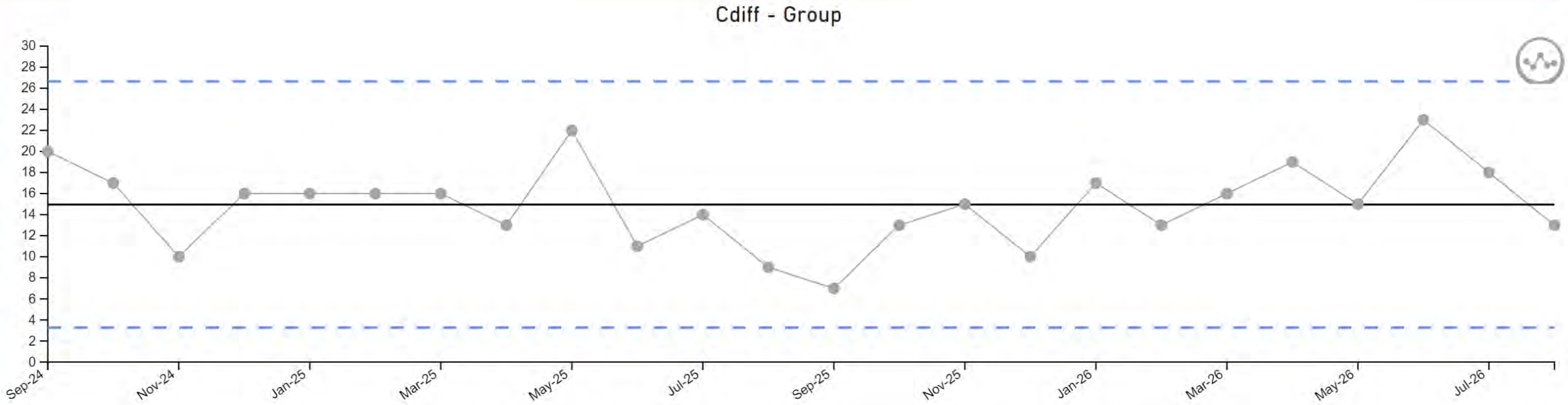
Risks and Mitigation

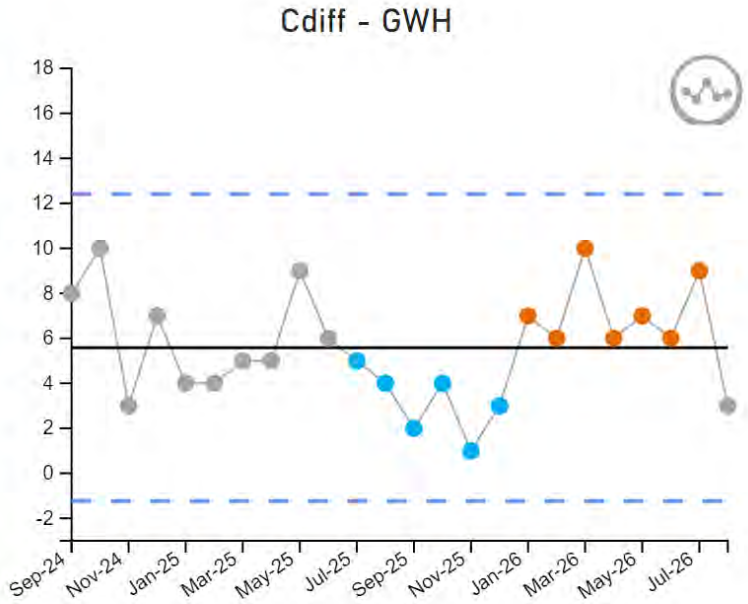
GWH: The Trust remains above the South West regional average for E. coli bloodstream infections. There is a risk that factors associated with skin integrity, wound management, and pressure ulcer care may be contributing to the sustained infection rate. Mitigating actions include enhanced case review, strengthened multidisciplinary oversight, and ongoing monitoring through established IPC governance arrangements.

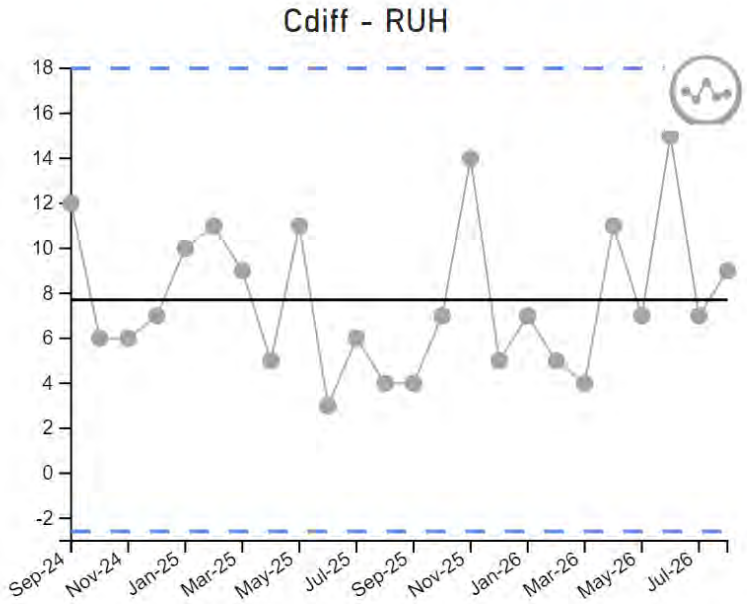
SFT: Ongoing catheter audits drive timely interventions to improve the quality and consistency of care.

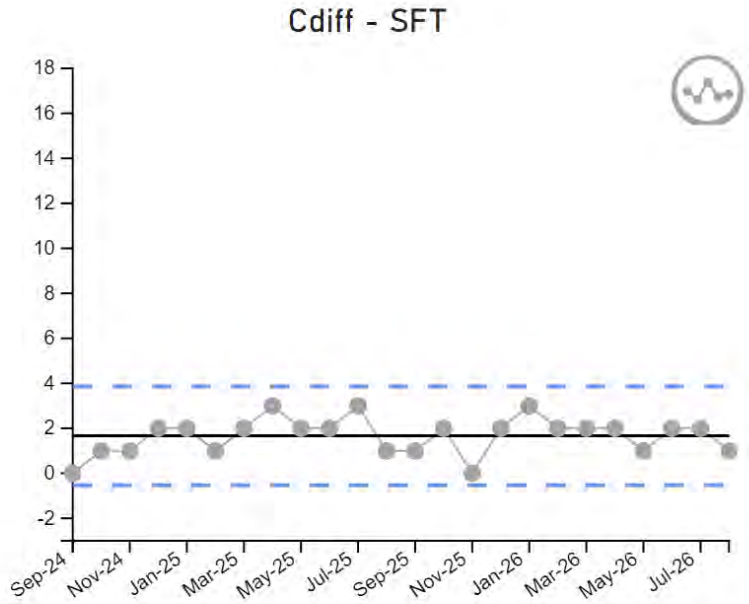
RUH: There is a risk that E.coli numbers continue to rise despite improvement interventions. Work is underway to implement recently published guidelines on UTI prevention and management pathways.

Cdiff


Cdiff - Group
30
28
26
24
22
20
18
16
14
12
10
8
6
4
2
0
Sep-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25
Sep-25
Nov-25
Jan-26
Mar-26
May-26
Jul-26


Cdiff - GWH
18
16
14
12
10
8
6
4
2
0
-2
Sep-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25
Sep-25
Nov-25
Jan-26
Mar-26
May-26
Jul-26


Cdiff - RUH
18
16
14
12
10
8
6
4
2
0
-2
Sep-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25
Sep-25
Nov-25
Jan-26
Mar-26
May-26
Jul-26


Cdiff - SFT
18
16
14
12
10
8
6
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2
0
-2
Sep-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25
Sep-25
Nov-25
Jan-26
Mar-26
May-26
Jul-26

Cdiff

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Cdiff	Group			Aug-26	13				Common Cause Variation
Cdiff	GWH			Aug-26	3				Common Cause Variation
Cdiff	RUH			Aug-26	9				Common Cause Variation
Cdiff	SFT			Aug-26	1				Common Cause Variation

Understanding Performance

Group: C. difficile performance remains within expected levels of variation across the BSW Group. Monthly case numbers continue to fluctuate between organisations, with no recurring Group-wide source or common theme identified. Ongoing surveillance and case review processes continue to support understanding of variation and inform targeted improvement activity.
GWH: The number of cases decreased to 3 in August from 9 in July. Antibiotic exposure remains a contributory factor, as does the use of Proton Pump Inhibitors (PPI) and those with diabetes as a risk factor.
SFT: July recorded two hospital-onset healthcare-associated (HOHA) C. difficile cases, consistent with the previous three months and remaining within common cause variation.
RUH: There has been 9 cases reported during August. Further analysis has not identified any clear principal causes. Testing has not identified any evidence of cross infection

Countermeasures

Group: BSW IPC and antimicrobial stewardship workstreams continue to support improvement through shared learning, case review and targeted prevention initiatives. Ongoing surveillance and multidisciplinary review processes are being used to identify themes, reduce unwarranted variation and strengthen learning across the Group.
GWH: IPC improvement activity continues to focus on antimicrobial stewardship, hand hygiene, environmental cleanliness, and the effective decontamination of patient care equipment, including commodes. This work is supported by ongoing surveillance through IPC governance structures.
SFT: *C. difficile* reviews and multidisciplinary virtual ward rounds continue to support oversight, learning, and improvement, with actions monitored through IPC governance
RUH: Delivery of IPC improvement programme remains centred on key priorities, including antimicrobial stewardship, hand hygiene, environmental cleanliness and equipment decontamination. The Regional NHSE Infection Prevention and Control Team has undertaken a peer visit in September to review case management and improvement workstreams.

Risks and Mitigation

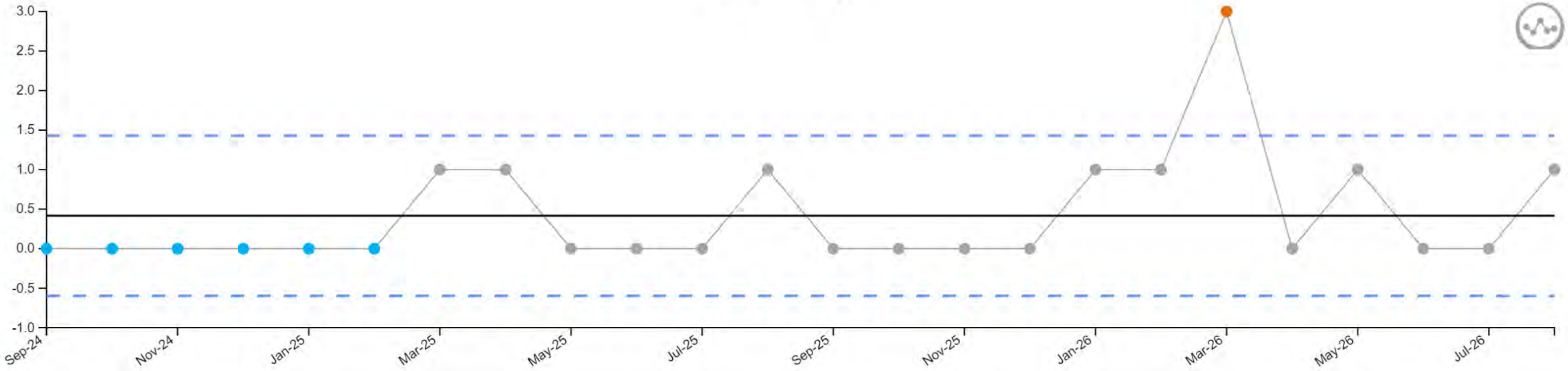
GWH: There remains a risk that patient complexity and healthcare-associated infection factors may contribute to ongoing variation in infection rates. This is being mitigated through enhanced case review, IPC oversight, antimicrobial stewardship, and continued monitoring through established governance processes.

SFT: Risks associated with HCAIs, delayed investigations and incomplete actions are mitigated through enhanced oversight, robust monitoring and timely escalation

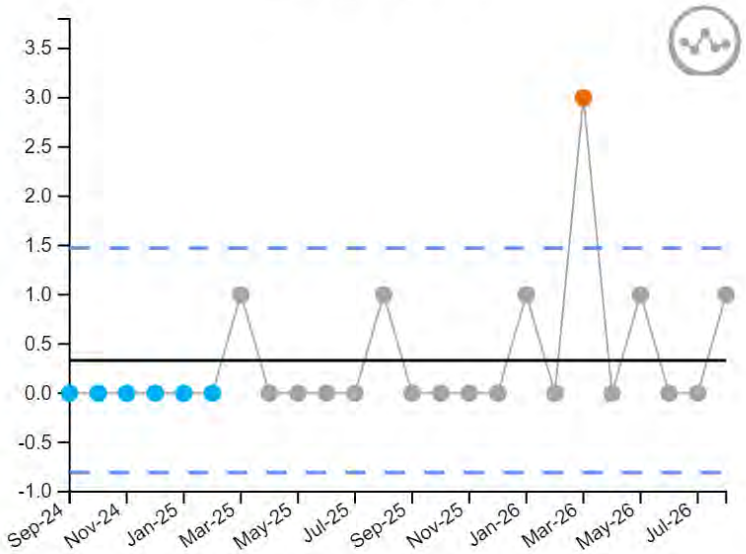
RUH: A risk remains of ongoing variation in infection rates. An external review by NHSE and UKHSA has been requested. This continues to be mitigated through robust case reviews and IPC team oversight, monitored by the Infection Prevention and Control Committee.

MRSA

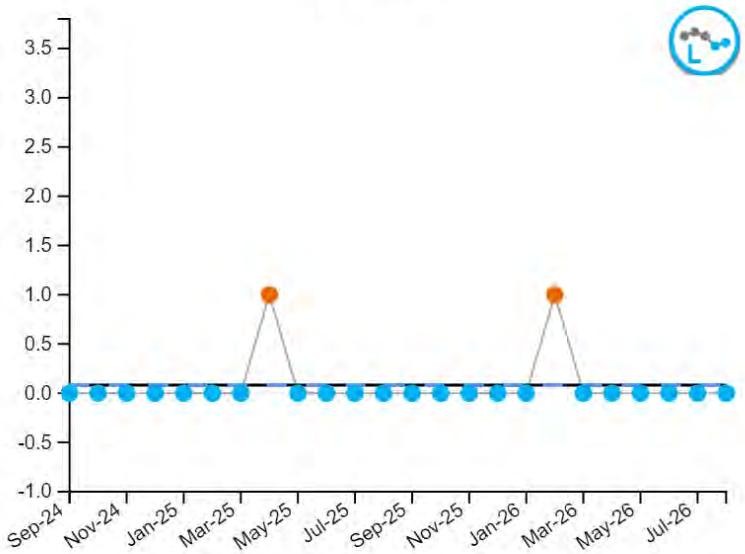
MRSA - Group



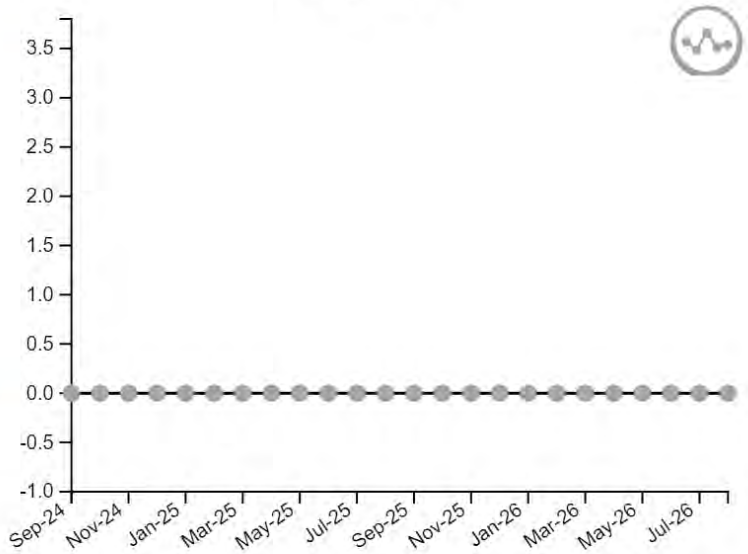
MRSA - GWH



MRSA - RUH



MRSA - SFT



MRSA

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
MRSA	Group			Aug-26	1				Common Cause Variation
MRSA	GWH			Aug-26	1				Common Cause Variation
MRSA	RUH			Aug-26	0				Special Cause Improving - Below Lower Control Limit
MRSA	SFT			Aug-26	0				Common Cause Variation

Understanding Performance

Group: Two methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia cases were reported across the Group in month.

GWH: There was one case of healthcare associated MRSA bacteraemia reported during August 2026, which highlighted learning around early swabbing of wounds.

SFT: There was no healthcare associated MRSA bacteraemia reported during July 2026.

RUH: There was one healthcare associated MRSA bacteraemia reported during August 2026.

Countermeasures

Group: System-wide IPC work continues to focus on maintaining current performance through screening, hand hygiene, antimicrobial stewardship, surveillance, and ongoing staff education.

GWH: IPC work continues to focus on early identification and management of infection risks through screening, hand hygiene, antimicrobial stewardship and ongoing surveillance. All cases continue to be reviewed to identify learning and maintain good practice.

SFT: Continued monitoring and escalation of cases.

RUH: Workstreams continue focusing on MRSA screening on admission, together with delivering core IPC standards including decolonisation. Improving blood culture technique and sepsis management also remains a focus.

Risks and Mitigation

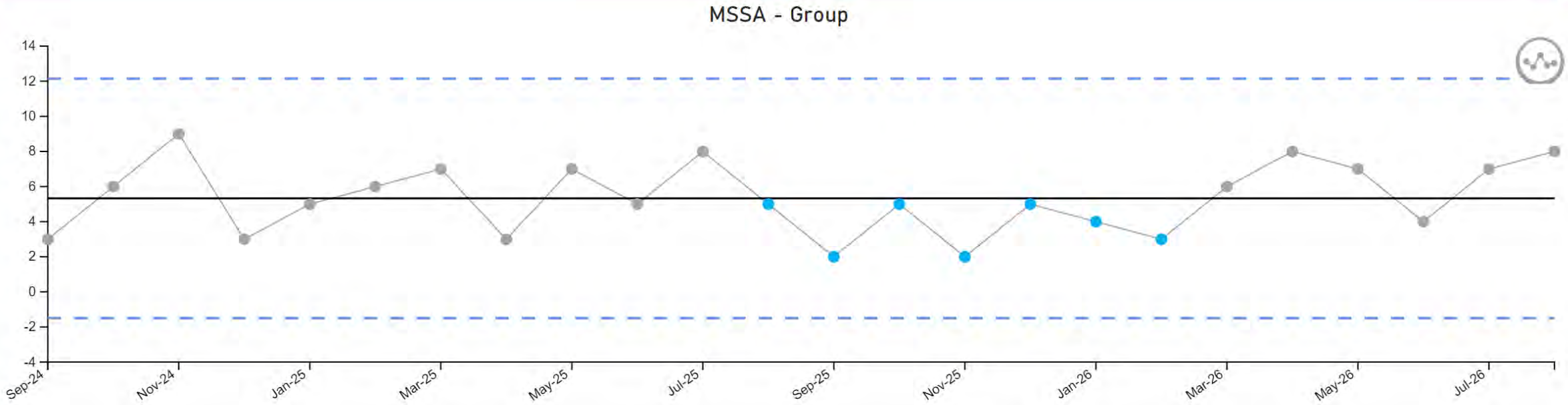
Group: Whilst performance remains stable, there remains an ongoing risk of healthcare-associated infection if prevention and control measures are not consistently applied. This is mitigated through continued IPC oversight, staff training, compliance monitoring, quality assurance activity and system-wide sharing of learning across the Group.

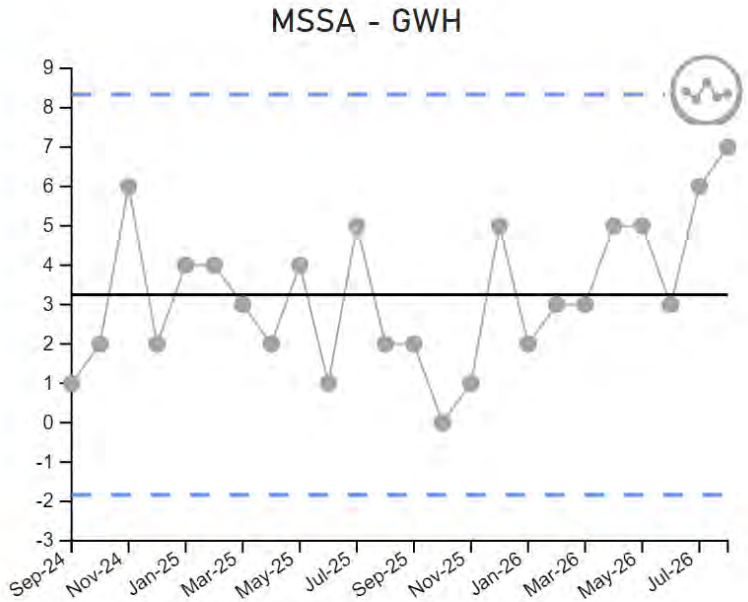
GWH: The Trust continues to maintain vigilance, monitoring and staff awareness activities to minimise the risk of healthcare-associated infection and sustain current performance.

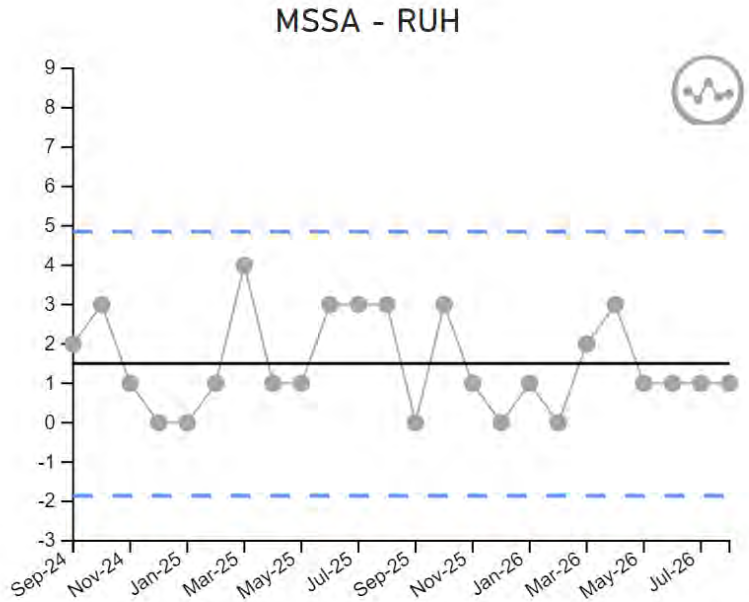
SFT: Ongoing IPC audits, peer reviews, ward visits and staff education maintain assurance and drive continuous improvement.

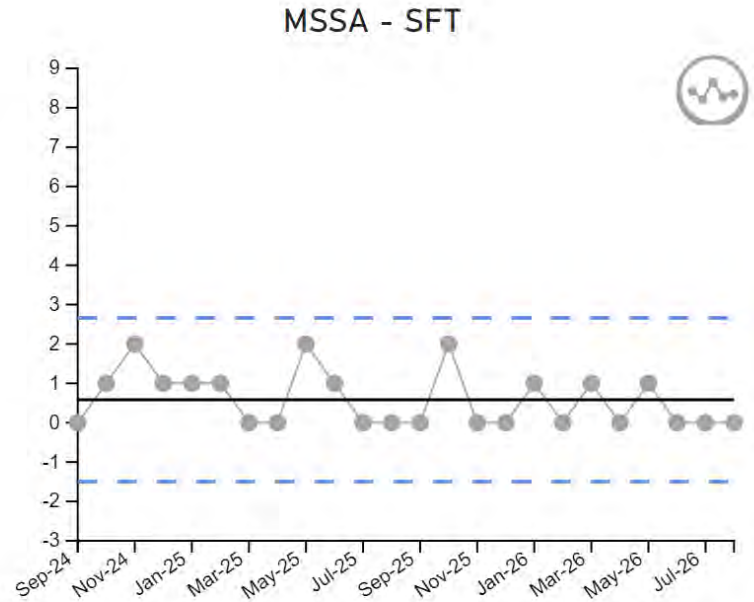
RUH: IPC & the QI team are jointly leading the delivery of six core quality improvements workstreams, designed to provide a holistic and organisation wide impact on IPC outcomes.

MSSA


MSSA - Group
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6
4
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-4
Sep-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25
Sep-25
Nov-25
Jan-26
Mar-26
May-26
Jul-26


MSSA - GWH
9
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-2
-3
Sep-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25
Sep-25
Nov-25
Jan-26
Mar-26
May-26
Jul-26


MSSA - RUH
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Sep-24
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Jan-25
Mar-25
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Jan-26
Mar-26
May-26
Jul-26


MSSA - SFT
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Sep-24
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May-26
Jul-26

MSSA

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
MSSA	Group			Aug-26	8				Common Cause Variation
MSSA	GWH			Aug-26	7				Common Cause Variation
MSSA	RUH			Aug-26	1				Common Cause Variation
MSSA	SFT			Aug-26	0				Common Cause Variation

Understanding Performance

Group: Methicillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia continues to demonstrate variation across the Group, with most cases reported at GWH and RUH, whilst SFT reported no cases in August 2026. Overall variation remains within expected limits and is consistent with common cause variation.

GWH: There was 7 MSSA infections reported during August 2026.

SFT: There was 0 MSSA reported in July 2026.

RUH: There was 1 MSSA infection reported during August 2026.

Countermeasures

Group: IPC teams continue to undertake case reviews and share learning to identify common themes, emerging risks and opportunities for improvement. Improvement activity across the Group remains focused on catheter and vascular access care, hand hygiene compliance, antimicrobial stewardship, and the cleaning and decontamination of patient care equipment.

GWH: A review of cases has identified that Aseptic Non-Touch Technique(ANTT) may be a contributory factor. A quality improvement project is underway, including a policy review.

SFT: Ongoing monitoring and review of all cases with ward teams and IPC provide assurance that learning is identified and improvement actions implemented.

RUH: A quality improvement project is underway looking at central and intravenous access device management. This will also include work which will align to the NVAS guidelines and contribute to the reduction of infections.

Risks and Mitigation

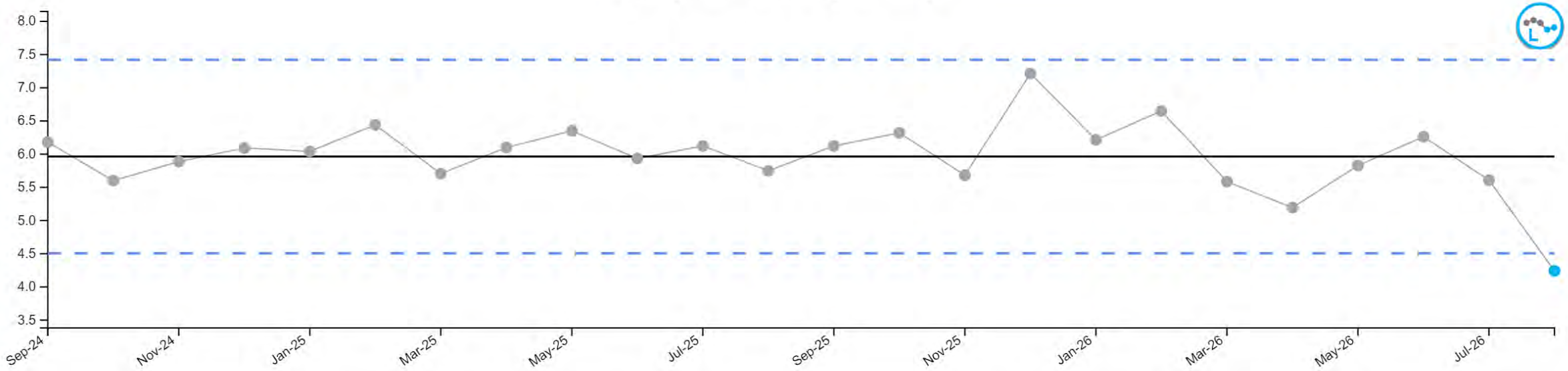
GWH: GWH remains above the Southwest average. Mitigations through established IPC workstreams, ongoing case reviews, compliance monitoring and continued focus on key infection prevention measures to reduce future cases.

SFT: Ongoing IPC audits, peer reviews and targeted education provide assurance that effective controls are maintained and performance sustained.

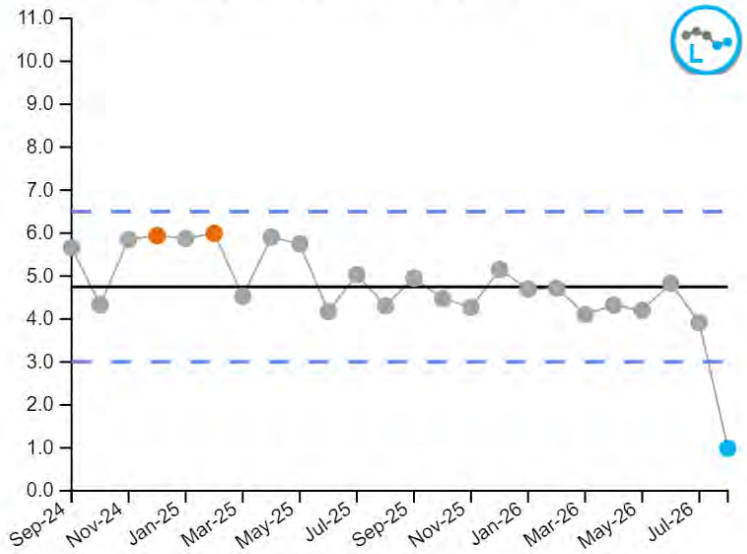
RUH: A programme of ongoing mitigation is in place which includes compliance audits and monitoring to support improvement.

Falls per 1000 bed days

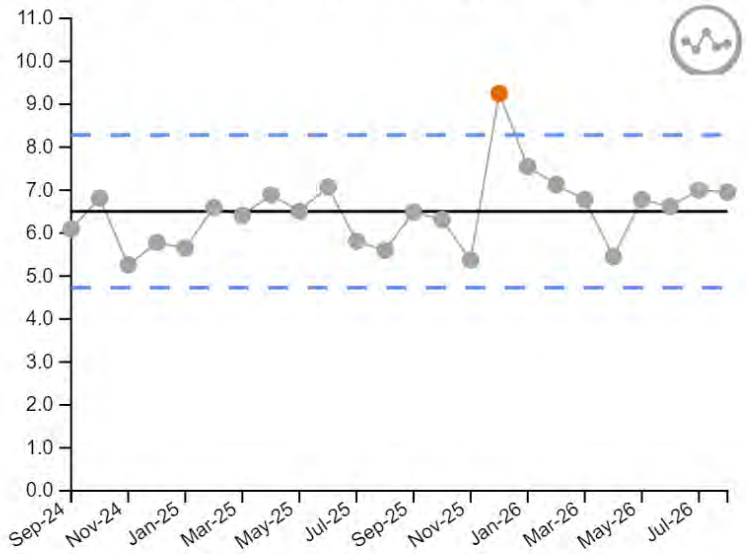
Falls per 1000 bed days - Group



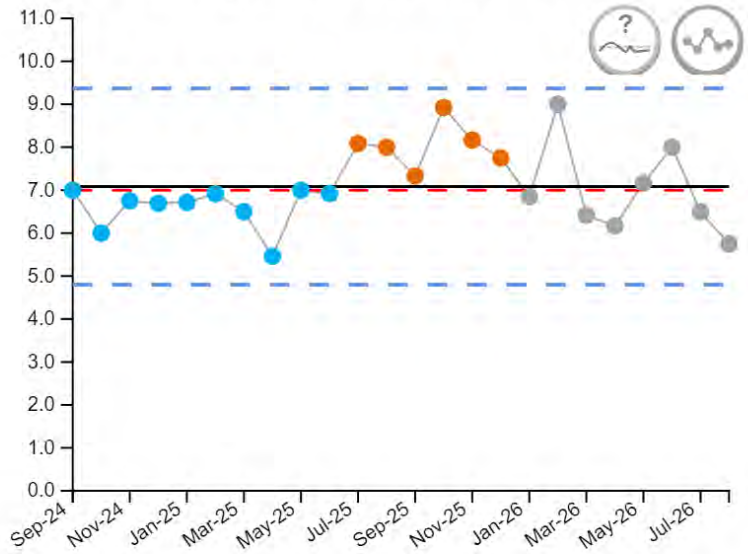
Falls per 1000 bed days - GWH



Falls per 1000 bed days - RUH



Falls per 1000 bed days - SFT



Falls per 1000 bed days

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Falls per 1000 bed days	Group			Aug-26	4.2				Special Cause Improving - Below Lower Control Limit
Falls per 1000 bed days	GWH			Aug-26	1.0				Special Cause Improving - Below Lower Control Limit
Falls per 1000 bed days	RUH			Aug-26	7.0				Common Cause Variation
Falls per 1000 bed days	SFT		7.0	Aug-26	5.8	✓			Common Cause Variation

Understanding Performance

Group: Falls performance across the BSW Group remains better than the national benchmark and continues to demonstrate common cause variation. While RUH reports a higher falls rate than other organisations, overall Group performance remains stable, with improving trends evident at GWH and performance at SFT remaining within target.

GWH: Falls decreased from 3.9 per 1,000 bed days in July to 1.0 in August. Falls performance overall continues to improve, with a sustained reduction over time.

SFT: Falls decreased to 6.1 per 1,000 bed days in July, from 7.7 in June, exceeding the Trust target.

RUH: There were 7.0 falls per 1,000 bed days in August which is slightly above the National Audit for inpatient falls (NAIF) benchmark of 6.6, but within the SPC control limits.

Countermeasures

GWH: Weekly multidisciplinary review of falls incidents continues to support organisational learning and the identification of improvement opportunities. Current areas of focus include enhancing meaningful activity for patients requiring enhanced care, improving communication of mobility needs at handover, and promoting effective continence management and mobilisation.

SFT: Falls reduction measures have been strengthened across all wards in response to ongoing operational pressures, contributing to improved performance in July

RUH: Improvement projects regarding Lying and standing blood pressure in place in several wards. Review and redesign in progress with key stakeholders to improve how we collate insights and themes from falls at trust and divisional level.

Risks and Mitigation

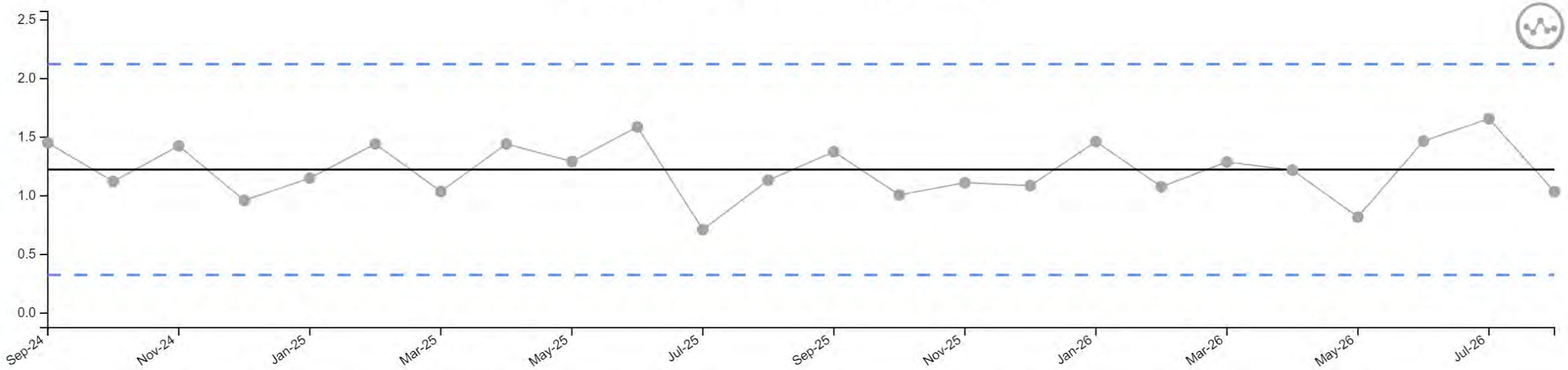
GWH: Work is progressing with the deconditioning programme to reduce risk of falls. Performance continues to improve.

SFT: Staffing and patient safety are monitored at least three times daily, with mitigations continuously reviewed. Despite ongoing risks associated with operational pressures, escalation beds and higher patient acuity, falls prevention measures remain effective, with levels of harm remaining low.

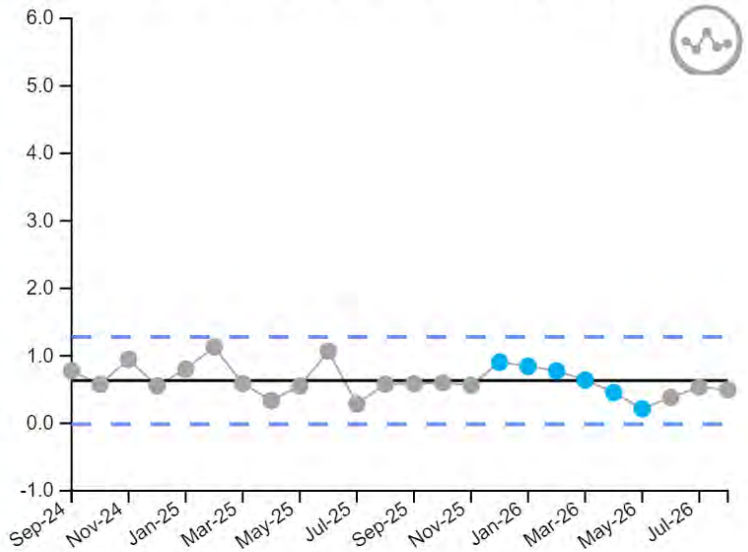
RUH: There is a risk to compliance if focused work is reduced or stopped. Improvement work is progressing aligned with the Enhanced Therapeutic Observations of care workstream. There will be a temporary reduction in the fall's prevention central resource due to a vacancy in the Quality Improvement team from the end of August.

Pressure Ulcers per 1000 beddays

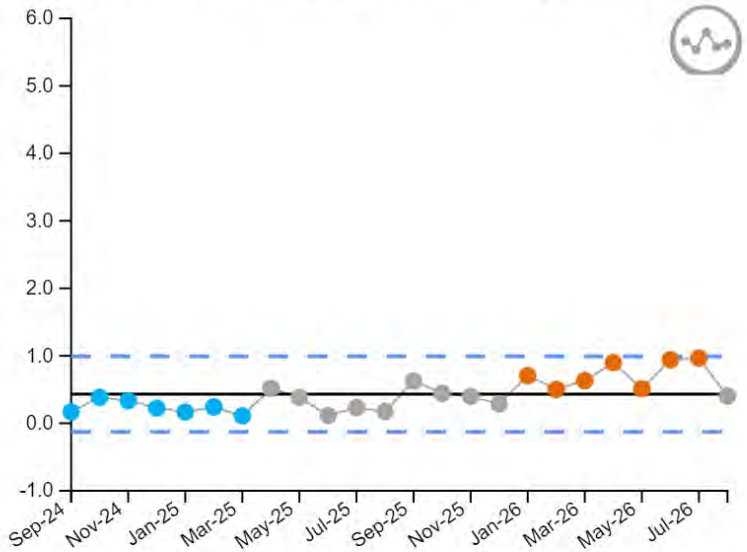
Pressure Ulcers per 1000 beddays - Group



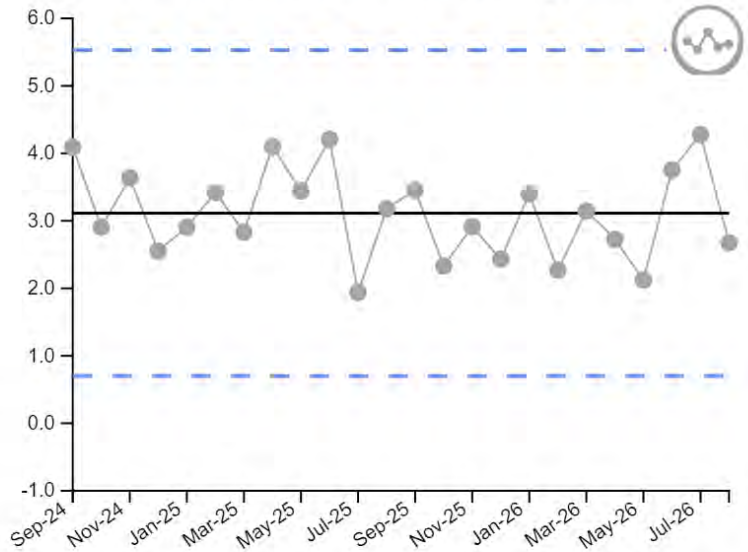
Pressure Ulcers per 1000 beddays - GWH



Pressure Ulcers per 1000 beddays - RUH



Pressure Ulcers per 1000 beddays - SFT



Pressure Ulcers per 1000 beddays

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Pressure Ulcers per 1000 beddays	Group	Category 2/3/4, excluding specialist areas		Aug-26	1.0				Common Cause Variation
Pressure Ulcers per 1000 beddays	GWH	Category 2/3/4, excluding specialist areas		Aug-26	0.5				Common Cause Variation
Pressure Ulcers per 1000 beddays	RUH	Category 2/3/4, excluding specialist areas		Aug-26	0.4				Common Cause Variation
Pressure Ulcers per 1000 beddays	SFT	Category 2/3/4, excluding specialist areas		Aug-26	2.7				Common Cause Variation

Understanding Performance

Group: Pressure ulcer rates remain relatively low across the BSW Group and continue to demonstrate expected variation between organisations. GWH and RUH remain at low levels overall, while SFT reported an increase during the month. No Group-wide themes have been identified, and performance continues to be monitored through established governance arrangements.
GWH: Pressure ulcers incidents remained at 0.5 pressure ulcers per 1,000 bed days in August 2026. No category 3 or 4 pressure ulcers were reported.
SFT: Pressure ulcer incidence increased to 4.5 per 1,000 bed days in July (3.8 in June), driven by higher rates reported within Medicine division. No Category 4 pressure ulcers were reported. Performance improved across Surgical and FASS services, although MASD incidence and admissions with pressure ulcers and MASD increased.
RUH: For August 2026, the RUH reported 0.4 pressure ulcers per 1,000 bed days which is an improvement

Countermeasures

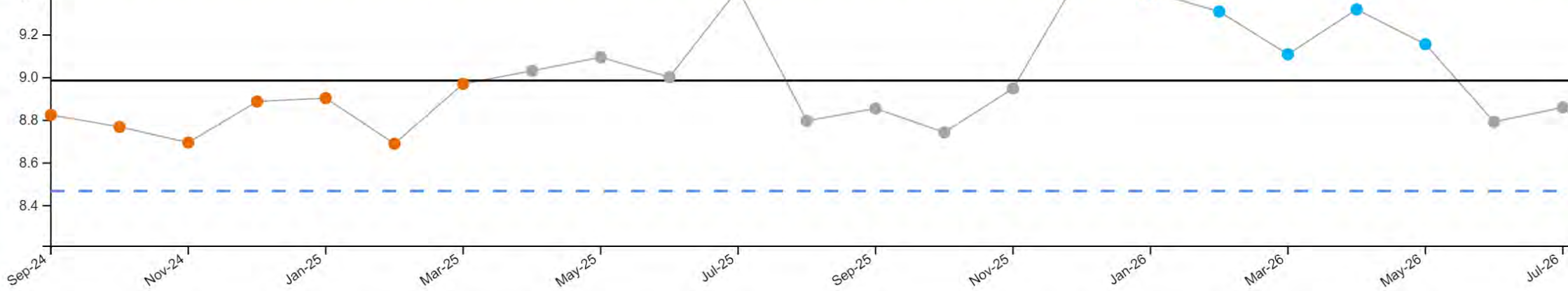
Group: A BSW-wide focus remains on early identification of patients at risk of pressure damage, consistent assessment, shared learning and preventative interventions. Improvement activity continues across all organisations to strengthen risk assessment, staff education, skin care management and the prevention of device-related pressure damage.
GWH: Teams are focusing on improving the quality and timeliness of skin assessments and risk assessments for pressure ulcers.
SFT: Pressure ulcer prevention measures continue to be strengthened through the implementation of air-cooling units, rollout of a new continence formulary, staff training and ward champions, revised continence care practices, updates to the MASD pathway, and thematic review of pressure ulcer incidents and assessment processes.
RUH: Targeted countermeasures are in place, led by the Tissue Viability Improvement Group. Senior Nursing Team are holding exceptional meetings to discuss a plan to release nurses from some tasks to give them time to care – including pressure ulcer prevention which is an essential element of nursing.

Risks and Mitigation

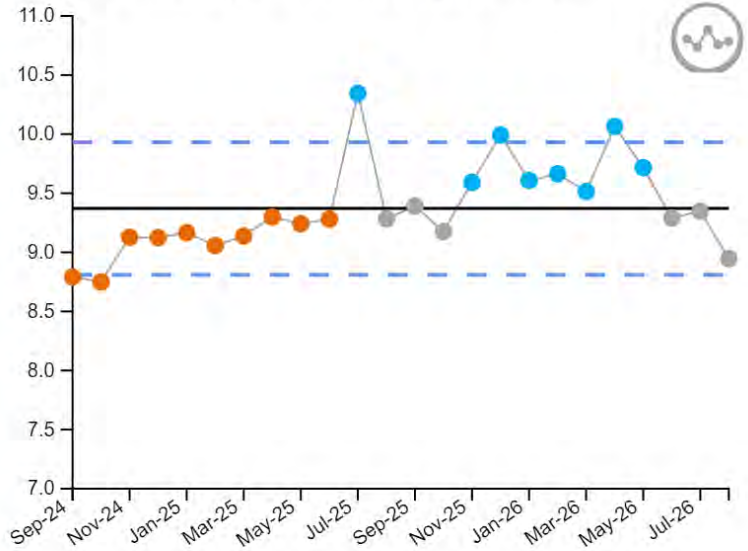
GWH: The risk remains of increased pressure harms given levels of acuity and increase in use of trolleys and corridor care. Focus remains on ensuring early and accurate assessments, so patients receive the right care as early as possible.

SFT: There is a risk of **i**ncreased MASD and pressure ulcer incidence associated with extreme heat and operational pressures. Targeted pressure ulcer prevention measures and Tissue Viability team support remain in place to mitigate risk.

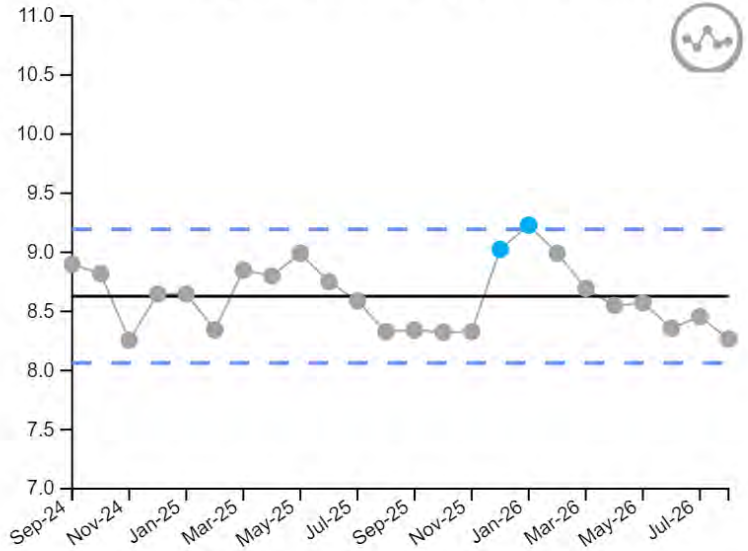
RUH: There is a risk of increased pressure injuries due to operational pressures, acuity and increased frailty, increasing corridor care and use of trolleys. Focus remains ensuring early and accurate assessment of individual patient risk and the delivery of preventative care.



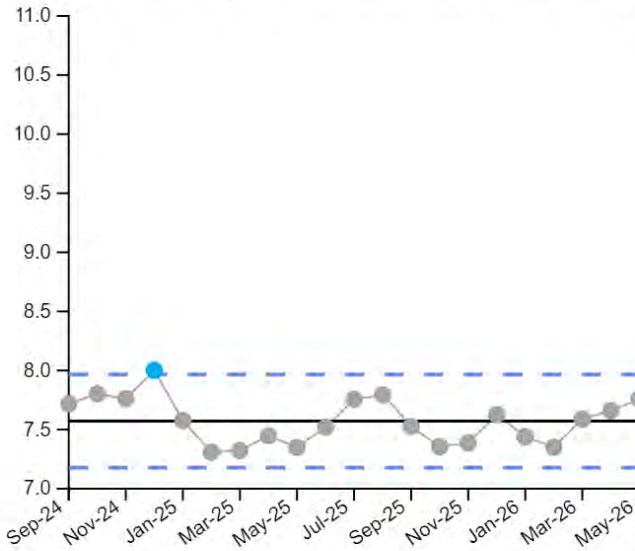
Care Hours per Patient Day (CHPPD) - GWH



Care Hours per Patient Day (CHPPD) - RUH



Care Hours per Patient Day (CHPPD) - S



Care Hours per Patient Day (CHPPD)

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Care Hours per Patient Day (CHPPD)	Group			Aug-26	8.6				Common Cause Variation
Care Hours per Patient Day (CHPPD)	GWH			Aug-26	8.9				Common Cause Variation
Care Hours per Patient Day (CHPPD)	RUH			Aug-26	8.3				Common Cause Variation
Care Hours per Patient Day (CHPPD)	SFT			Aug-26	7.5				Common Cause Variation

Understanding Performance

GWH: CHPPD performance remains stable and within expected levels of variation. Higher CHPPD continues to be driven predominantly by enhanced care requirements, additional escalation capacity and increased deployment of support staff in response to patient acuity and dependency.

SFT: CHPPD reduced slightly in July due to lower shift fill rates and continued use of escalation capacity. ETOC demand increased significantly to 2,277 hours (1,705 in June), reflecting higher levels of 1:1 care for vulnerable patients. Despite increased bank and agency deployment, unfilled RMN and HCA ETOC hours remained a challenge. Off-framework agency usage totalled 40 shifts, predominantly within ICU.

RUH: Slight reduction in the month of August at 8.3 CHPPD compared to 8.5 in July 2026. The CHPPD variance corresponds with the reduced fill rates below 90% on day shifts, alongside additional escalation capacity open within inpatient units.

Countermeasures

GWH: Daily safe staffing reviews and escalation processes continue to align workforce resources to patient acuity and dependency. Workforce deployment and enhanced care requirements are actively monitored to maintain safe staffing levels and support delivery of safe patient care during sustained operational pressures.

SFT: Enhanced staffing governance is maintained through three-times-daily staffing reviews, weekly safe staffing oversight led by the DCNO and Safe Staffing Matron, and monthly Safer Staffing meetings, providing assurance on workforce capacity, staff unavailability, temporary staffing usage, and associated risks and mitigations.

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

Risks and Mitigation

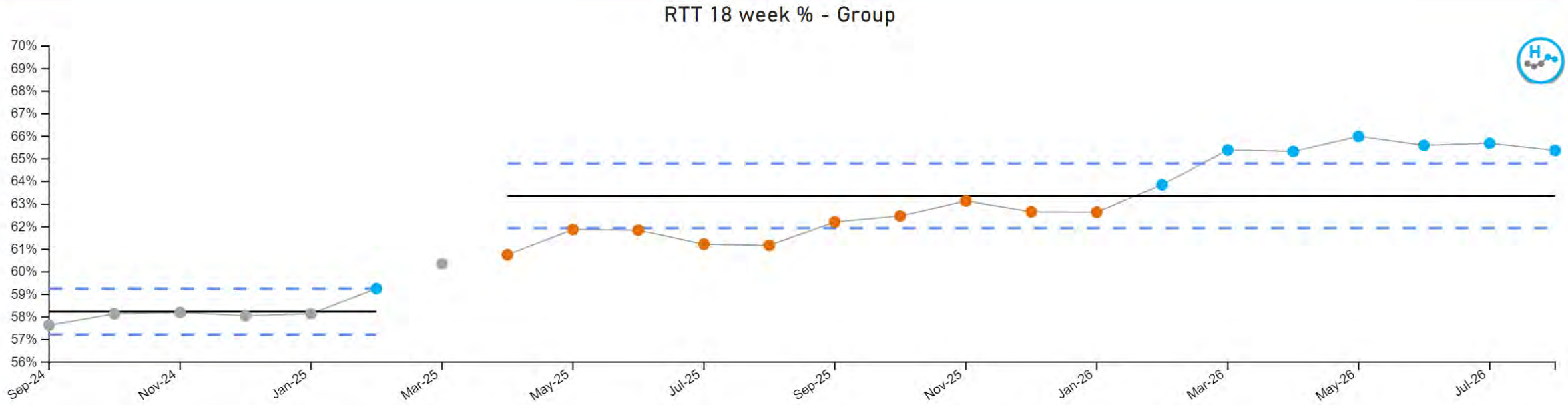
Group: Sustained operational pressures, enhanced care requirements and the ongoing use of escalation capacity continue to place pressure on workforce resources across the Group. Risks are mitigated through established safe staffing governance processes, regular workforce reviews, professional judgement and proactive deployment of staff to maintain safe and effective patient care.

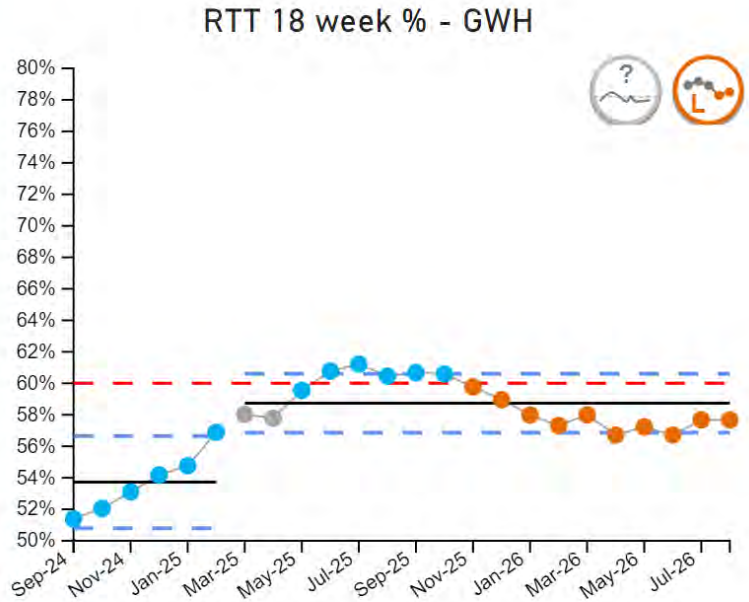
GWH: Sustained operational pressures, increased enhanced care requirements and the continued use of escalation capacity place ongoing pressure on workforce resources and CHPPD. This is mitigated through daily safe staffing reviews, escalation processes, flexible workforce deployment and executive oversight to maintain safe patient care.

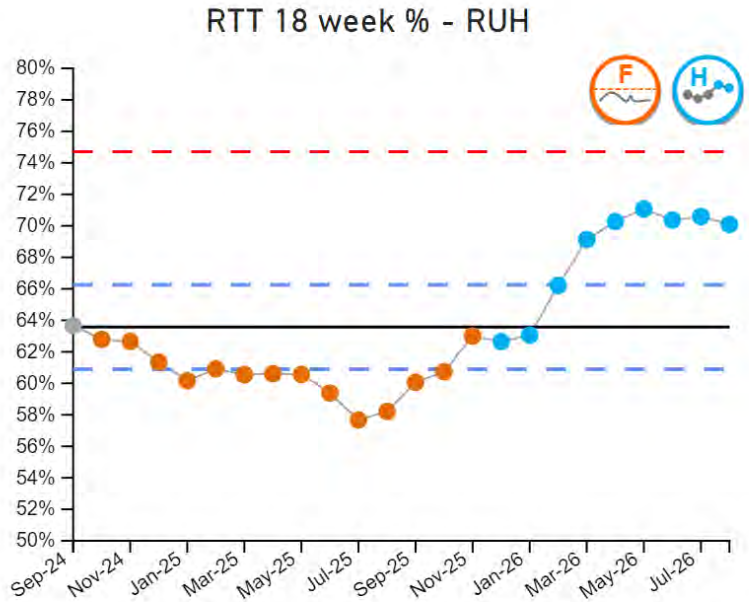
SFT: High sickness absence and increased demand for additional observations, and care needs including RMN cover continue to impact staffing capacity. Enhanced divisional oversight, daily redeployment and processes now in place to strengthen bank fill, mitigate risk and maximise workforce availability.

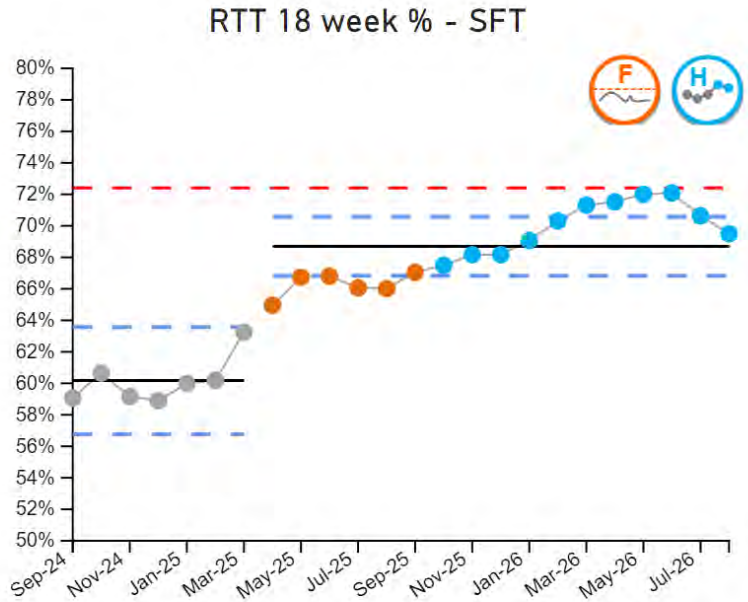
RUH: The risks identified from SafeCare in August show continued raised levels of short-term absence, alongside existing vacancy and the operational need for additional escalation capacity to support operational pressures. Risks are mitigated with twice daily safer staffing meetings chaired by a senior nurse and utilising established

RTT 18 week %


RTT 18 week % - Group
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RTT 18 week % - GWH
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RTT 18 week % - RUH
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RTT 18 week % - SFT
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RTT 18 week %

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
RTT 18 week %	Group			Aug-26	65.4%				Special Cause Improving - Above Upper Control Limit
RTT 18 week %	GWH		60.0%	Aug-26	57.7%	X			Special Cause Concerning - Run Below Mean
RTT 18 week %	RUH		74.7%	Aug-26	70.1%	X			Special Cause Improving - Above Upper Control Limit
RTT 18 week %	SFT		72.4%	Aug-26	69.5%	X			Special Cause Improving - Run Above Mean

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

Understanding Performance

Group
August RTT performance was below plan at all three trusts. GWH held steady, while RUH and SFT declined.

GWH 57.7% (provisional), unchanged from July and 4.3 percentage points below the 62% plan. The waiting list fell to 43,128 against a plan of 44,000.

RUH 70.1%, down 0.5 percentage points from July and below trajectory. Referrals grew 19% year to date against a flat plan. No patients waited over 65 weeks.

SFT 69.6%, down from 71.0% in July and below plan for the first time in over a year. Over-52-week waits rose to 126, with eight patients over 65 weeks.

Countermeasures

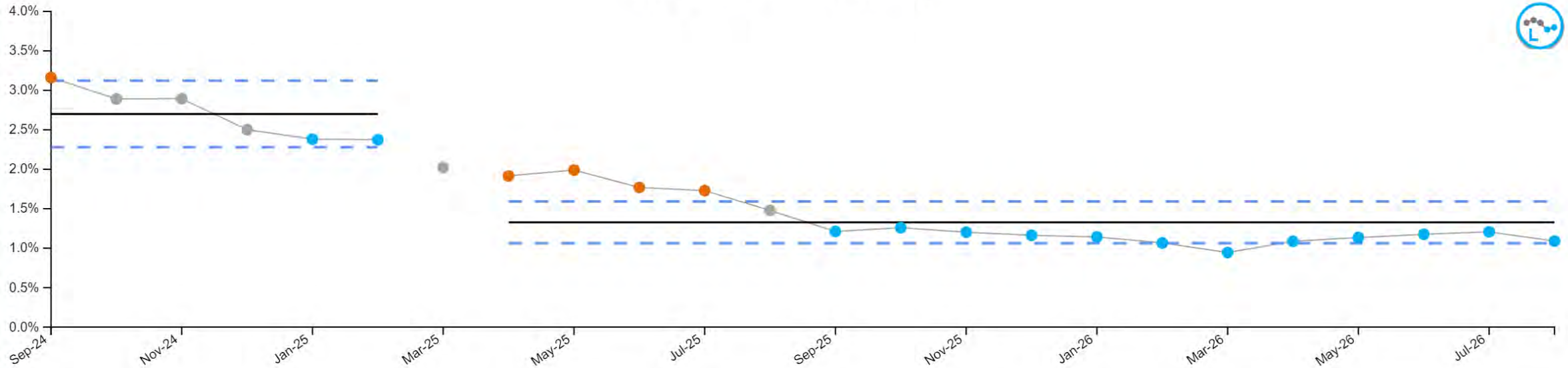
- **RUH** is adding surgical and cardiology capacity and transferring suitable patients to Sulis. A H2 recovery plan is being formalised to recover the position given increased demand.
- **SFT** Patient Led Validation removes 8% of responding patients from targeted lists, with further validation and booking support underway. A H2 recovery plan is being drafted.
- **GWH** continues targeted specialty recovery and waiting-list control. Over-52-week waits fell by 107 to 1,000, but remain well above the 319 plan. Focus remains on treating the longest waiters and sustaining recovery.
- **Group** continues RTT toolkit adoption and 2027/28 elective planning. Existing group plans include a Q4 Elective Coordination Centre and Gynaecology and Dermatology transformation for 2027.

Risks and Mitigation

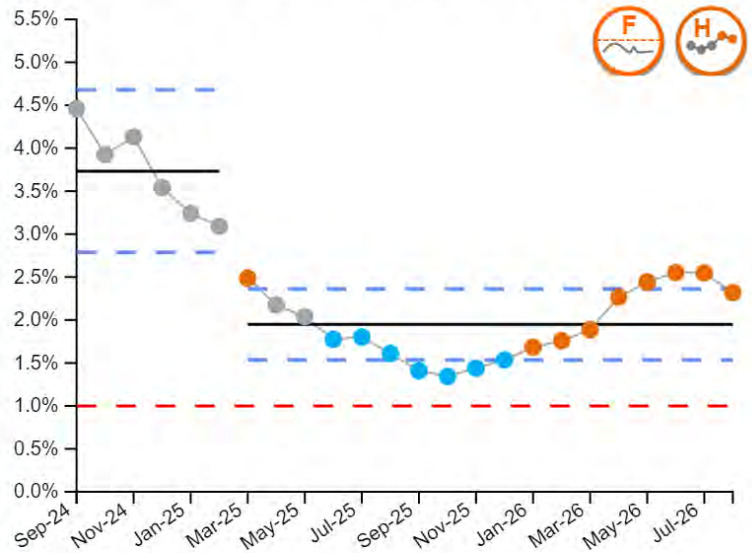
- Risk: referral growth exceeds capacity. Mitigation: group Advice & Refer and Cinapsis expansion. Trusts plan first 10 specialties for October, supported by clear referral criteria and phased implementation.
- Risk: diagnostic and clinical capacity delays prolong waits. Mitigation: CDC mobilisation on course to increase capacity, RUH Head and Neck radiology capacity from September, and SFT work on first appointments and diagnostic turnaround.
- Risk: Advice & Refer may disrupt RTT performance during transition but will significantly help reduce demand. Mitigation: phased rollout, utilisation and compliance reporting, and continued pathway validation. Modelling being undertaken on potential impact.

RTT % Over 52 Weeks

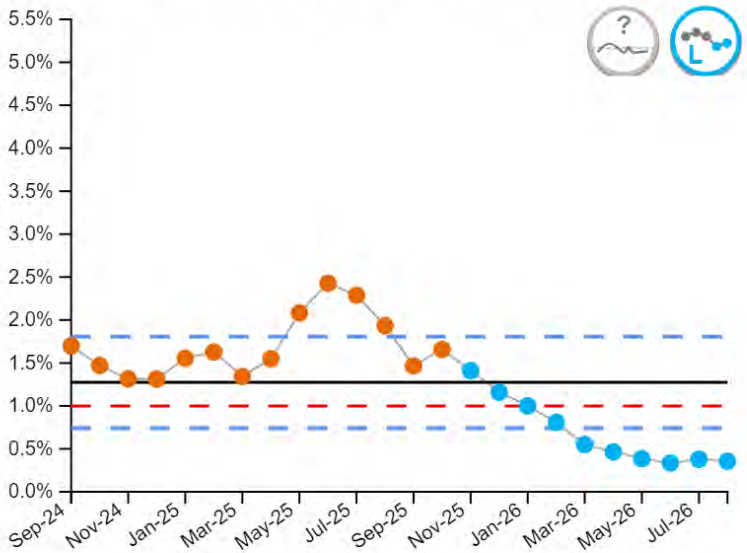
RTT % Over 52 Weeks - Group



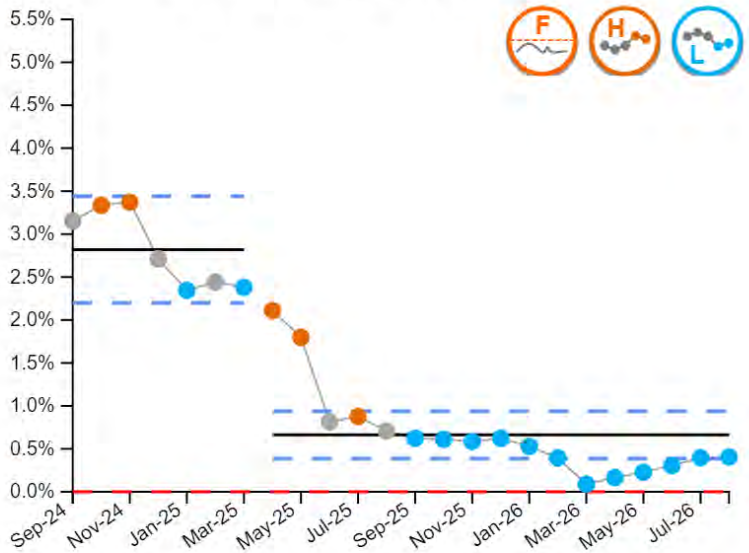
RTT % Over 52 Weeks - GWH



RTT % Over 52 Weeks - RUH



RTT % Over 52 Weeks - SFT



RTT % Over 52 Weeks

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
RTT % Over 52 Weeks	Group			Aug-26	1.1%			L	Special Cause Improving - Run Below Mean
RTT % Over 52 Weeks	GWH		1.0%	Aug-26	2.3%	✗	F	H	Special Cause Concerning - Two Out of Three High
RTT % Over 52 Weeks	RUH		1.0%	Aug-26	0.4%	✓	?	L	Special Cause Improving - Below Lower Control Limit
RTT % Over 52 Weeks	SFT		0.0%	Aug-26	0.4%	✗	F	H	Special Cause Concerning - Increasing Run

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

Understanding Performance

Group
August long waits improved at GWH, remained broadly stable at RUH and increased at SFT. GWH remains the main recovery challenge.

GWH reported 1,000 patients over 52 weeks (provisional), down 107 but above the 319 plan. This represents 2.3% of the list. Over-65-week waits rose to 18.

RUH reported 154 patients over 52 weeks, or 0.36% of the list, within its 1% target. ENT waits rose, while Pain and General Surgery improved. No patients waited over 65 weeks.

SFT reported 126 patients over 52 weeks, up from 120. Over-65-week waits doubled to eight, with first-appointment and diagnostic delays driving long waits.

Countermeasures

GWH continues targeted specialty recovery and waiting-list control, focusing on the longest waiters while sustaining reductions in the overall list.

RUH maintains weekly long-wait reviews, additional General Surgery capacity, Pain locum sessions and review of ENT theatre lists to maximise capacity.

SFT Patient Led Validation shows an 8% removal rate among targeted responders. The Patient not Present programme supports validation, with extra capacity where needed.

Group continues the established RTT toolkit approach, with mutual aid and targeted use of available capacity to support long-wait recovery. All Trusts are implementing H2 elective recovery plans (GWH's is included within their original RTT recovery plan).

Risks and Mitigation

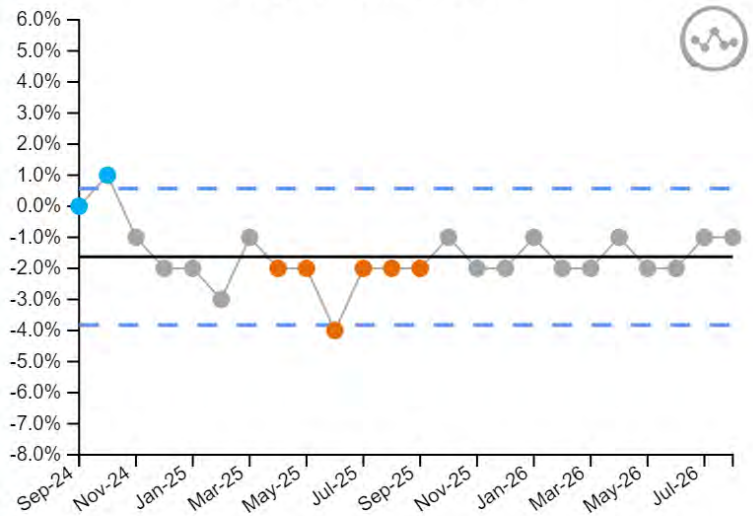
- Risk: GWH remains above plan with rising 65-week waits. Mitigation: specialty recovery, long-wait oversight and established group mutual aid led by Elective Recovery Director.
- Risk: RUH radiology and outpatient capacity constrain recovery. Mitigation: weekly cohort review, and focussed capacity in challenged specialties such as ENT and pain.
- Risk: SFT appointment and diagnostic delays prolong waits. Mitigation: validation and extra capacity. Group Advice & Refer/Cinapsis plans address demand through phased rollout.

RTT wait times top versus bottom quintile of social deprivation

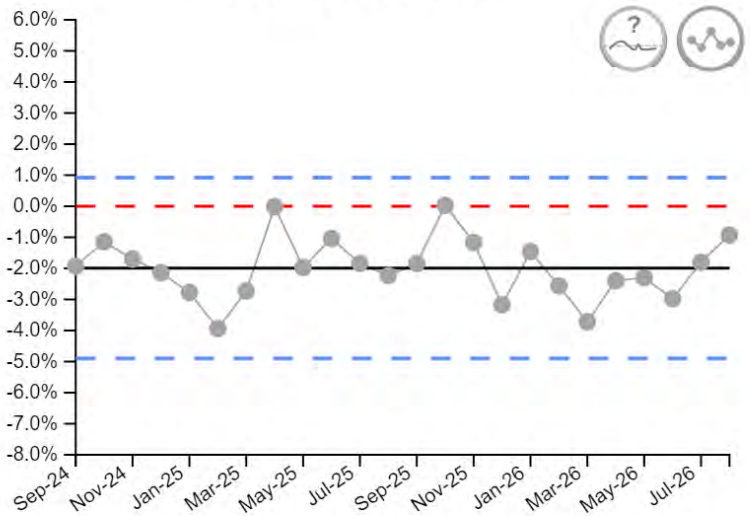
Please note that the RTT social deprivation metric cannot be aggregated across multiple trusts.

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

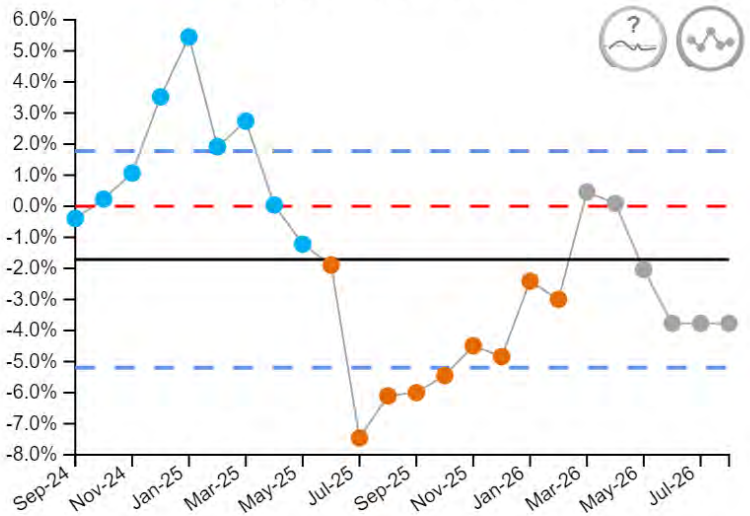
RTT wait times top versus bottom quintile of social deprivation - GWH



RTT wait times top versus bottom quintile of social deprivation - RUH



RTT wait times top versus bottom quintile of social deprivation - SFT



RTT wait times top versus bottom quintile of social deprivation

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
RTT wait times top versus bottom quintile of social deprivation	GWH			Aug-26	-1.0%				Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	RUH		0.0%	Aug-26	-0.9%	X			Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	SFT		0.0%	Aug-26	-3.8%	X			Common Cause Variation

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

Understanding Performance

The data currently statistically shows 'common cause' variation in RTT performance between the top and bottom quintiles of social deprivation for all three of the acute Trusts. There were consistent and sustained improvements in the performance data for SFT from July '25.
Collectively, we have a good understanding of where our CORE20population is and have established governance meetings in each Trust where health inequalities are regularly being discussed.

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

Countermeasures

Cross-Trust (SFT, RUH, GWH): Health Inequalities Leads have agreed to work more closely together via 7 shared actions: to align dashboards and CORE20 reporting; review and standardise forms, templates, and governance processes to embed health inequalities considerations more consistently; share best practice (incl. GWH Equity Framework); run a joint awareness campaign (undertaken in June 2026); develop shared training/resources; and maintain regular joint oversight and annual review. 3-metrics have now been agreed for BI devlopment work (to use standard methodologies for reporting RTT/DNA/Ethnicity data).

Other actions being taken:
SFT: Refreshing A3 with Public Health input; 2 BSW-funded paediatrics and cancer projects to reduce inequalities, task-and-finish group to develop a rurality framework which will support service planning, re-configuring internal ops group.
RUH: Targeted follow-up for missed appointments in deprived groups; pilots on digital exclusion; University of Bath research on urgent and emergency care by deprivation; A3 refresh underway.
GWH: Developing a health inequalities dashboard aligned to NHSE board requirements.

Risks and Mitigation

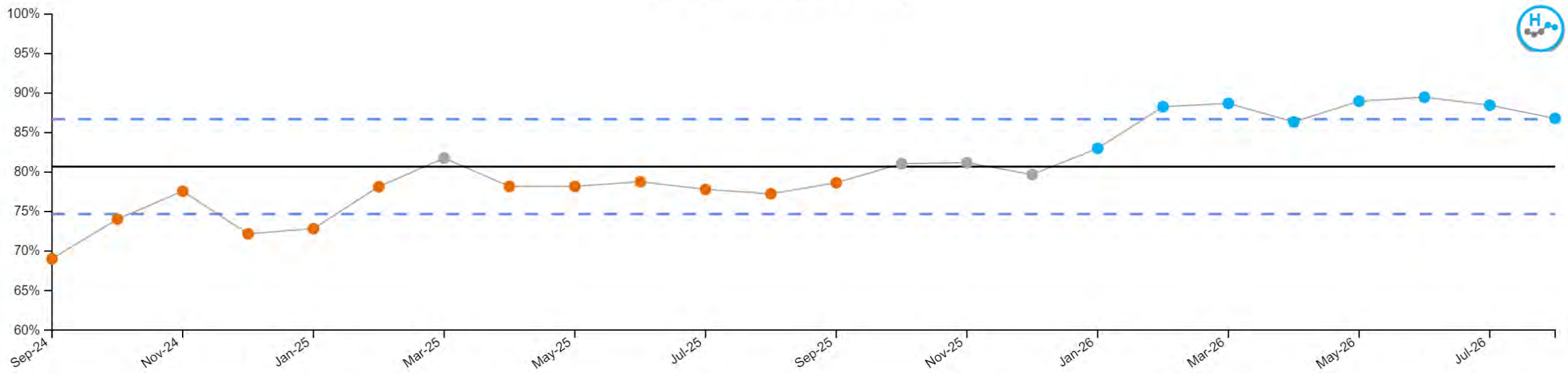
There is a degree of operational complexity in factors that drive the data. The is mitigated through having good oversight of the data and having established governance groups across the group with focus on reducing health inequalities. There is also significant variation in governance structures, reporting arrangements, and priorities across the three Trusts, which may affect alignment and delivery.
SFT: The Ops HI Group feeds into the wider Wiltshire Health Inequalities Group (WHIG). Additional groups operate in BANES (meeting bi-monthly) and Swindon (established summer 2025).
GWH: An internal Inclusion and Health Inequalities Sub-Committee meets bi-monthly. The Health Inequalities Lead also attends the quarterly Performance, Population and Place Committee.
RUH: Re-establishing an internal operations group to support health inequalities work.

Planned mitigations include looking to establish:

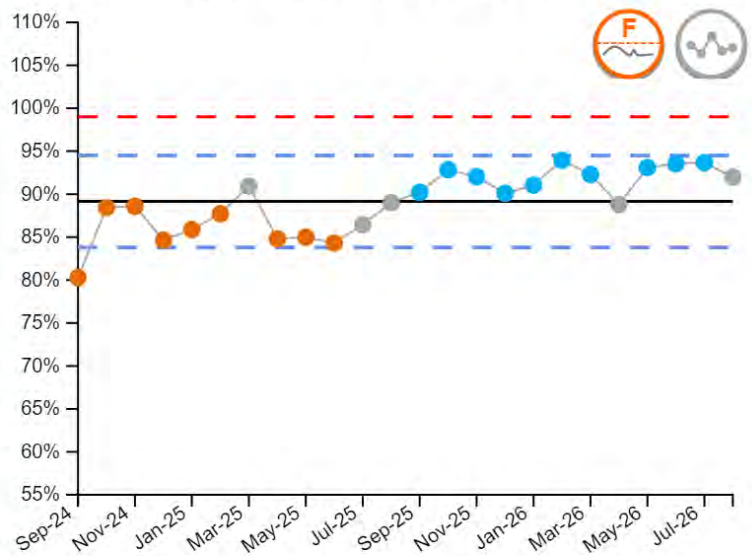
- Joint BI and EPR working groups.
- Shared templates, frameworks, and reporting approaches.
- Common education and awareness resources.
- Regular collaborative meetings and Board-level engagement to maintain oversight and accountability.

DM01 Performance

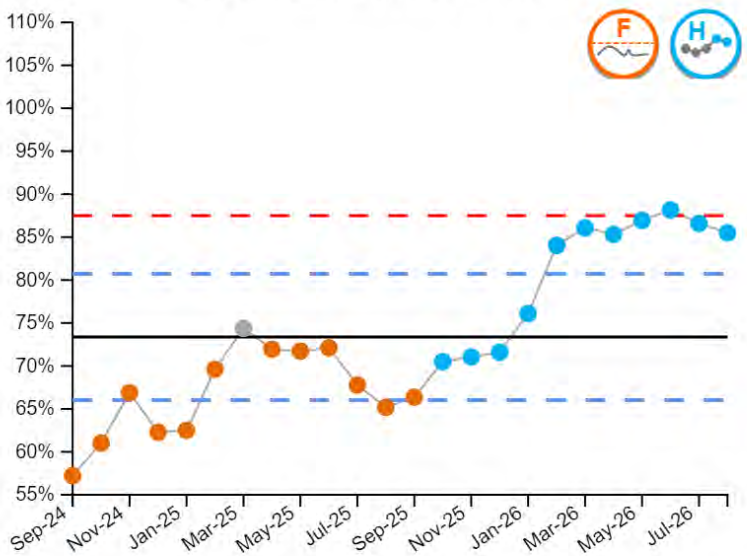
DM01 Performance - Group



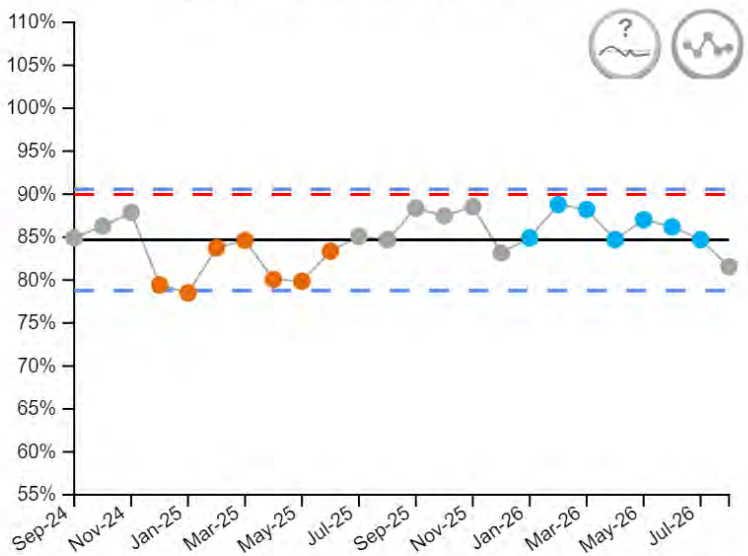
DM01 Performance - GWH



DM01 Performance - RUH



DM01 Performance - SFT



DM01 Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
DM01 Performance	Group			Aug-26	86.8%				Special Cause Improving - Above Upper Control Limit
DM01 Performance	GWH		99.0%	Aug-26	92.0%	X			Common Cause Variation
DM01 Performance	RUH		87.5%	Aug-26	85.5%	X			Special Cause Improving - Above Upper Control Limit
DM01 Performance	SFT		90.0%	Aug-26	81.6%	X			Common Cause Variation

Understanding Performance

Group
August diagnostic performance declined at all three trusts. Workforce and booking constraints reduced activity, with persistent pressure in non-imaging services.

GWH 92.0%, down from 93.7% in July. Over-six-week waits rose to 618. Imaging remained above 95%, while Respiratory Physiology fell to 40.5%.

RUH 85.8% against an 86.5% plan, with 78 more six-week breaches. Ultrasound, Audiology, Endoscopy and DEXA account for the largest breach cohorts.

SFT 81.6% against an 88% plan. Cardiac CT capacity, Audiology vacancies and Endoscopy underutilisation remain key pressures. August reporting now includes Sleep Studies.

Countermeasures

GWH plans an AccuPebble pilot from late September, alongside Endoscopy insourcing, West Swindon CDC optimisation and Cystoscopy recovery.

RUH continues extra diagnostic sessions and ultrasound capacity, with weekly modality reviews and refreshed demand and capacity plans.

SFT has signed a Nuffield capacity agreement. A third Cardiac CT list awaits approval, alongside booking support and Audiology recruitment.

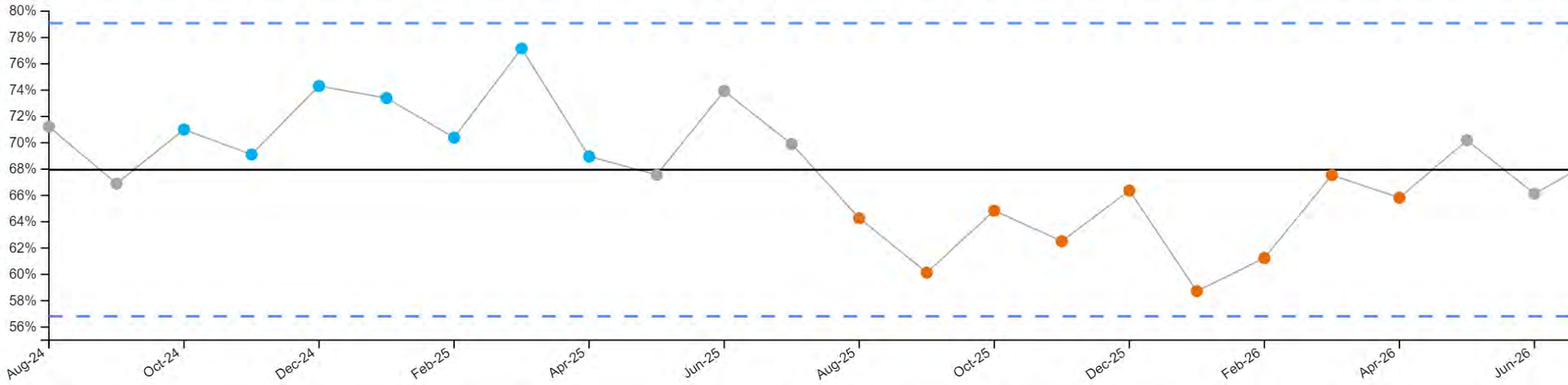
System. Diagnostic Delivery Group reviews CDC utilisation and diagnostic pathways in Gastroenterology, ENT/Audiology and Cardiology to make better use of capacity.

Risks and Mitigation

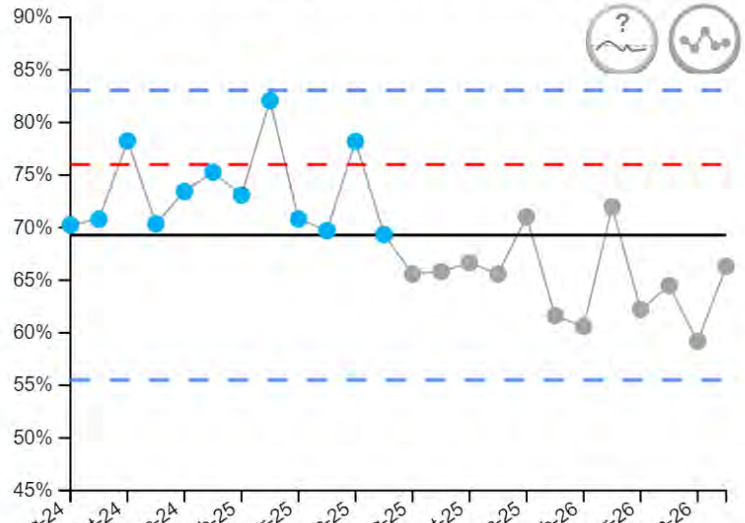
- Risk: workforce gaps constrain recovery. Mitigation: BSW sonography and endoscopy training programmes being rolled out with NHSE funding.
- Risk: Sulis doesn't deliver full capacity due to CDC income cap. Mitigation: RUH working up approach to maximise CDC income and activity via H2 recovery plan.
- Risk: recovery depends on pathway changes and approvals. Mitigation: focused modality plans, weekly review at RUH and group governance for capacity schemes, including SFT's Cardiac CT business case.

Cancer 62 Day Performance

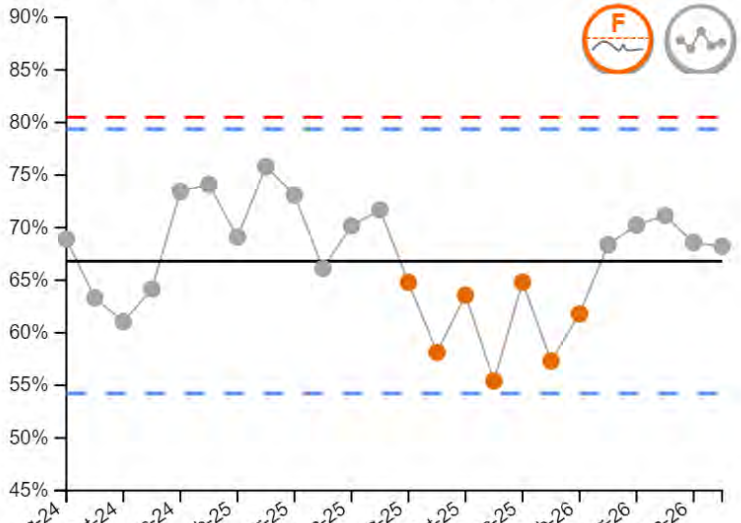
Cancer 62 Day Performance - Group



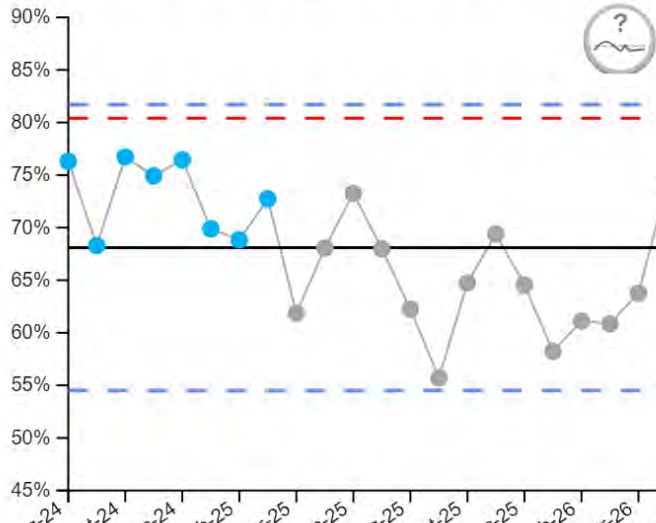
Cancer 62 Day Performance - GWH



Cancer 62 Day Performance - RUH



Cancer 62 Day Performance - SFT



Cancer 62 Day Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Cancer 62 Day Performance	Group			Jul-26	69.0%				Common Cause Variation
Cancer 62 Day Performance	GWH		76.0%	Jul-26	66.3%	X			Common Cause Variation
Cancer 62 Day Performance	RUH		80.5%	Jul-26	68.2%	X			Common Cause Variation
Cancer 62 Day Performance	SFT		80.4%	Jul-26	73.5%	X			Common Cause Variation

Understanding Performance

Group
July performance remained below target across all three trusts, with diagnostic and treatment delays continuing to drive breaches.

GWH 66.3% in July. Urology accounted for 39% of allocated breaches and Breast 21%, reflecting appointment, diagnostic and repeat-test delays.

RUH 68% in July. Colorectal, Lung, Skin and Urology remain constrained by imaging, outpatient and reporting delays.

SFT 73.5% in July, below its 75% target. Lower GI, Lung and Urology remain key pressures, alongside complex diagnostics and patient-related delays.

Countermeasures

GWH has £50k of TVCA funding for additional Breast sessions. Radiology recruitment and mapping of Breast clinic and surgical capacity support recovery.

RUH is pursuing extra CT, Skin outpatient and treatment capacity, alongside Breast recruitment and further Urology capacity.

SFT Cancer 360 is live for Urology and Lung, with other sites due by November. Timed-pathway training and an extra scheduling post support tracking and treatment access.

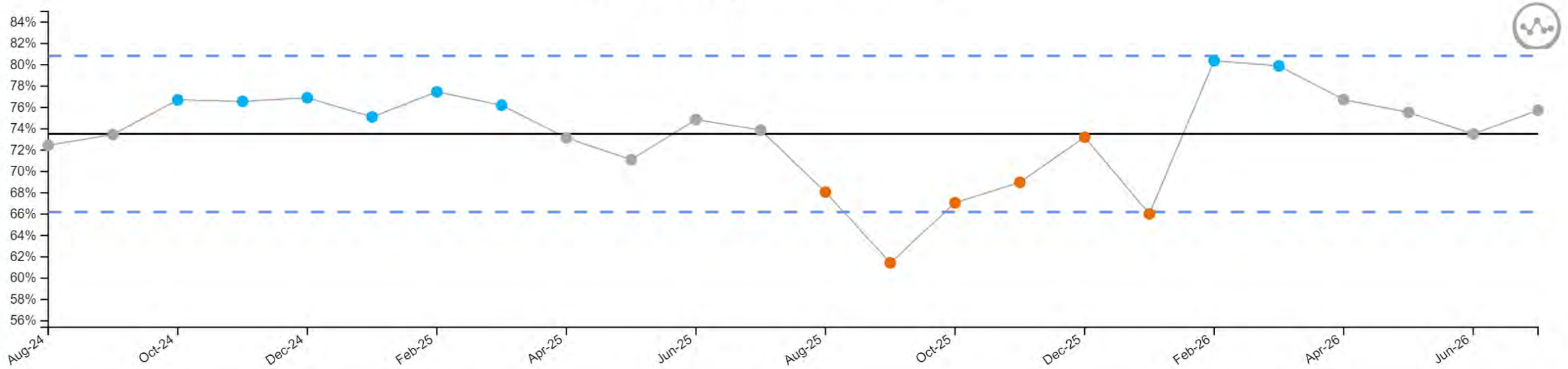
System
Cancer Alliance support continues through targeted capacity funding and pathway improvement. SWAG supports RUH specialist diagnostics and SFT escalation of patient-choice delays

Risks and Mitigation

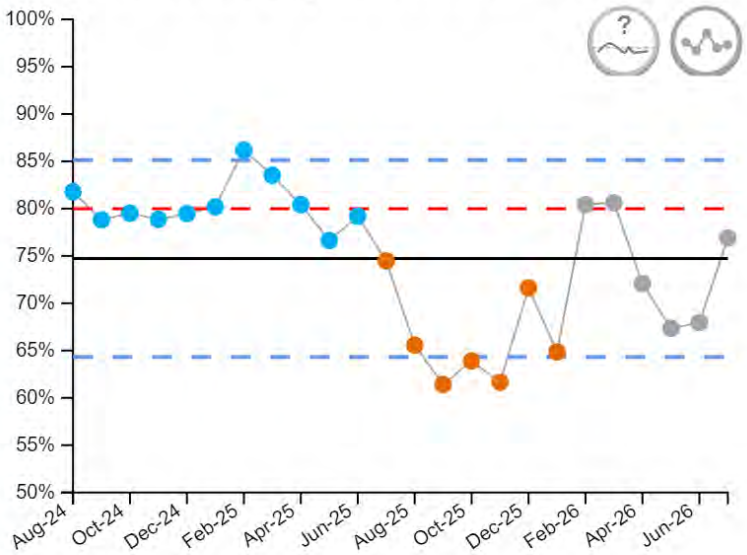
- Risk: diagnostic reporting and treatment capacity delay care. Mitigation: targeted recruitment, additional sessions and Cancer Alliance-supported pathway recovery.
- Risk: rising demand and reliance on temporary capacity threaten recovery. Mitigation: RUH workforce and pathway plans, plus GWH funded Breast sessions and capacity review. BSW Dermatology Transformation is key to return to sustainable delivery
- Risk: SFT Breast reconstruction demand has doubled and reporting delays persist. Mitigation: retain cancer reporting in-house and add capacity. MDT recruitment is complete, restoring full establishment.

Cancer 28 Day Performance

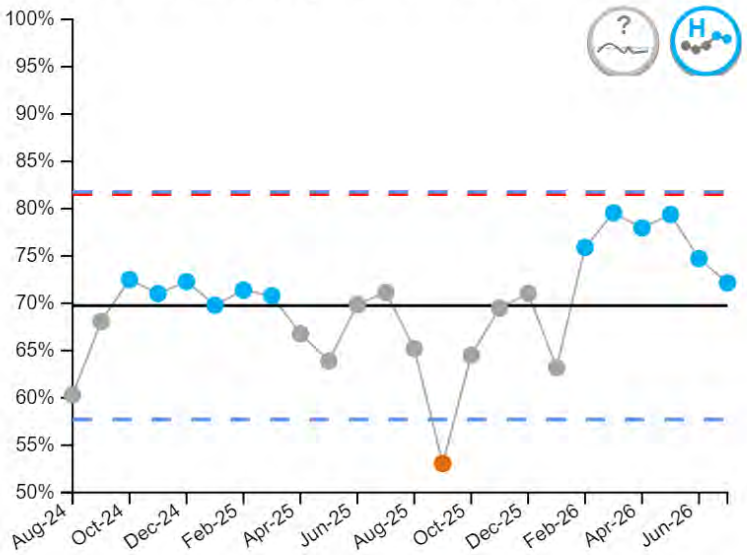
Cancer 28 Day Performance - Group



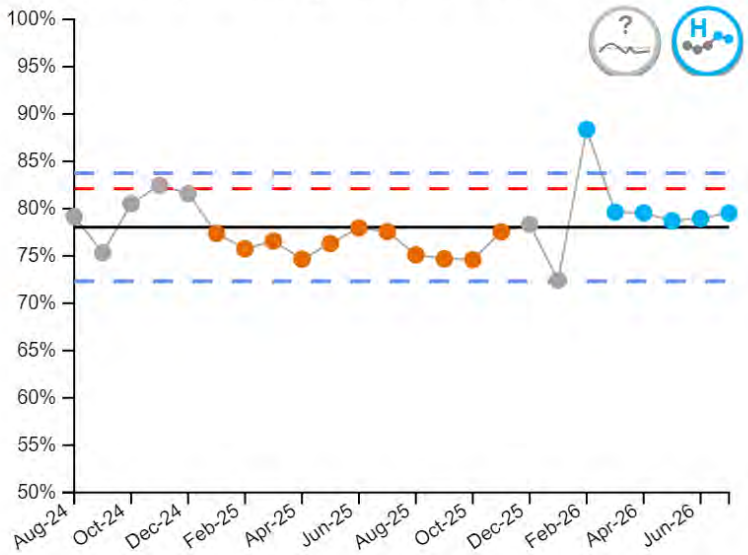
Cancer 28 Day Performance - GWH



Cancer 28 Day Performance - RUH



Cancer 28 Day Performance - SFT



Cancer 28 Day Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Cancer 28 Day Performance	Group			Jul-26	75.7%				Common Cause Variation
Cancer 28 Day Performance	GWH		80.0%	Jul-26	76.9%	X			Common Cause Variation
Cancer 28 Day Performance	RUH		81.5%	Jul-26	72.1%	X		H	Special Cause Improving - Run Above Mean
Cancer 28 Day Performance	SFT		82.1%	Jul-26	79.5%	X		H	Special Cause Improving - Run Above Mean

Understanding Performance

Group
July faster-diagnosis performance remained below 80% at all three trusts. Outpatient access and diagnostic reporting continue to delay diagnosis.

GWH 76.9%, up from 67.9% in June. Outpatient delays accounted for 44% of breaches, with Colorectal responsible for 40% of all breaches.

RUH 73.4% for July (improved from initial submitted position). Breast, Colorectal, Skin and Urology remain priorities for diagnostic and outpatient recovery.

SFT 79.5%, just below its 80% target. Lower GI achieved 58.5%, Lung 57.5% and Urology 50.4%. Reporting delays and complex diagnostic pathways persist.

Countermeasures

System
- Cancer Alliance support and established group diagnostic work focus on outpatient access and reporting capacity.
- The existing group Dermatology Transformation plan targets an October business case and mobilisation from 2027.

GWH recovery focuses on Colorectal outpatient capacity and Gynaecology administration and pathology delays. Alliance-funded Breast sessions add capacity.

RUH plans Breast one-stop sessions, targeted radiology review, more Skin capacity and Urology recruitment. The Gynaecology Wid-Easy pathway launched on 24 August.

SFT Cancer 360 is live for Urology and Lung, with other sites due by November. Timed-pathway training continues and MDT recruitment is complete.

Risks and Mitigation

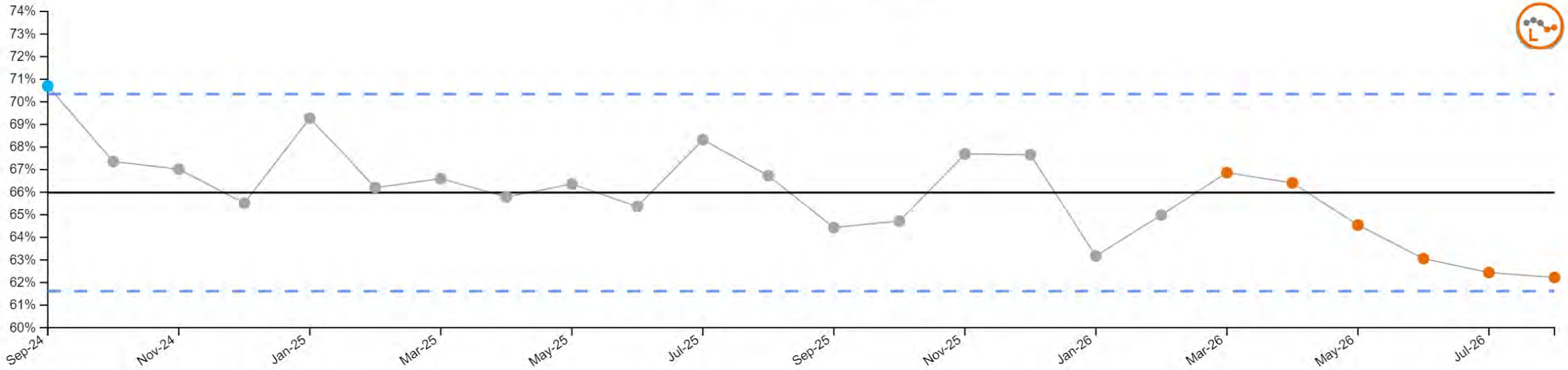
- Risk: Skin demand outpaces capacity. Mitigation: targeted additional clinics and teledermatology, alongside the existing group Dermatology Transformation plan.

- Risk: diagnostic and outpatient delays prolong waits. Mitigation: locality recovery plans, Cancer Alliance capacity support and diagnostic requirements within CDC planning.

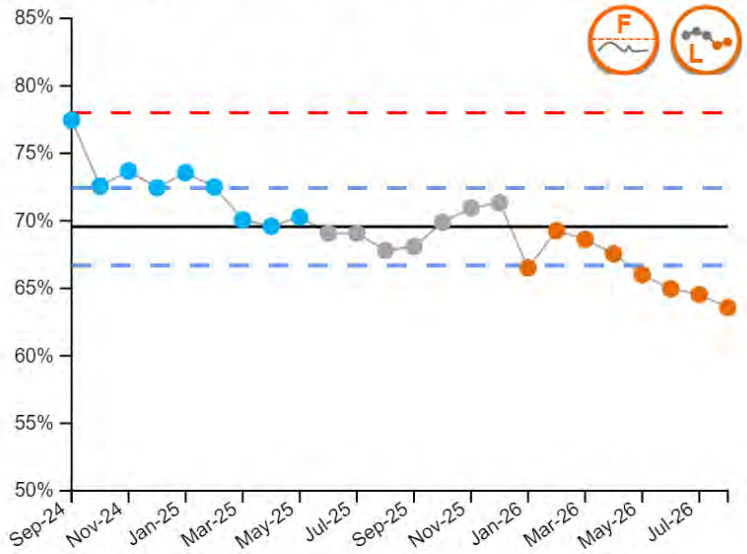
- Risk: patient-choice and tracking delays persist. Mitigation: SFT Cancer 360 rollout, timed-pathway training and navigator support. SWAG has escalated patient-choice issues nationally.

ED 4 Hour Performance

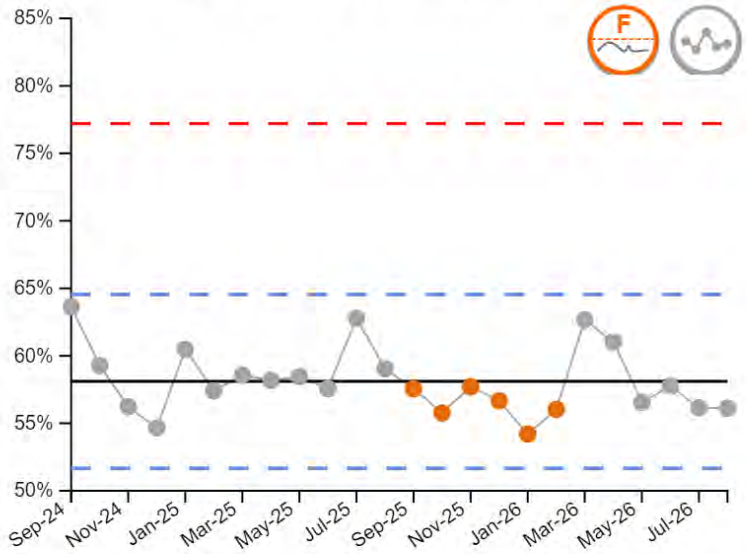
ED 4 Hour Performance - Group



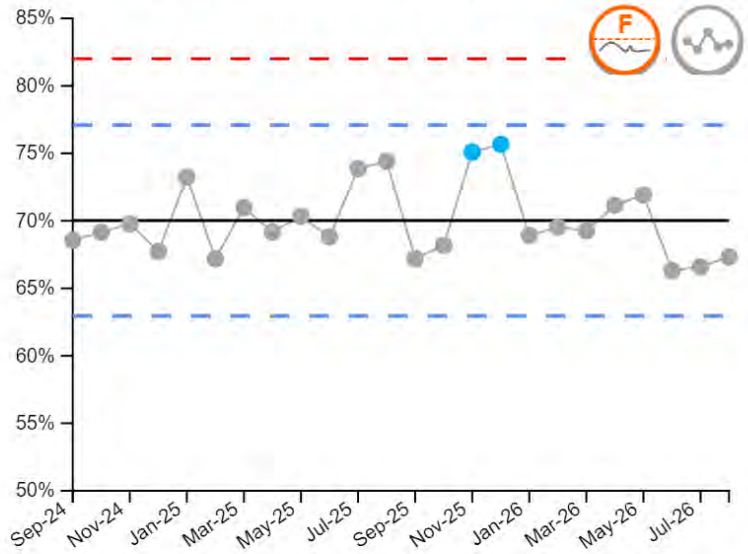
ED 4 Hour Performance - GWH



ED 4 Hour Performance - RUH



ED 4 Hour Performance - SFT



ED 4 Hour Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
ED 4 Hour Performance	Group	All Types		Aug-26	62.2%				Special Cause Concerning - Decreasing Run
ED 4 Hour Performance	GWH	All Types	78.0%	Aug-26	63.6%	X			Special Cause Concerning - Decreasing Run
ED 4 Hour Performance	RUH	All Types	77.2%	Aug-26	56.1%	X			Common Cause Variation
ED 4 Hour Performance	SFT	All Types	82.0%	Aug-26	67.3%	X			Common Cause Variation

Understanding Performance

GWH remains the most challenged.
Achievement of 4-hour performance remains challenging and currently the Trusts are not delivering against plan with no overall improvement in the group position . The likelihood of achievement of the 4-hour standard as set out in planning for 26/27 is low due to trajectory that was set at the outset. 4-hour performance is an overall indicator of system flow not just of ED processes and this continues to be a challenge across BSW both in acute trusts and across the system.
Whilst there was a tolerance of 2% growth included in the planning for 26/27 there is significant variability in the profile of that demand presenting at EDs and this creates significant challenges in the ability to meet the demand at times of surge. We continue to see increased demand across all but particularly noted for RUH and GWH in terms of ambulance conveyance.

Countermeasures

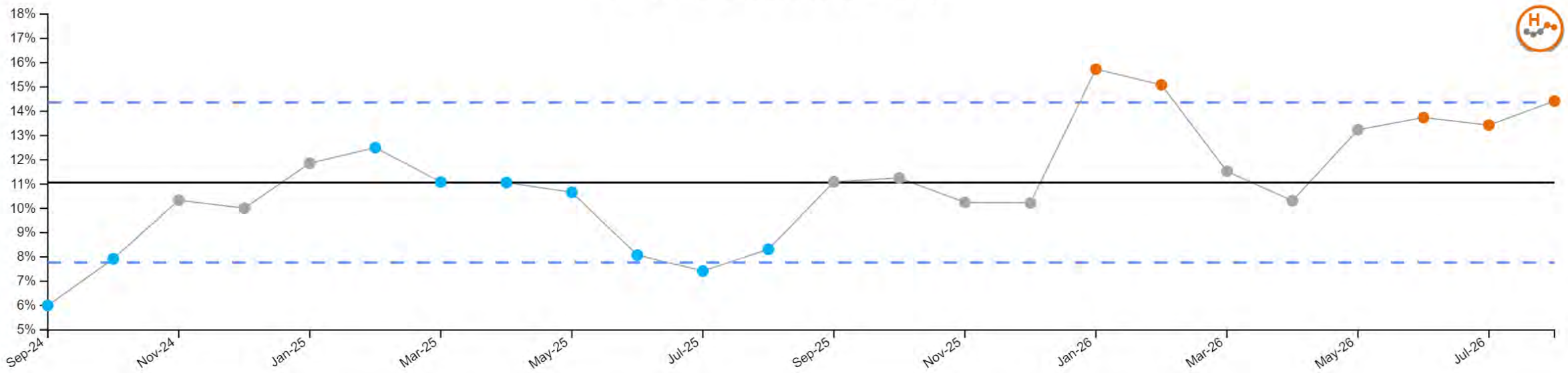
- Each organisation has an improvement plan that focuses on ED process improvements incorporating actions to increase SDEC capacity to avoid attendance at ED. RUH have a refreshed plan focusing on ED.
- There is a system wide care coordination (Care Co) function that is key to ensuring only appropriate patients conveyed to acute trusts to ensure the right patients present at EDs
- There is refocused UEC reset being planned to support system improvement.
- System wide groups are in place to support delivery of alternatives to ED conveyance
- Ongoing improvements in SWASFT to improve see and treat and hear and treat numbers.
- System actions needed to mitigate the risk of high demand.
- UEC Summit on 15th July identified system areas for improvement. System improvement plan formulated and will be governed through UEC Reset

Risks and Mitigation

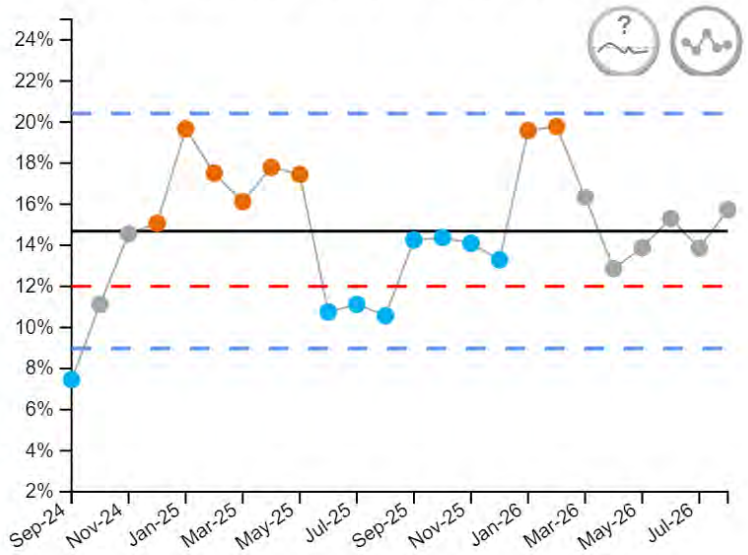
R – lack of community capacity leading to delays in discharge
M – ongoing demand profiling across the system to ensure the correct capacity is in place to meet demand
R – the ability for internal and system responses to keep with the pace of change needed
M- trust and system oversight of challenges with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

ED 12 Hour Performance

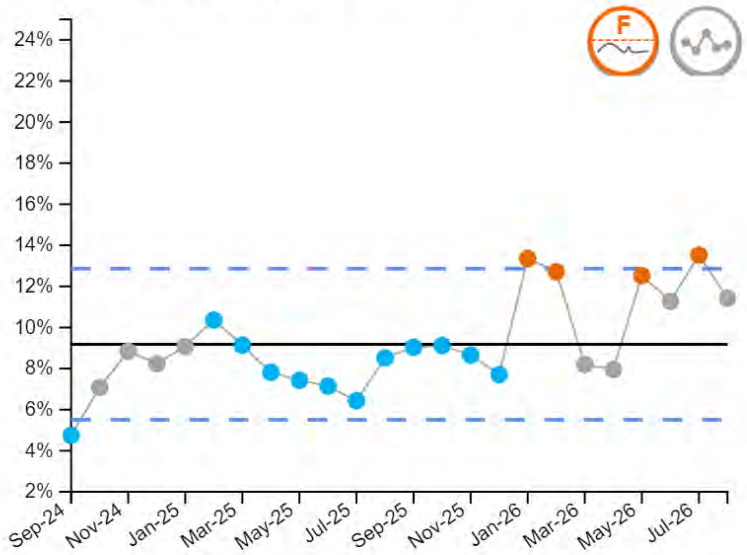
ED 12 Hour Performance - Group



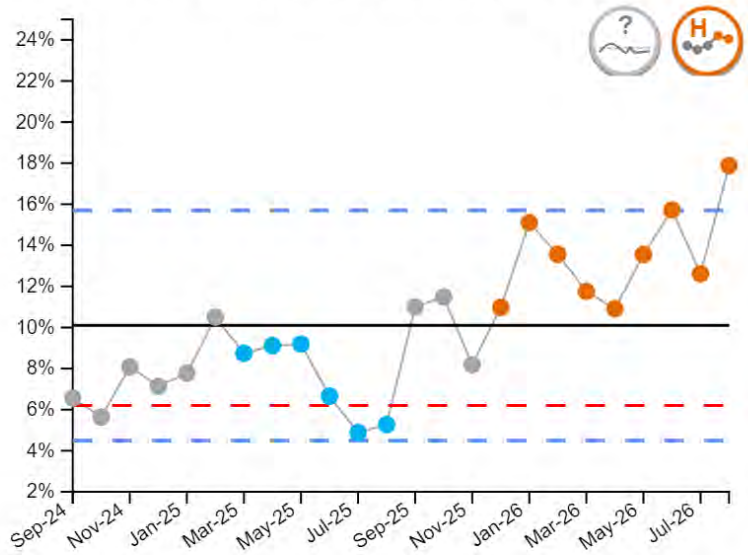
ED 12 Hour Performance - GWH



ED 12 Hour Performance - RUH



ED 12 Hour Performance - SFT



ED 12 Hour Performance

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
ED 12 Hour Performance	Group	Type 1 and Type 2 attendances		Aug-26	14.4%			H	Special Cause Concerning - Above Upper Control Limit
ED 12 Hour Performance	GWH	Type 1 and Type 2 attendances	12.0%	Aug-26	15.7%	X	?		Common Cause Variation
ED 12 Hour Performance	RUH	Type 1 and Type 2 attendances	0.0%	Aug-26	11.4%	X	F		Common Cause Variation
ED 12 Hour Performance	SFT	Type 1 and Type 2 attendances	6.2%	Aug-26	17.9%	X	?	H	Special Cause Concerning - Above Upper Control Limit

Understanding Performance

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

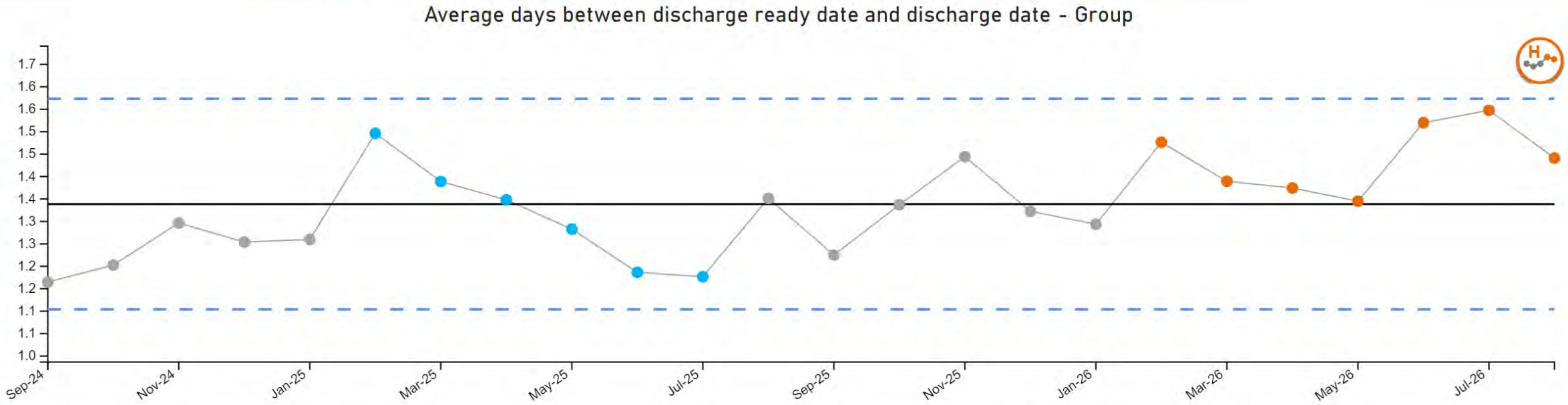
Countermeasures

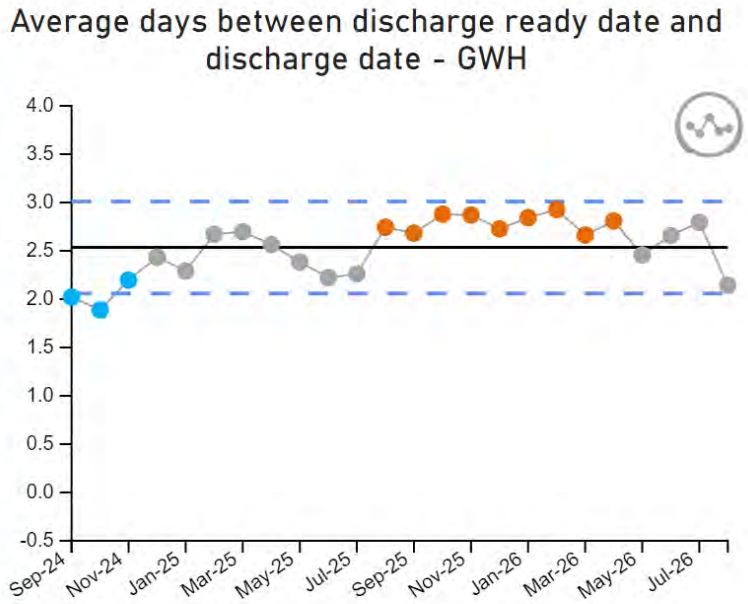
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- System wide groups are in place to support delivery of alternatives to ED conveyance
- Ongoing improvements in SWASFT to improve see and treat and hear and treat numbers.UEC Summit held on 15th July identifed areas for flow improvement that will impact on flow to reduce delays in EDs.

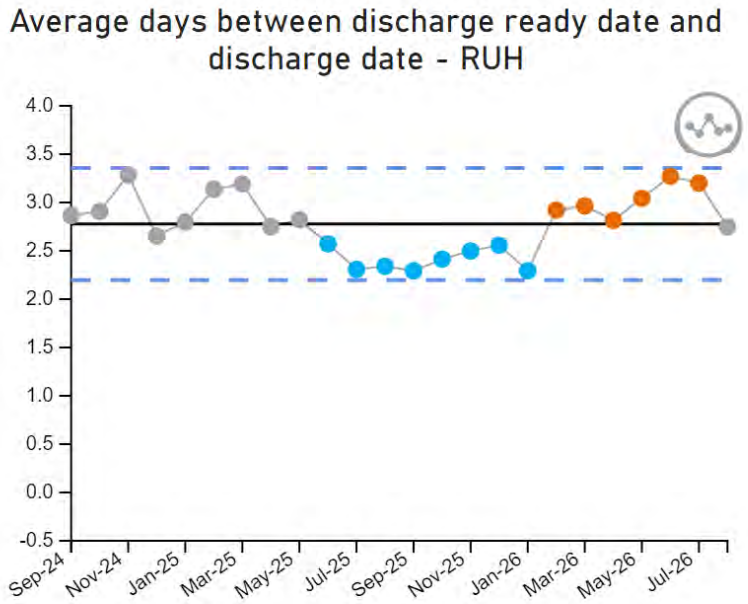
Risks and Mitigation

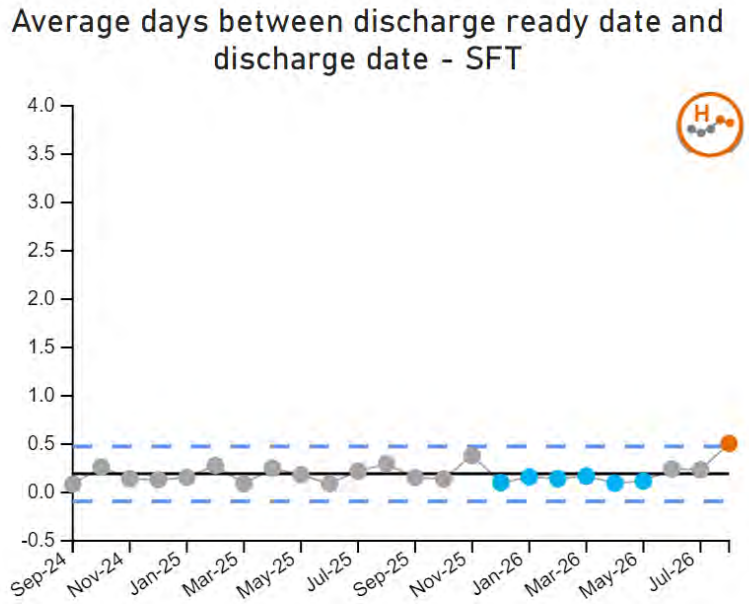
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- Ongoing improvements in SWASFT to improve see and treat and hear and treat numbers.
- Front door event with Health Hero and key stakeholders in Care co in May 2026.
- Winter Debrief held in April with key learning to be shared and actions taken.

Average days between discharge ready date and discharge date









Average days between discharge ready date and discharge date

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average days between discharge ready date and discharge date	Group			Aug-26	1.4				Special Cause Concerning - Run Above Mean
Average days between discharge ready date and discharge date	GWH			Aug-26	2.1				Common Cause Variation
Average days between discharge ready date and discharge date	RUH			Aug-26	2.7				Common Cause Variation
Average days between discharge ready date and discharge date	SFT			Aug-26	0.5				Special Cause Concerning - Above Upper Control Limit

Understanding Performance

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

Countermeasures

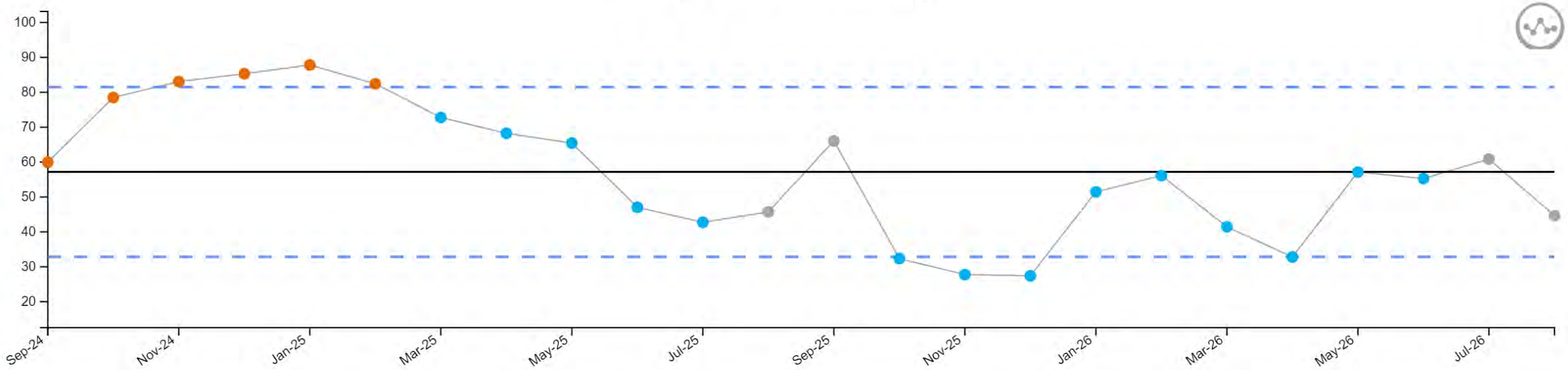
- There is significant work ongoing in each organisation to reduce delays in discharging patients due to hospital reasons
- Internal improvement plans across all three trusts have actions and activities relating to reducing delays in P0 discharges and those that are more complex that have hospital actions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

Risks and Mitigation

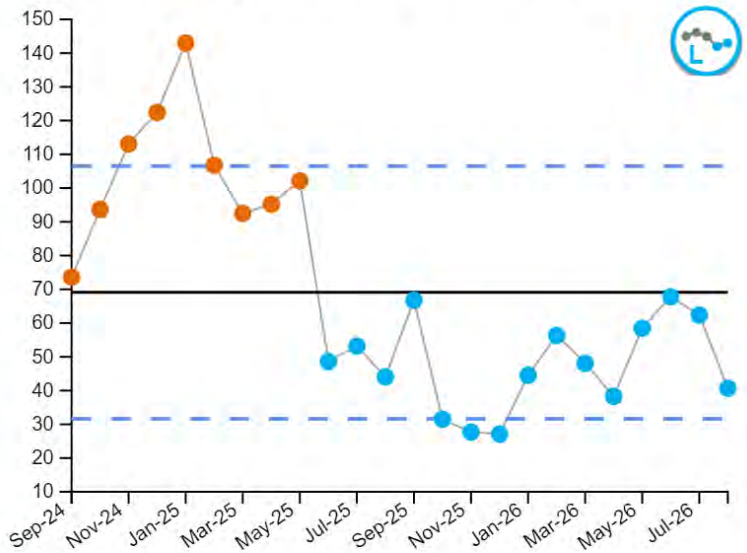
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Average handover time

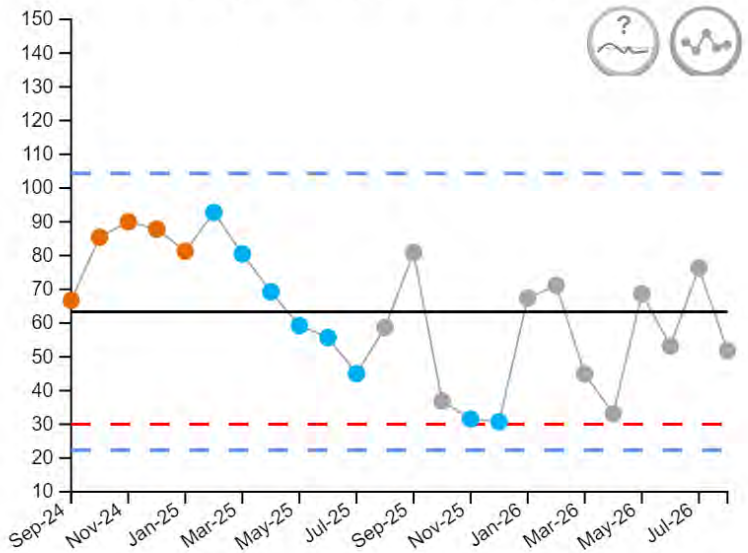
Average handover time - Group



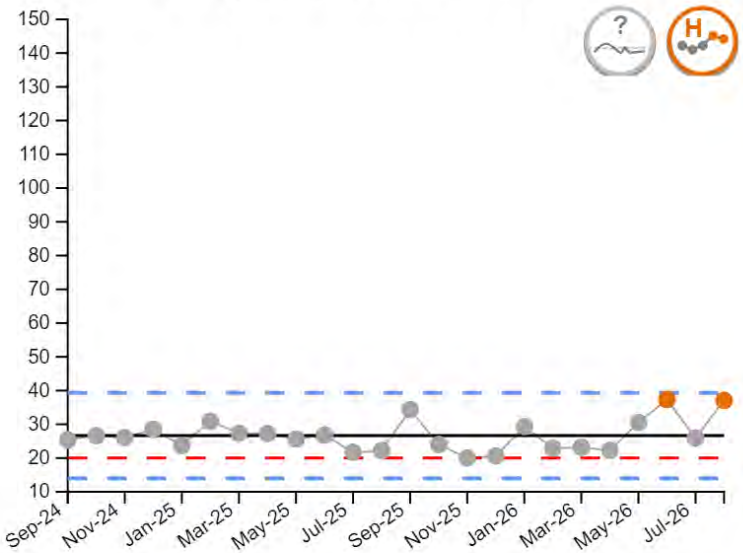
Average handover time - GWH



Average handover time - RUH



Average handover time - SFT



Average handover time

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average handover time	Group	Minutes		Aug-26	45				Common Cause Variation
Average handover time	GWH	Minutes		Aug-26	41				Special Cause Improving - Run Below Mean
Average handover time	RUH	Minutes	30	Aug-26	52	X			Common Cause Variation
Average handover time	SFT	Minutes	20	Aug-26	37	X			Special Cause Concerning - Two Out of Three High

Understanding Performance

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

Countermeasures

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

Risks and Mitigation

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

Average Daily Number of Patients in Corridor Care within ED

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average Daily Number of Patients in Corridor Care within ED	Group			Aug-26	45.09				
Average Daily Number of Patients in Corridor Care within ED	GWH			Aug-26	23.19				
Average Daily Number of Patients in Corridor Care within ED	RUH			Aug-26	17.10				
Average Daily Number of Patients in Corridor Care within ED	SFT		0.00	Aug-26	4.80	X			

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

Understanding Performance

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

Countermeasures

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Risks and Mitigation

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

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

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	Group			Aug-26	11.49				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	GWH			Aug-26	6.42				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	RUH			Aug-26	0.00				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	SFT		0.00	Aug-26	5.07	X			

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RUH have very few areas to board in and in June no corridor care outside of the ED.

Countermeasures

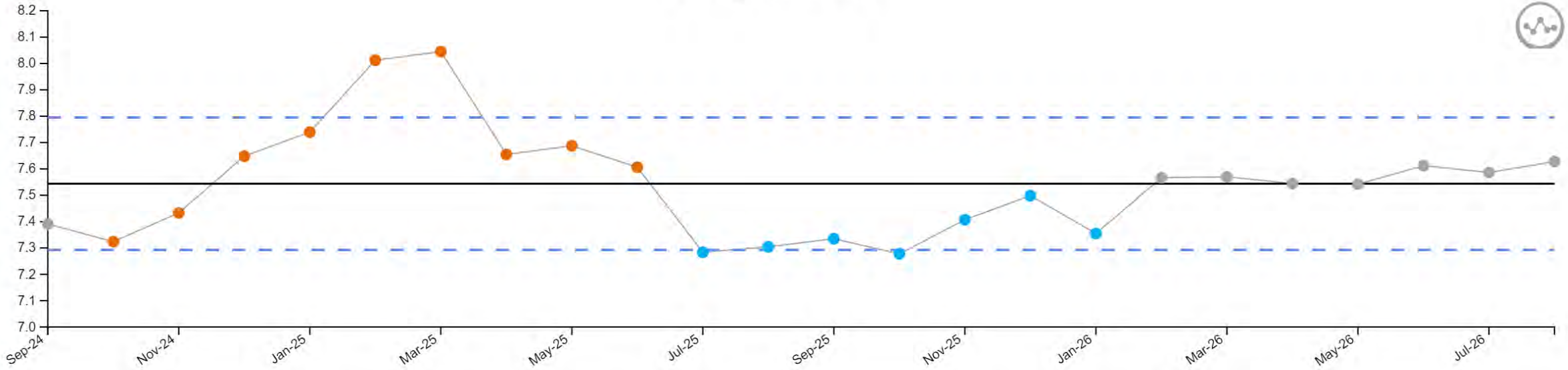
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Risks and Mitigation

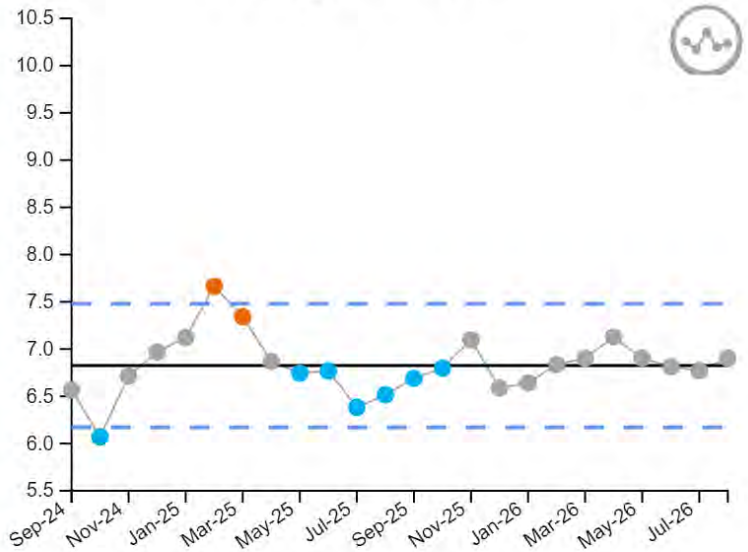
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R: Lack of oversight of UEC pathways that leads to no change in the system position **M:** see above
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Average LoS

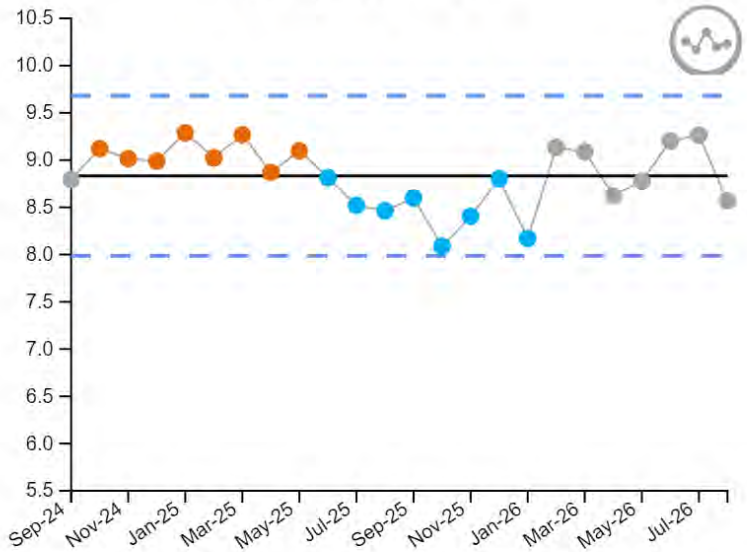
Average LoS - Group



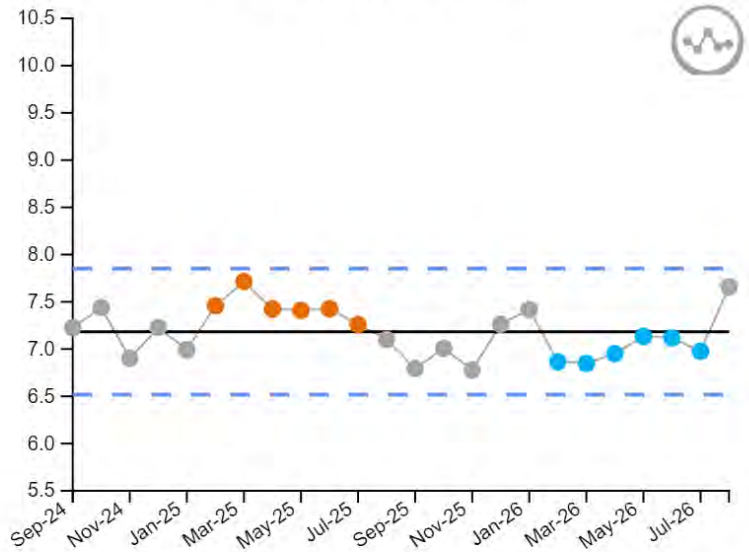
Average LoS - GWH



Average LoS - RUH



Average LoS - SFT



Average LoS

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average LoS	Group			Aug-26	7.6				Common Cause Variation
Average LoS	GWH			Aug-26	6.9				Common Cause Variation
Average LoS	RUH			Aug-26	8.6				Common Cause Variation
Average LoS	SFT			Aug-26	7.7				Common Cause Variation

Understanding Performance

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

Countermeasures

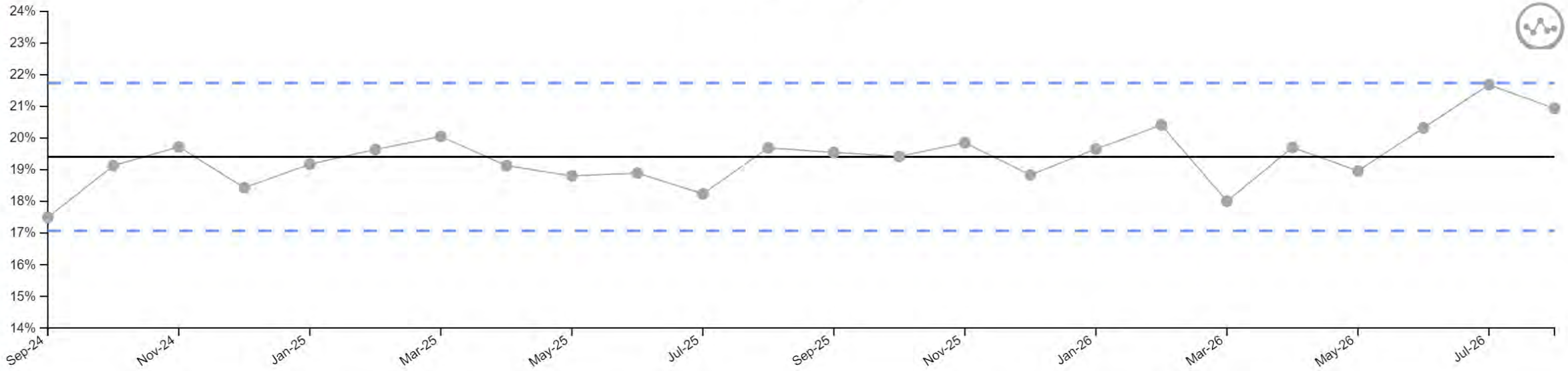
- Internal flow improvements across all three trusts as part of UEC improvement plans– including ward process improvements and referral process improvements to reduce delays across all internal elements of the pathways
- Engagement with clinicians across specialties across all three acutes to improve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

Risks and Mitigation

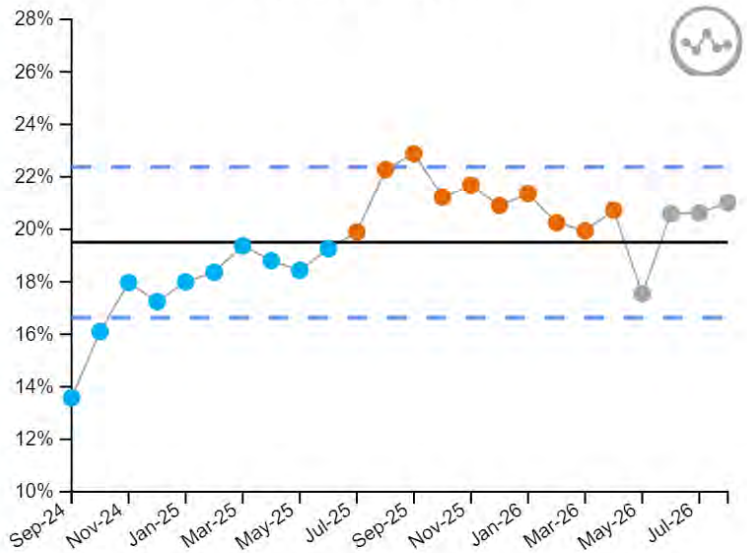
- R - Inability to deliver improvement programmes at the pace required to see improvement
- M - oversight at trust and Delivery group in place to identify where there are challenges to delivery and unblock any issues, ongoing go and see approach by execs at trust level to support delivery, clear objectives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

% of NCTR

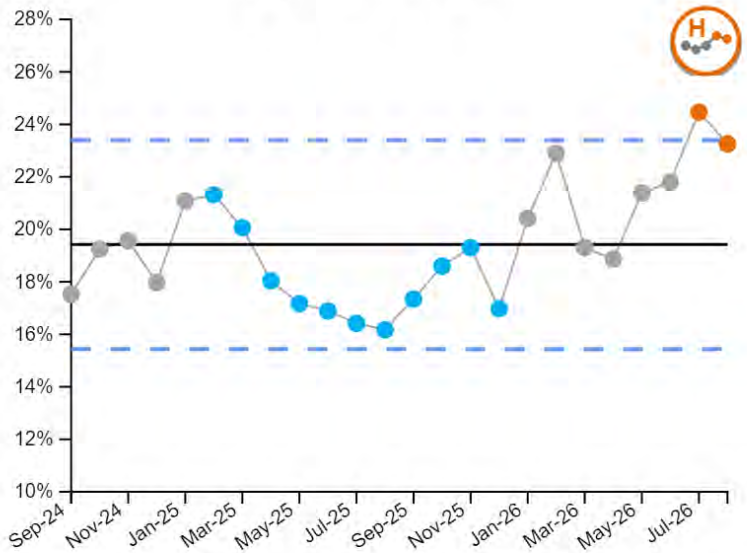
% of NCTR - Group



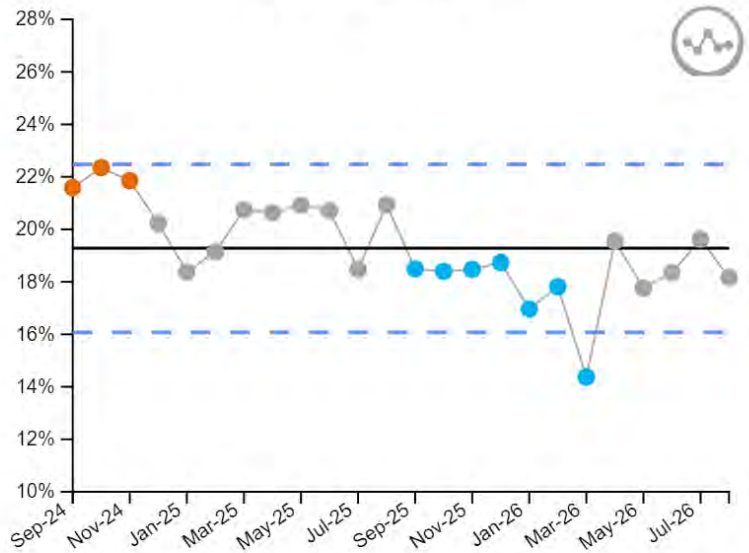
% of NCTR - GWH



% of NCTR - RUH



% of NCTR - SFT



% of NCTR

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
% of NCTR	Group			Aug-26	20.9%				Common Cause Variation
% of NCTR	GWH			Aug-26	21.0%				Common Cause Variation
% of NCTR	RUH			Aug-26	23.3%			H	Special Cause Concerning - Two Out of Three High
% of NCTR	SFT			Aug-26	18.2%				Common Cause Variation

Understanding Performance

NCTR remains the most significant challenge across BSW across all three acutes. SFT continues to see improvements, but the challenge remains with delays in discharge pathways. Significant internal focus on pathway 1-3 delays and the ESD service expansion supporting improvement.
This is a system wide measure that requires whole system actions to improve. Whilst there are some weeks that there is improvement there are not sustained actions to see consistent improvement.
There are aspects of the NCTR that are within the acute trusts ability to improve (P0) , the main challenge is for those patients that are waiting for P1 to P3 ongoing care in the community. There are some capacity challenges, and they are varied across BSW though interface delays is an area that is of concern.
There are system thresholds set for discharge of P1 – 3 to enable measurement of delays and identify areas of focus, though these are not consistently met and no way of capturing the data has been found.

Countermeasures

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

Risks and Mitigation

R: lack of capacity to discharge patients into the community.

M: various schemes under consideration by acutes to support discharge from hospital.

R: system ways of working not able to transform in a timely way to support reduction in NCTR.

M: actions being taken across the system with various workstreams in place; locality meetings have been reinstated.

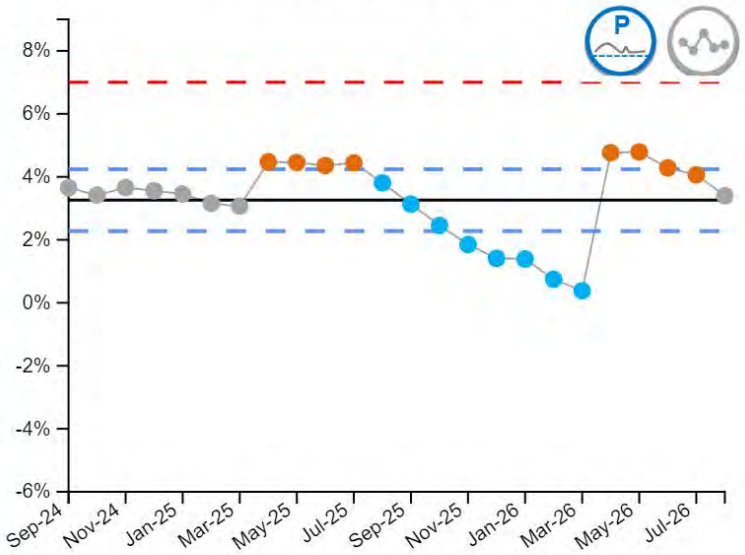
R: due to non-reduction in NCTR acute trusts will be unable to reduce beds in line with recovery plan.

M: additionality in acute trusts being identified to support winter through winter plans.

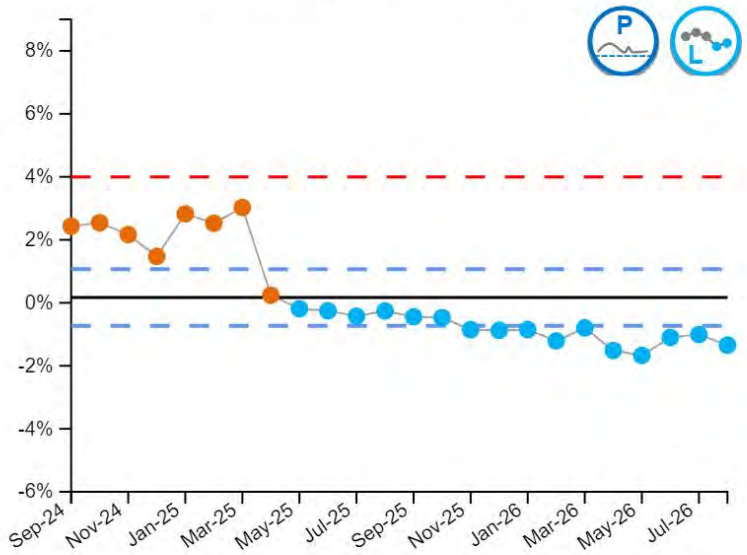
Vacancy Rate

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

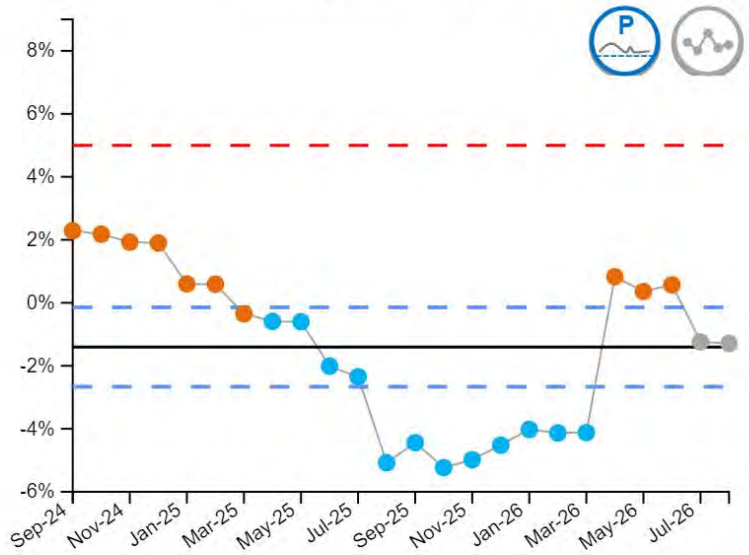
Vacancy Rate - GWH



Vacancy Rate - RUH



Vacancy Rate - SFT



Vacancy Rate

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Vacancy Rate	GWH		7.0%	Aug-26	3.4%	✓			Common Cause Variation
Vacancy Rate	RUH		4.0%	Aug-26	-1.3%	✓			Special Cause Improving - Below Lower Control Limit
Vacancy Rate	SFT		5.0%	Aug-26	-1.3%	✓			Common Cause Variation

Understanding Performance

GWH: This figure is likely overstated due to unidentified CIP savings and CIP adjustments that have not yet been removed from the establishment baseline and therefore the current vacancy position is unaffordable .

SFT: Vacancy position is 14.75 WTE, representing a significant change since M12. This is primarily due to a reset of establishments, moving from a previously over-recruited position to a vacancy position.

RUH: The trend line remains in an over-recruited position (92 WTE), with the over-recruitment continuing to increase.

Countermeasures

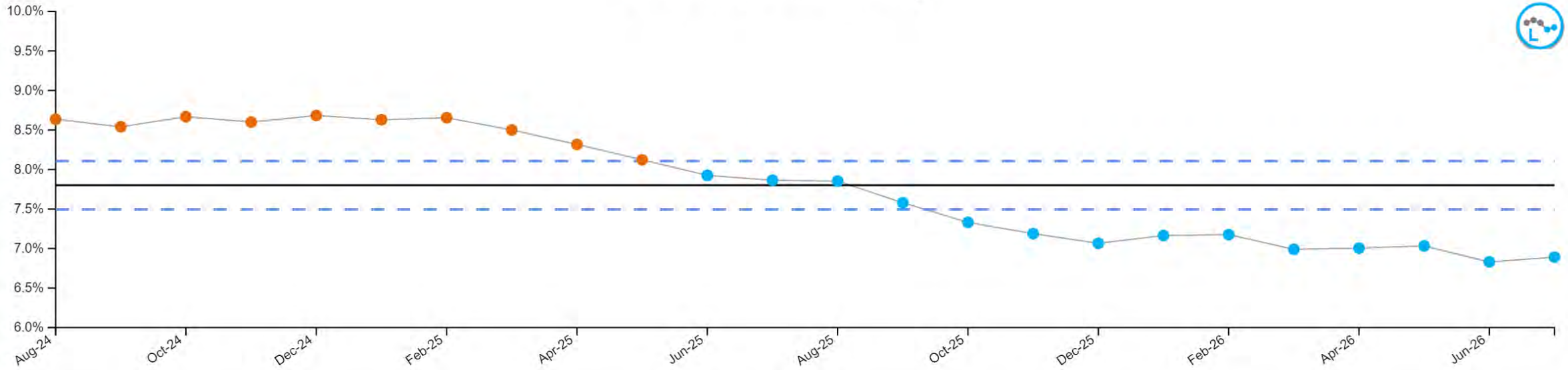
Standardise vacancy and establishment reporting methodology across all Trusts for consideration at GLT.

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

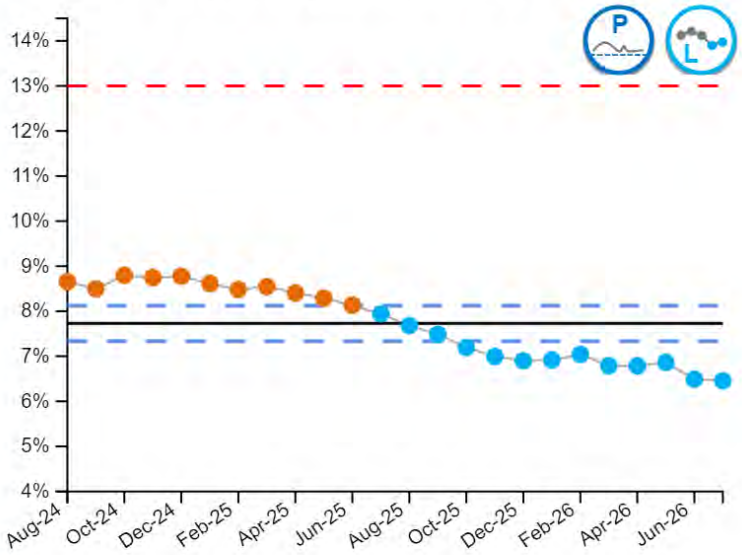
Risks and Mitigation

% Voluntary Turnover

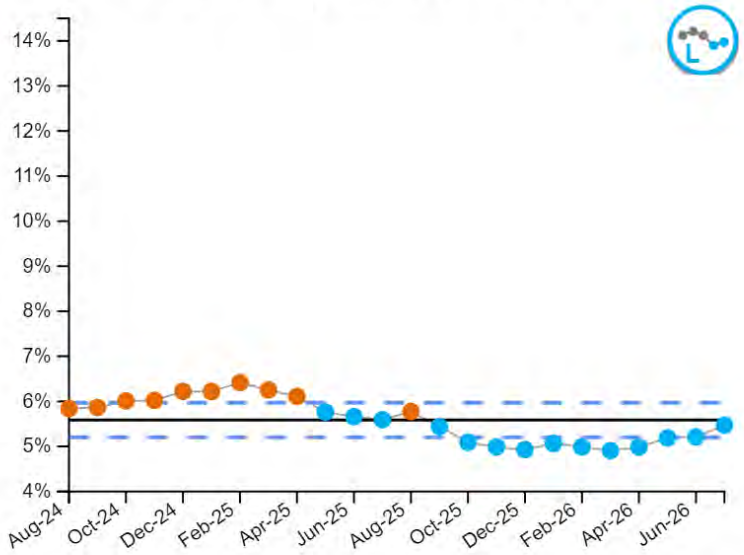
% Voluntary Turnover - Group



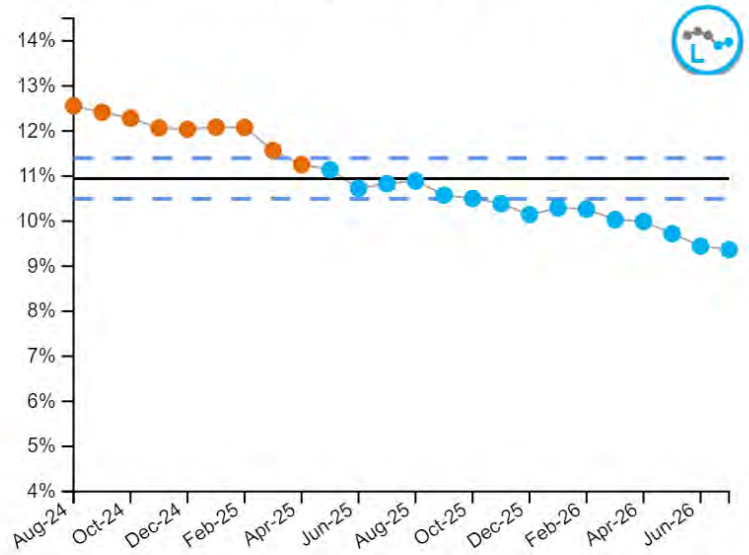
% Voluntary Turnover - GWH



% Voluntary Turnover - RUH



% Voluntary Turnover - SFT



% Voluntary Turnover

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
% Voluntary Turnover	Group			Jul-26	6.89%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	GWH		13.00%	Jul-26	6.46%	✓			Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	RUH			Jul-26	5.47%				Special Cause Improving - Run Below Mean
% Voluntary Turnover	SFT			Jul-26	9.37%				Special Cause Improving - Decreasing Run

Understanding Performance

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

Trend in all 3 Trusts demonstrates an improving trend.

Countermeasures

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

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

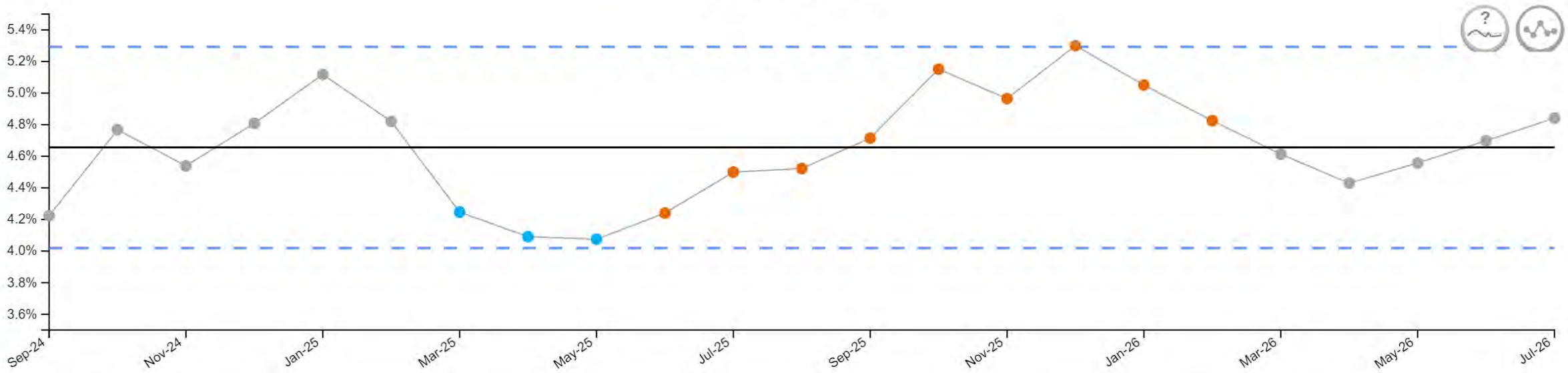
Risks and Mitigation

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

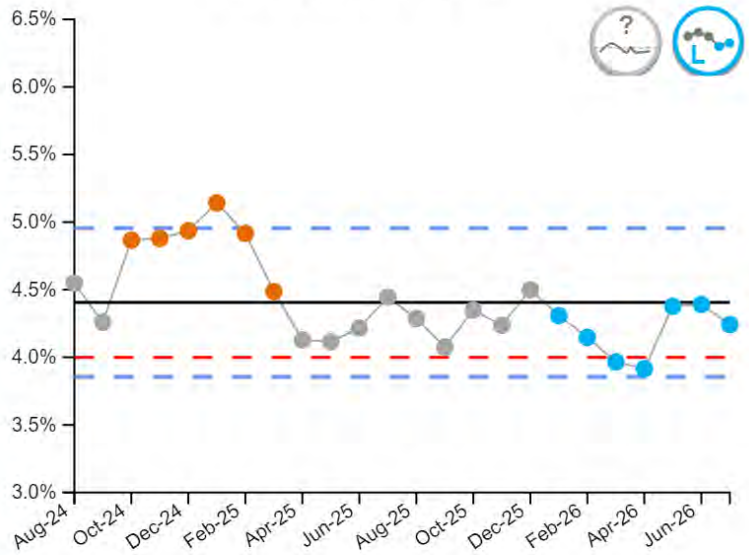
A persistently stagnant workforce may limit innovation, reduce adaptability, and hinder the Trust's ability to respond effectively to emerging challenges.

% Sickness

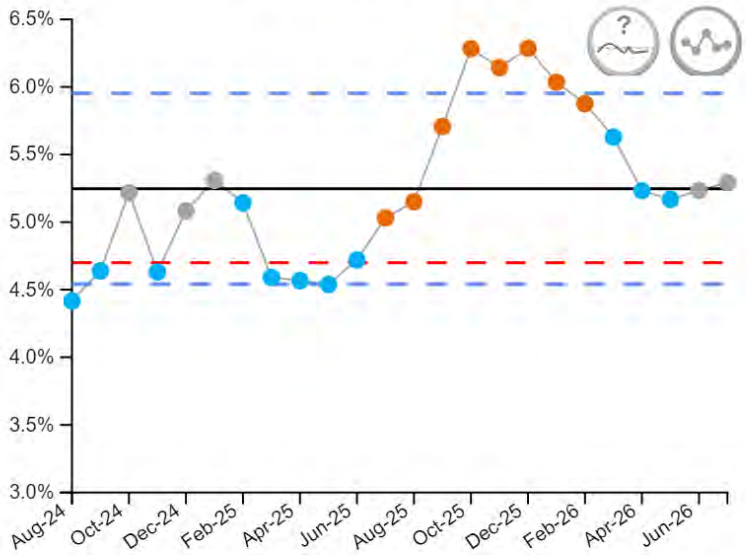
% Sickness - Group



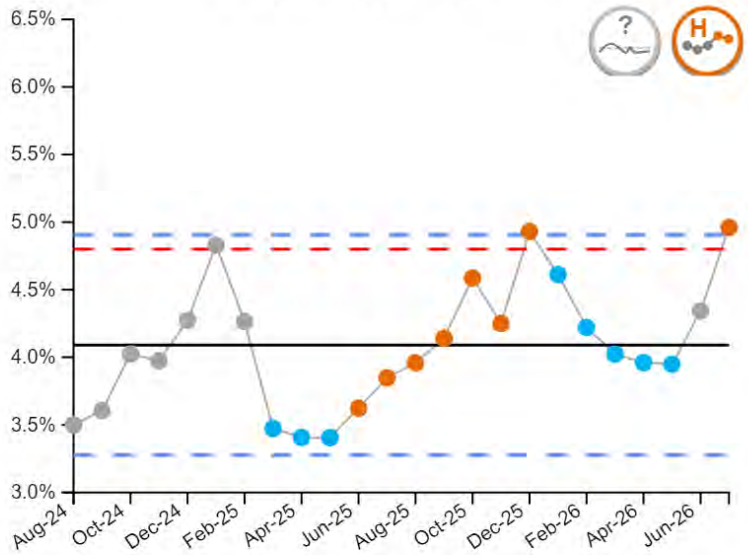
% Sickness - GWH



% Sickness - RUH



% Sickness - SFT



% Sickness

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
% Sickness	Group			Jul-26	4.84%				Common Cause Variation
% Sickness	GWH		4.00%	Jul-26	4.24%	X			Special Cause Improving - Run Below Mean
% Sickness	RUH		4.70%	Jul-26	5.29%	X			Common Cause Variation
% Sickness	SFT		4.80%	Jul-26	4.96%	X			Special Cause Concerning - Above Upper Control Limit

Understanding Performance

Sickness Absence Rates – July

RUH reports the highest sickness absence rate at 5.29% significantly above the group average, however sustained improvement over the last 4 months.

GWH has the lowest rate at 4.24%, while SFT is currently at 4.96%.

Countermeasures

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

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

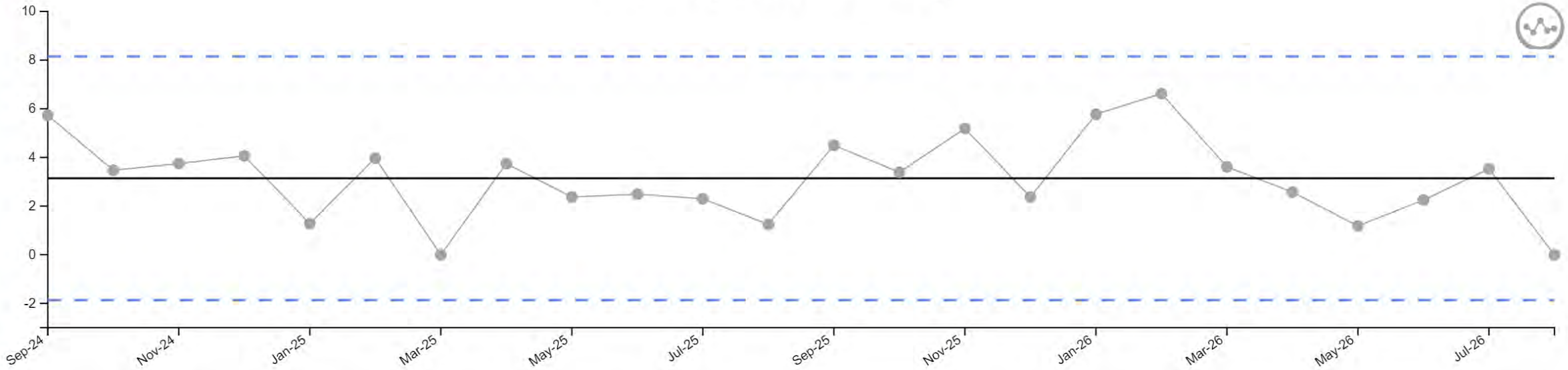
Risks and Mitigation

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

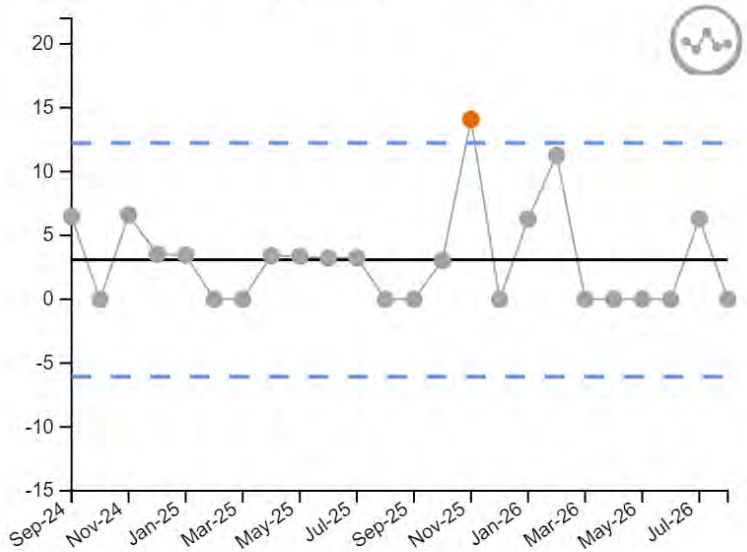
Staff engagement/moral during financial turnaround could impact sickness level at GWH

Stillbirths per 1000 Births

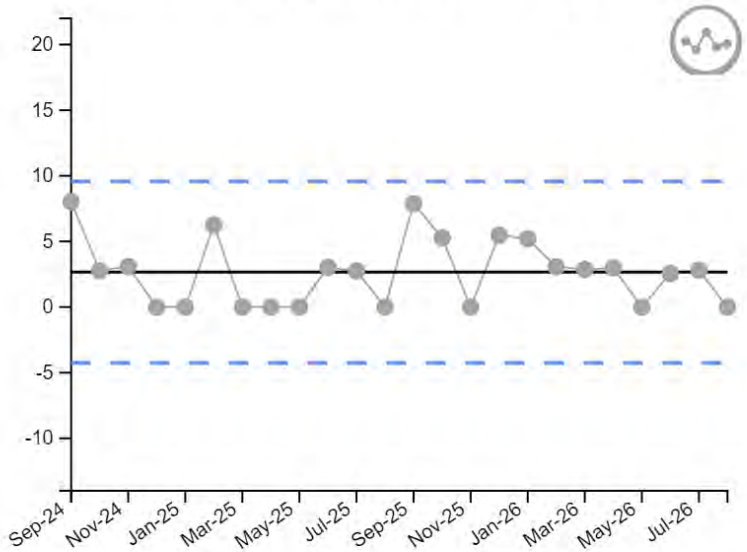
Stillbirths per 1000 Births - Group



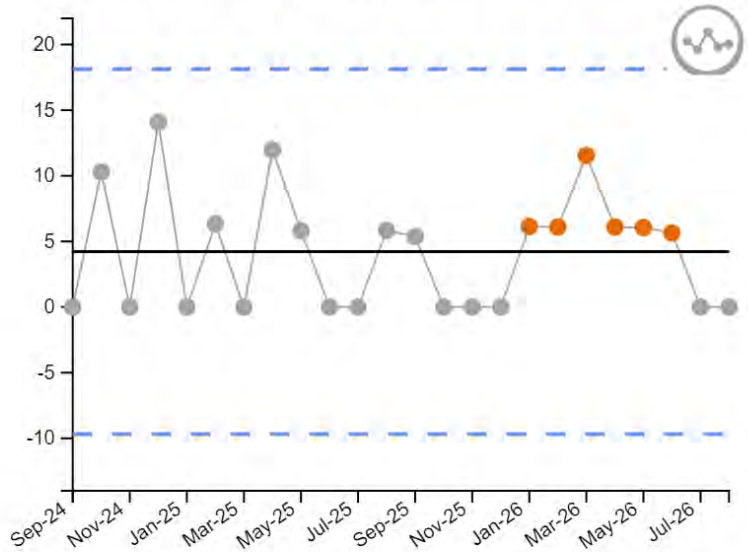
Stillbirths per 1000 Births - GWH



Stillbirths per 1000 Births - RUH



Stillbirths per 1000 Births - SFT



Stillbirths per 1000 Births

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

Understanding Performance

RUH:
August stillbirth rate: 0.0 per 1000 births.
12-month rolling average 3.2 per 1000 births.
August performance is in line with MBRRACE reported national average for 2024, published June 2026, of 3.18 per 1000.
Historic 2025/2026 data capture discrepancies identified impacted historic data quality now corrected and process changed.

SFT:
- 0 stillbirths in August
- The rolling 12-month stillbirth rate is 3.4/ 1000 births which has reduced but remains above the national average of 3.2/ 1000 births.

GWH: August stillbirth rate: 0.0 per 1000 births.
mortality rate has demonstrated a statistically significant upward variation, although the absolute increase remains small.

Countermeasures

RUH: Comprehensive monitoring system in place to track service performance against both local and national averages supporting performance oversight and early identification of concern. Systematic reviews conducted for all stillbirths via PMRT to support safety intelligence insight and identification of learning opportunities and preventative strategies.
Q1 2026/2027 Saving Babies Lives v3.2 compliance 93%

SFT: Reviews conducted for all stillbirths via national PMRT to support safety intelligence insight and identification of learning opportunities and preventative strategies.

GWH: Data anomaly escalated to Informatics team. All cases receive prompt multidisciplinary review through PSIRF and PMRT to support learning, improvement, and quality assurance.

Risks and Mitigation

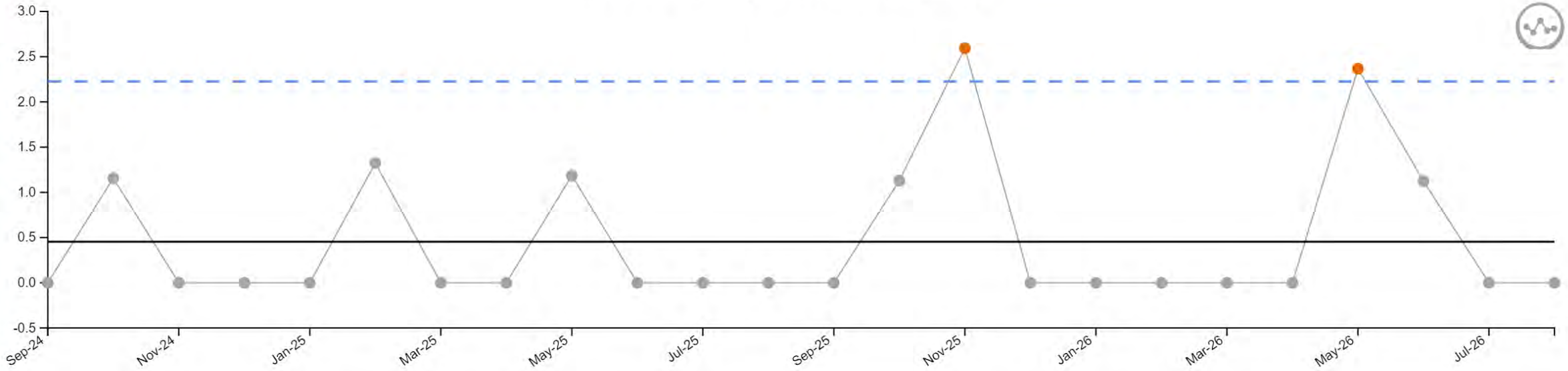
RUH: Data analytics and quality have been assessed as a service risk and is identified on the risk register with an action plan in place monitored to progress data quality and analytic capabilities.
Data quality Risk ID 3267.

SFT: Nil

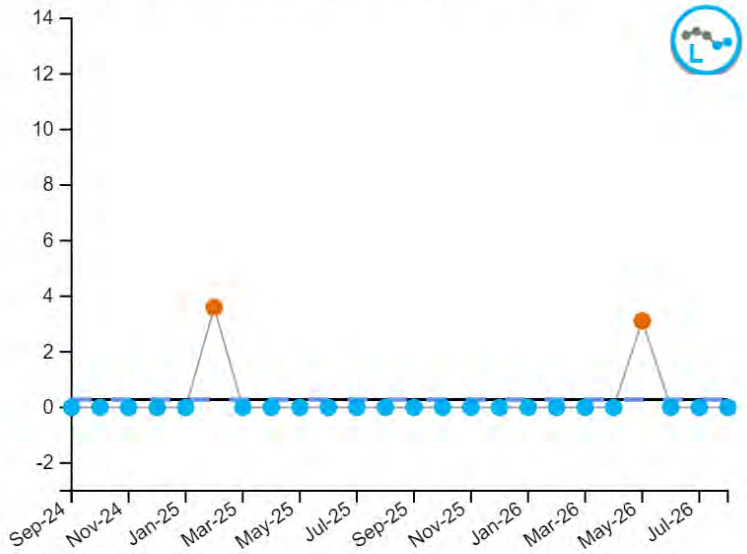
GWH: A comprehensive review and monitoring process, supported by a local tracking system, is in place to oversee all stillbirths and identify learning opportunities.

Neonatal Deaths per 1000 Births

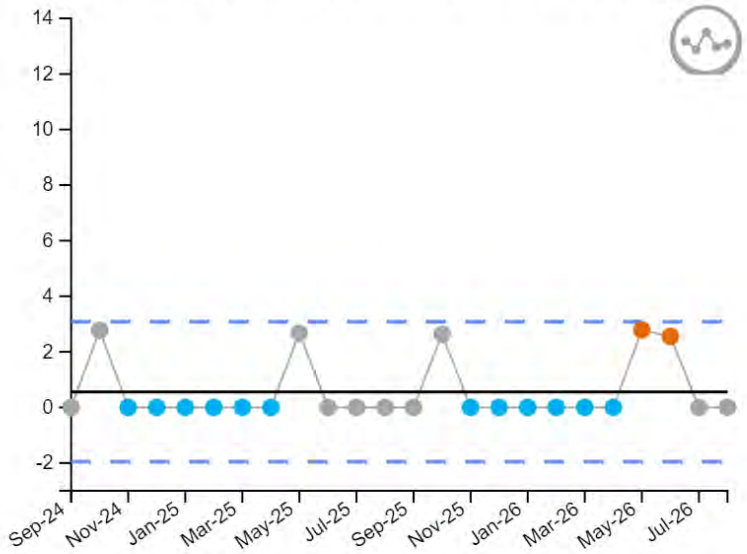
Neonatal Deaths per 1000 Births - Group



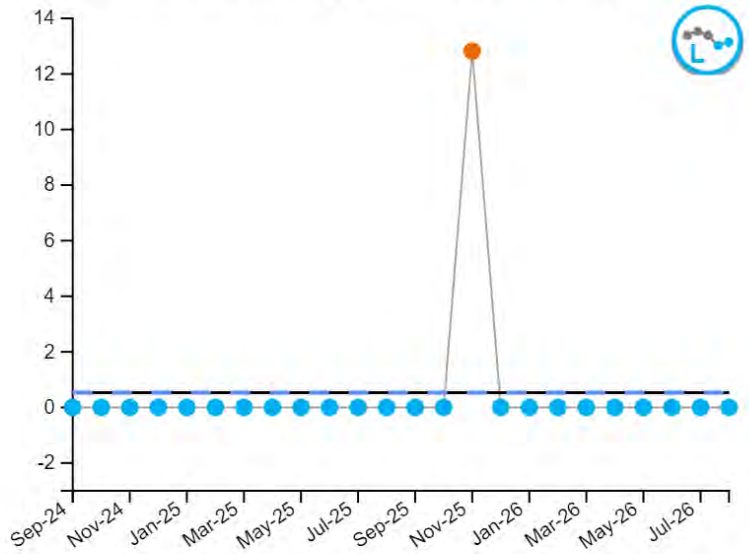
Neonatal Deaths per 1000 Births - GWH



Neonatal Deaths per 1000 Births - RUH



Neonatal Deaths per 1000 Births - SFT



Neonatal Deaths per 1000 Births

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

Understanding Performance

RUH:
Neonatal death rate for August 2026 0.0 per 1000.
12-month rolling average 0.46 per 1000.
Complex reporting framework relating to extreme prematurity presenting data variation dependent upon gestation viability and national body reporting regulations.
Historic 2025/2026 data capture discrepancies identified impacted historic data quality now corrected and process changed.

SFT:
- 0 Neonatal deaths in August
- The rolling 12 month neonatal death rate is 1.06/1000 live births and remains under the national average of 1.63/1000 live births

GWH: No neonatal deaths in August 2026.

Countermeasures

RUH: Comprehensive monitoring system in place to track service performance against both local and national averages supporting performance oversight and early identification of concern. Systematic reviews conducted for all neonatal deaths via PMRT/PSIRF/MNSI to support safety intelligence insight and identification of learning opportunities and preventative strategies
Q1 2026/2027 Saving Babies Lives v3.2 compliance 93%
Publication of the Thirlwall report anticipated for September 26.

SFT: Reviews conducted for all stillbirths via national PMRT to support safety intelligence insight and identification of learning opportunities and preventative strategies.

GWH: Robust governance processes in place to review all neonatal deaths.

Risks and Mitigation

RUH: Data analytics and quality have been assessed as a service risk and is identified on the risk register with an action plan in place, monitored to progress data quality and analytic capabilities.
Data quality Risk ID 3267.

SFT: Nil

GWH: Robust governance processes in place to review all neonatal deaths.

BSW Hospitals Group Board

Agenda item	4.2.1
Report title	Group Quality and Safety Report
Date of meeting	5th November 2026
Sponsor	CNOs/ CMOs
Prepared by	Luisa Goddard, Chief Nursing Officer (GWH) Kathryn Bateman Chief Medical Officer (GWH) Jason Lugg, Chief Nursing Officer (RUH), Becky Maxwell Chief Medical Officer (RUH) Jo Howarth, Chief Nursing Officer (SFT), Duncan Murray Chief Medical Officer (SFT)
Approval Process:	Group Executive Committee October 2026

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

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R8	Reducing Avoidable Harm

KEY MESSAGES

The report highlights the quality alerts for the BSW Hospital Group for November and gives an update on the actions being taken in response to recent national guidance / CQC activity.

RECOMMENDATION

The Board is asked to:

Note the updates on quality and safety across the Group and the actions being undertaken to address.

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

1. Alert, Advise, Assure

1.1 Alert

Overcrowding / Corridor Care

All 3 Care Organisations continue to see an impact on safety metrics related to overcrowding and corridor care.

- There is also a significant impact on patient experience metrics relating to overcrowding and waits for care (elective and non elective pathways).
- Eliminating corridor care through the UEC transformation programmes remains the priority with focus on safety actions for those patients that experience corridor care including duty of candour, patient information, safety checks and monitoring of quality outcomes.

A recent study found ED overcrowding may be associated with up to 550 excess deaths per week in the UK (Uncorked European Society for Emergency Medicine 2026).

A recent complaint is illustrative of the experience.

- The patient was cared for in the corridor despite their end-of-life diagnosis and lack of independent mobility. Beds were placed close together with no barriers in place to allow for dignity. Relatives raised concerns about dignity and subsequently privacy screens were placed between beds. The patient was unable to manage their own hygiene and was incontinent, which led to a toileting accident in the corridor.

National evidence supported by Care Organisation data has shown that patient admitted to a bed after being cared for in a corridor have a 22% longer length of stay.

Deconditioning is an important aspect of overcrowding with the impact of 4 hours on an 84 year old has the same impact as 4 days for someone in their forties.

Stroke Care

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

Never Events
A never event has occurred within GWH theatres relating to a retained piece of drill bit embedded into the bone. No harm has been identified and the patient does not require further intervention. Learning relates to thorough checking of the equipment during surgery and a thematic review is underway which will include learning across the group.

Stop before you block
A thematic review is underway regarding learning from near misses in Emergency Departments, with the emphasis on the safety pause must be a deliberate, two-person check immediately before needle insertion.

Hospital Onset Healthcare Associated infections
All Care Organisations across the Group have infection rates above the South West average.

RUH has the highest rate per 100,000 occupied bed days for C.Diff in the South West.

GWH has the highest rate per 100,000 occupied bed days for MSSA the South West.

RUH and GWH have has the highest rates per 100,000 occupied bed days for E.Coli in the South West.

The 3 Infection Prevention leads are working collaborative on actions to address and improve infection control practices including promoting thorough hand hygiene, improvements in device management and Aseptic Non Touch Techniques and good antimicrobial management.

It should be noted that falls, pressure ulcer rates and infections are 'nurse sensitive indicators' and there is a strong evidence base that reduce nurse to patient staffing ratios will increase harms. These indicators are closely monitored against ratios and fill rates with an increase in falls with harm, infections and pressure ulcer rates (at SFT) noted in the last 2 months IPR.

1.2 Advise

Regulation / CQC Updates

CQC inspection activity continues to increase across the Group, particularly in relation to historical inspection activity. CQC are also increasing inspection activity nationally on the Well Led domain. The Group continues to strengthen its regulatory preparedness through a formal Group CQC Engagement Forum, oversight of improvement plans, shared learning and a focus on leadership, governance, culture and quality assurance.

Work remains underway to ensure clear accountability, effective risk escalation and consistent quality governance across the Group**.**

GWH underwent JAG accreditation in October 2026 with a 6-month action plan in place relating to RTT and environmental considerations.

Mortality / Coronial activity
Coronial activity continues with no Prevention of Future Deaths notices received. The triangulation of complaints, legal cases and patient safety investigations for learning continues.

The first ICB Cluster mortality group meeting has taken place, each Care Organisation SHMI remain within expected range. It should be noted GWH Mortality lead post is currently vacant.

Quality Concerns regarding community discharges
Each Care Organisation are collaborating with the ICB quality leads to ensure there is a thematic review relating to discharge and improvement work with partners.

Complaints at GWH
GWH continue to see high volumes of complaints and response rates remain below expected standards. Alongside the A3 improvement work there is a review of the PALS and complaints service ongoing.

1.3 Assure

ETOC / Deconditioning Work:
Falls and deconditioning remain a significant patient safety and quality challenge, particularly for older people and those experiencing prolonged delays. Reduced mobility, extended bed rest and delayed rehabilitation can lead to rapid deconditioning, resulting in loss of strength, balance and independence, which in turn increases the risk of falls, longer lengths of stay and poorer outcomes following discharge. All Care Organisations are leading work to address this through improvement work relating to Enhanced Therapeutic Observations of Care and prevention of deconditioning work. Reporting of deconditioning incidents are improving and supporting the learning.

National Quality Strategy
The BSW Hospitals Group is aligning its quality priorities with the NHS National Quality Strategy, strengthening its focus on the three core domains of quality: safety, effectiveness and patient experience. Across the Group, work is underway to enhance quality governance, improve transparency of outcomes, support shared learning and reduce unwarranted variation between organisations. This includes a continued emphasis on quality improvement, leadership development, data-driven decision-making and addressing health inequalities, ensuring that group-wide collaboration delivers measurable improvements in patient outcomes, staff experience and the quality of care provided across all Care Organisations**.**

NHS England have this month published their approach to reporting of quality data which will be available to the public as well as individual providers. Each metric will map to a commitment in the Quality Strategy with Tier 3 Operational Signals giving early warning to emerging quality themes. There will also be a National Quality Board Insights pack for each Trust which will give an overview of early warning signals, watch list surveillance, and outcome data. The Group have volunteered to be an early adopter.

2.0 Maternity and Neonatal Care

NHS England 10 Point Plan

Each Perinatal Service submitted the initial benchmarking against the NHS England 10-Point Plan in early October. Immediate actions for trusts including board accountability, triage, equity, staffing, homebirth review, Maternal Care Bundle implementation and Martha's Rule rollout. Progress is monitored through each Care Organisation Quality and Safety Committee and oversight will be given at the group Perinatal Services Oversight meeting which will present a highlight report in September.

Areas of concern across the 3 Care Organisations remain:

- Alignment of triage standards to the NHSE service specification
- Alignment of neonatal staffing to BAPM standards (British Association of Perinatal Medicine)

The ICB CNO has updated the Directors of Midwifery the plans for the Local Maternity and Neonatal System (LMNS).

Maternity Incentive Scheme
MIS Year 8 represents a significant reset of the Maternity Incentive Scheme, reducing the programme to six core safety actions focused on workforce and capacity, training, learning from incidents, service-user voice and equity, evidence-based care and Board leadership and governance. The scheme places greater emphasis on outcomes and demonstrable improvements in safety, preparedness and quality of care for women and babies, rather than process compliance alone. Current work is focused on strengthening governance, embedding SPEN (Perinatal Event Notification) reporting, enhancing organisational learning through thematic reviews, maintaining training compliance and ensuring robust Board oversight of maternity and neonatal safety improvement.

Each Care Organisations submission is due at Group Board in January 2027.

BSW Hospitals Group Board

Report to:	BSW Hospitals Group Board	Agenda item:	4.4
Date of meeting:	05/11/2026		

Report title:	Trust Response to the Thirlwall Inquiry Report and Recommendations			
Status:	Information	Discussion	Assurance	Approval
		✓		
Approval Process: (where has this paper been reviewed and approved):	Initial review through relevant Trust leads and governance routes; further assurance to follow through the Quality and Safety Committee.			
Prepared by:	Kat Simpson, Director of Midwifery and Neonatal Services Jodie Da Rosa Director of Midwifery and Neonatal Services Vicki Marston Director of Midwifery and Neonatal Services			
Executive Sponsor:	Luisa Goddard, Chief Nurse Jason Lugg Chief Nurse Jo Howarth Chief Nurse			
Appendices	Group Response to the Thirlwall Inquiry Report and Recommendations			
BAF Risk Link	R8 Reducing Avoidable Harm R2 Taking our People with us			

Recommendation:

The Group Board is asked to:

- Note the findings, national recommendations and mandatory deadlines arising from the Thirlwall Inquiry.
- Reflect on whether similar events could occur within the Trust and whether current systems would identify, escalate and act on concerns quickly enough.
- Note the current position of partial assurance and the principal gaps and dependencies set out in the paper.
- Support the Care Organisations action plans and governance arrangements, including escalation through the Quality and Safety Committees.
- Require a further assurance update following completion of the recommendation-level gap analysis and ODN self-assessment.

Executive Summary:

The Thirlwall Inquiry makes 17 national recommendations addressing medicines security, safeguarding, mortality oversight, data and interoperability, speaking up, leadership accountability and regulatory arrangements. NHS England has asked Boards to consider whether similar events could occur locally and whether existing systems would identify, escalate and act on concerns promptly.

The Care Organisations can currently provide partial assurance. Each Care Organisation is completing a gap analysis, recommendation leads have been identified and the immediate SUDIC awareness action has been completed. Existing neonatal mortality review and reporting arrangements provide a level of assurance, and work has commenced on insulin security, safeguarding requirements and system interoperability.

Principal gaps and dependencies include the need for a clearer ward-to-Board pathway for all baby and child deaths, completion of Care Organisation safeguarding evidence, confirmation of delivery arrangements for enhanced insulin controls, and implementation of recommendations that remain dependent on national guidance. Each Care Organisation has an action plan that will be overseen through existing governance routes, with further assurance provided following completion of the recommendation-level gap analysis and ODN self-assessment.

Group Vision Metrics	Select as applicable:
Developing an engaged workforce	x
Making our teams diverse and inclusive	
Making our services safer	x
Improving timely access to our services	
Improving the experience of those who use our services	x
Improving our financial sustainability	
Improving health equity	

BSW Group Response to the Thirlwall Inquiry Report and Recommendations

1. Purpose

This paper provides the Group Board with an initial assurance position following publication of the Thirlwall Inquiry report and the subsequent NHSE Letter dated 22nd September 2026 that sets out 5 immediate recommendations.

The Thirlwall Report recognises the devastating failure of individuals and the system to act quickly enough to safeguard babies and the NHS culture that prevented this. The Care Organisations thoughts remains with the families affected.

The report gives current progress within each of the Care Organisations with the 5 key actions, principal gaps and dependencies, and opportunities for a pan-group approach to ensure alignment and consistent governance arrangements.

NHS England has asked that Trust and ICB Boards consider the report at a public Board meeting, reflect on whether similar events could occur locally, and seek assurance that sufficient measures are in place to keep babies and children safe.

2. Executive Summary

The NHSE Letter dated 22nd September 2026 asks for Trusts to immediately progress:

- Every trust and ICB board to review the Thirlwall report and to consider its findings at the next available public board meeting.
- Sudden and Unexpected Death In Children (SUDIC): The inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death.
- National Bereavement Care Pathway for stillbirth and neonatal death: ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the Medium Term Planning Framework (October 20025). on thresholds.
- Neonatal insulin security, including access controls, interim CCTV and recording retention by 30th November. By 31 March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT Neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, each trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.
- Safeguarding: Trusts and ICBs should ensure that all staff and board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required

Each Care Organisation has reviewed the report and recommendations, completed a gap analysis, recommendation leads have been identified and the immediate Sudden Unexpected Death in Infancy and Childhood (SUDIC) awareness action is complete. Existing neonatal mortality review and reporting arrangements provide a level of assurance, and work has commenced on medicines security, safeguarding requirements and system interoperability.

3. Progress on Immediate Actions

- SUDIC implementation and evidence that relevant staff understand the process.

Actions completed and reported through the Executive route by the deadline of 28th September 2026. There is an opportunity to establish common escalation expectations across Group and this will be led by CMOs and CNOs.

- Neonatal insulin security, including access controls, interim CCTV and recording retention by 30th November.

The Chief Pharmacists are working collaboratively across the 3 Care Organisations to take forward biometric fridges and access. Scoping exercises and installation planning is in progress and it is expected to be achievable by the 30th November 2026.

- National Bereavement Care Pathway for stillbirth and neonatal death

Each Care Organisation has Bereavement team and care pathway in place.

- Safeguarding training, including deliberate harm by staff, for Staff and Board members.

Each Care Organisation has established safeguarding governance, leadership, training and escalation arrangements. These provide a strong foundation for responding to the safeguarding implications of Thirlwall.

However, the review identifies four areas requiring continued assurance.

- Suspicion of Deliberate Harm Protocol
  Existing safeguarding, Managing Allegations and Persons in Positions of Trust arrangements provide an established basis for managing concerns about staff. These arrangements should include clear processes for bringing together intelligence from all sources.

- Training and workforce
  Safeguarding training is established and appropriate to staff roles, in line with Intercollegiate Guidance. It needs to include potential signs of deliberate harm and how to recognise and escalate concerns involving healthcare staff. National protocols and employment guidance are anticipated by March 2027 and will further inform these arrangements.

- Triangulation and escalation
  Each Care Organisation has mechanisms for bringing together safeguarding, mortality, incident, Freedom to Speak Up, workforce and patient-safety intelligence. These mechanisms need strengthening so that emerging patterns and ‘weak signals’ are identified and acted upon promptly.

  Further work is required to embed national expectations on deliberate harm through a single Group framework covering Safeguarding, People, Legal, professional-regulatory processes, Whistleblowing/Freedom to Speak Up and police interfaces.

  Board level Safeguarding training is planned for Board Development Day in December 2026.

  Work is underway with Chief Medical Officers and Chief Nursing Officers to progress Medical Examiner scrutiny and to develop a single auditable assurance framework across the Group.

4. Next Steps

Care Organisations will progress with standardising Ward-to-Board reporting for all child deaths.

Employment-contract requirements regarding safeguarding will be included in the standard employment contract for BSW Hospitals Group work that is underway.

Freedom to Speak Up mechanisms are established within each Care Organisation; however, Thirlwall highlights the importance of assurance beyond the existence of reporting routes. Each Care Organisation will therefore review the effectiveness of escalation, triangulation, organisational response and Board visibility of themes, alongside any emerging national requirements.

In addition, Care Organisations have been asked by NHS England to complete a separate assurance template by 2nd December via Neonatal Operational Delivery Networks (ODNs).

Progress and compliance will be monitored via the Group Perinatal Oversight Group in the first instance with reporting via Quality and Safety Committees taking primacy. A further progress report will be submitted to Board in January 2027.

Appendix 1 Immediate requirements and current position

Requirement	Deadline	Current assurance	Further assurance required
Public Board consideration	Next available public Board	This paper supports the Board discussion.	Board reflection and agreement of the assurance position.
SUDIC awareness	28 Sep 2026	Completed and reported through the Executive route. Local pathways require further strengthening.	Confirmation of the strengthened, accessible pathway and evidence.
Interim CCTV for insulin storage	30 Nov 2026	Requirement scoped and capital process initiated.	Confirmed installation, governance, retention and contingency arrangements.
ODN self-assessment	1 Dec 2026	Regional self-assessment received.	Completion of the return within the required timeframe, aligned with the Care Organisation action plan.
Insulin access and storage	31 Mar 2027	Gap analysis undertaken and options being explored. Delivery is linked to infrastructure and refit planning.	Confirmed compliance plan, risk position, funding and delivery date.
Board monitoring of baby and child deaths	31 Mar 2027	Neonatal route established; strengthening of paediatric ward-to-Board route being explored	One coherent Group pathway, escalation criteria and Board reporting route.
Safeguarding training and contracts	Immediate / Mar 2027	Review underway. Full evidence of compliance and contract implementation is not yet available.	Group-wide assurance position and recovery or implementation plan.
Bereavement care	31 Aug 2027	The National Bereavement Care Pathway is in place, with compliance subject to formal audit.	One area of non-compliance remains at GWH: the absence of a separate entrance to the facilities for bereaved families.

Appendix 2 Recommendation-level assurance overview

Rec.	Theme	Key Trust position	Assurance status
1	Cot cameras	Awaiting national roadmap and funding approach. Local implementation paused pending national and parent guidance.	National dependency
2	Insulin security	Work underway, but delivery arrangements and infrastructure dependencies remain unresolved.	Further assurance required
3	Bereavement care	The National Bereavement Care Pathway is in place, with compliance subject to formal audit and one outstanding estates-related gap.	Partial assurance
4	Safeguarding training and contracts	Review underway; full Trust-wide evidence and implementation plan not yet complete.	Further assurance required
5	Interoperability	BSW-wide readiness work proposed; national roadmap awaited.	Partial assurance / national dependency
6	Board monitoring of deaths	Established neonatal route; paediatric and wider child-death reporting require clarification.	Further assurance required
7	Data reporting	Lead review frequency, escalation and Board reporting evidence require confirmation.	Further assurance required
8	SUDIC	Immediate awareness action completed; local pathway strengthening remains.	Partial assurance
9	Deliberate harm protocol	National protocol awaited; local implementation route to be confirmed.	National dependency
10	Independent expert panel	National consideration; no immediate local implementation requirement identified.	National action
11	Medical Examiner processes	Existing local controls provide some assurance; SOP strengthening and national guidance remain outstanding.	Partial assurance / national dependency
12	Pathology workforce	National workforce recommendation. Local access arrangements to be kept under review.	National action
13	Manager accountability	National framework awaited; local People and governance implications require review.	National dependency
14	CQC inspection arrangements	External recommendation. Trust readiness should focus on evidence of effectiveness.	External action
15	Assessment of CQC performance	No direct Trust implementation requirement identified.	External action
16	Speaking up	Local Freedom to Speak Up pathways are established. National changes are proposed, while local assurance should continue to test whether concerns are heard, triangulated, escalated and acted upon.	Local assurance / national dependency
17	Audit of implementation	Central action plan and evidence base being established in preparation for future scrutiny.	Partial assurance

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17	Audit of implementation	Central action plan and evidence base being established in preparation for future scrutiny.	Partial assurance

Appendix 3: Consolidated deadlines

Deadline	Requirement	Trust position
28 Sep 2026	SUDIC awareness communication	Completed; pathway strengthening remains.
30 Nov 2026	Interim CCTV focused on neonatal insulin storage	Delivery confirmation required.
1 Dec 2026	South West ODN self-assessment	Return required.
Mar 2027	Employment contracts to include safeguarding obligations	Implementation plan required.
31 Mar 2027	Key requirements covering insulin controls, Board mortality oversight and national guidance products	Trust evidence and national dependencies to be tracked.
31 Aug 2027	National Bereavement Care Pathway implementation	Baseline and trajectory required.
Sep 2027 onward	Manager barring and independent audit arrangements	National framework awaited; evidence trail required.
Dec 2028	Harmonised systems for baby and neonatal data	BSW readiness work to align with national roadmap.
Jun 2033	Paediatric and perinatal pathology workforce target	National action.
Sep 2032	Ambition for statutory regulation of managers	National action.

BSW Hospitals Group Board

Agenda item	4.2.3
Report title	BSW Hospitals Group Safer Staffing Six-monthly Review
Date of meeting	5 November 2026
Sponsor	Luisa Goddard, Chief Nursing Officer (GWH); Jason Lugg, Chief Nursing Officer (RUH); Jo Howarth, Chief Nursing Office (SFT)
Prepared by	Darren Pearson, Recovery and Workforce Transformation Lead (GWH); Simon Andrews, Safe Staffing and Professional Standards Lead Nurse (RUH); Jayne Sheppard, Deputy Chief Nursing Officer (SFT)
Approval Process:	GWH Quality and Safety Committee RUH Quality and Safety Committee SFT Quality and Safety Committee

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

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

BOARD ASSURANCE FRAMEWORK LINK	
BAF risk ID	**Principal risk title**
R9	Improve staff satisfaction
R2	Taking Our People With us

KEY MESSAGES

- The Group Board can take qualified assurance from established safer staffing governance across all three Care Organisations.
- Workforce availability, below-planned staffing and sustained operational pressures continue to constrain safe and sustainable staffing.
- Recruitment, retention and enhanced care improvements provide positive assurance, but local risks persist: ED and AHP capacity at GWH; daytime staffing and emergency-care vacancies at RUH; workforce availability and HCA capacity at SFT.
- Reported progress includes improved NQB self-assessed compliance at RUH and reduced agency and RMN utilisation at SFT; local staffing risks remain.
- SFT proposes 60.19 WTE and £2.632 million recurrent investment, subject to validation, affordability and quality and equality impact assessments. RUH identified no additional nursing establishment investment requirements; GWH reviews remain underway.
- The Board is asked to note qualified assurance position, risks and mitigating actions, and endorse a consistent Group approach to staffing reviews, workforce planning and reporting, retaining local context and investment scrutiny. Priorities include triangulating workforce and quality outcomes and completing Group-wide AHP assurance.

RECOMMENDATION

The Group Board is asked to:

1. **Receive the Group Safer Staffing Six-monthly Review Report and the supporting Care Organisation Reports appended to this paper**
2. **Note the current level of assurance in relation to safe and sustainable nursing and Allied Health Professional staffing across the three Care Organisations, including the areas of risk and variation identified.**
3. **Note the actions underway within each Care Organisation to address identified risks, strengthen staffing governance and improve the evidence base for workforce planning and establishment setting**
4. **Endorse the continued development of a group approach to safer staffing assurance, whilst recognising differences in context across the three Care Organisations.**

APPENDICES

Appendix A	Great Western Hospitals NHS Foundation Trust Six-monthly safer staffing Report
Appendix B	Royal United Hospitals Bath NHS Foundation Trust Mid-Year Review of Nursing Staffing Levels Report

Appendix C	Salisbury NHS Foundation Trust Annual Safer Staffing Review 2026 Report

BSW Hospitals Group Safer Staffing Six-monthly Review

1. Executive Summary

In line with National Quality Board (NQB) expectations, the Group Board is responsible for seeking assurance that staffing is safe and sustainable, underpinned by evidence-based tools, professional judgement and triangulation of quality outcomes. This six-monthly report provides assurance on Nursing and Allied Health Professionals (AHP) staffing across the three Care Organisations within BSW Hospitals Group, highlighting areas of positive assurance alongside risks, variation and opportunities for improvement.

To support consistent reporting and enable the Group Board to readily identify areas requiring attention alongside areas of positive assurance, the Executive Summary uses the Alert, Advise, Assure (AAA) framework to present the key findings for each Care Organisation. The AAA assessments have been informed by each Care Organisations six-monthly safer staffing report, which have been considered through the respective Care Organisations' Quality and Safety Committee. The individual reports are included as appendices and provide the supporting evidence underpinning the position presented.

1.1 Great Western Hospitals NHS Foundation Trust (GWH)

The overall safer staffing position provides a mixed picture of assurance. Nursing workforce supply and retention remain comparatively stable, supported by positive fill rates and established staffing governance; however, maintaining planned staffing remains challenging during periods of operational pressure and short-notice absence, with specific risks within ED and continued work required to strengthen CHPPD and establishment assurance. The AHP workforce is broadly stable, although pressures remain concentrated within therapies, imaging and smaller specialist services. Developing profession-specific workforce plans, capacity and demand modelling and job planning will strengthen the evidence base and future assurance across AHP services.

1.1.1 GWH Alert Advise Assure (Nursing)

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

	further reducing operational flexibility. The combined impact of demand, capacity and staffing pressures increases workforce risk and the challenge of consistently maintaining safe, high-quality care, particularly during periods of escalation. These pressures require continued oversight alongside workforce and quality indicators. • **The current CHPPD position requires continued scrutiny.** Validation identified that some occupied bed days had not been captured, resulting in previously reported CHPPD being overstated. Following corrections, September CHPPD was 8.8. Further work is required to account for different service configurations, for example SAU, where the health roster establishment covers both inpatient and assessment activity while CHPPD reflects inpatient beds only. CHPPD should also be considered alongside operational demand, patient flow, occupancy, acuity and dependency, as these factors influence staffing deployment and interpretation of the metric. Ongoing validation and monitoring will continue as part of the wider assessment of staffing requirements. • **ED remains an area of staffing risk.** The SNCT model indicated a lower quantitative requirement, particularly overnight, but professional judgement identified factors not fully captured by the tool, including overcrowding, prolonged stays, the department's footprint and the separate Children's Emergency Unit. During the collection period, an average of 17 patients per shift remained in ED for more than 12 hours.
ADVISE	• **SNCT** is one component of the Trust's approach to establishment setting. The February and June collections show variation both between collection periods and between calculated and funded establishments. Small and specialist wards and services where funded establishments cover activity outside the inpatient SNCT scope require particular interpretation. The forthcoming establishment reviews will therefore triangulate SNCT with acuity/dependency, quality and workforce indicators, professional judgement and service requirements. • All inpatient wards are funded to support a **minimum 1:8 RN-to-patient staffing assumption**. Actual ratios can temporarily exceed this during short-notice absence or operational escalation, which is managed through established escalation arrangements. Establishment reviews will also consider RN/HCSW skill mix, including movement towards 60:40 where clinically appropriate, particularly in surgical services, while recognising the requirements of high-acuity and specialist areas. • Recruitment and retention provide a comparatively positive workforce position. Overall ward RN vacancies are close to zero. Nursing turnover remains below 8%, below the Trust target, and

	Band 5 RN leavers have reduced to 3.60 WTE per month. HCSW recruitment also continues to be successful.
ASSURE	• Planned versus actual staffing fill rates remained above the report's 89% benchmark across the reporting period, although monthly variation remains. RN fill ranged from 90.4% to 94.3%, and HCSW fill from 95.3% to 106.2%. Recent fill rates have fluctuated and are lower than the six-month average. • Staffing risk is actively overseen through three-times-daily safe staffing meetings, chaired by a Divisional Director of Nursing or deputy, supporting real-time review, escalation, mitigation and redeployment. This is underpinned by the Trust-wide Safer Staffing Policy. • Monthly Nursing, Midwifery and AHP Workforce Group oversight and reporting to Quality and Safety Committee provide governance of workforce metrics, staffing performance and areas of concern. Annual Chief Nurse-led establishment reviews will further assess funded establishments and skill mix using SNCT, workforce and quality indicators and professional judgement.

1.1.2 GWH Alert Advise Assure (Allied Health Professionals)

● ALERT	• Workforce pressure remains concentrated in specific professions. Therapies continue to carry the largest vacancy burden, approximately 24–27 WTE and close to 15% during February–June. Imaging remains affected by national supply constraints, particularly sonography, and continues to require agency staffing to maintain safe service delivery. Smaller AHP services are also vulnerable to the impact of individual vacancies or absences. • There is currently no single nationally mandated safe-staffing ratio covering the full range of AHP services, and there remain gaps in demand, capacity and quality information. This limits the level of assurance that can be derived from workforce numbers alone.
ADVISE	• The overall AHP workforce is broadly stable at 387.3 WTE, comprising 75.4% qualified and 24.6% non-qualified staff. Overall turnover has reduced to 11.85 % (17.92% in 2025), including a reduction of more than 40% in voluntary turnover, although turnover remains above the 9% benchmark used in the report. • AHP workforce planning is increasingly being strengthened through profession-specific capacity and demand modelling, job planning and NHS England-supported optioneering. These need to mature further before the organisation can consistently demonstrate the relationship between establishment, demand, workforce capacity and patient outcomes across all professions.
ASSURE	• All relevant AHP groups have completed NHS England-supported optioneering and are developing longer-term workforce plans

	addressing profession-specific recruitment, retention, education, skill mix and workforce transformation. Capacity-and-demand tools are already in place for imaging and podiatric surgery, with further development underway for therapies, SLT and orthoptics; job planning is targeted for completion by April 2027.

1.2 Royal United Hospital Bath NHS Foundation Trust (RUH)

Overall, the nursing safer staffing position provides qualified assurance, supported by established staffing governance, low turnover, and progress in recruitment and enhanced care provision. However, sickness absence above funded headroom, below-planned daytime fill rates and continuing vacancies specifically in emergency and urgent care constrain staffing resilience amid sustained operational and patient-flow pressures. The review identified no specific safety themes linked to nursing staffing, but continued triangulation of workforce and quality indicators remains essential. Targeted recruitment and retention remain priorities; no additional establishment investment requirements were identified during this review.

1.2.1 RUH Alert Advise Assure (Nursing)

● **ALERT**	• **Daytime staffing remains below planned levels.** Between April and September 2026, RN Day fill rates ranged from 78–86% and HCSW day fill rates from 82–90%. Sickness absence remains significantly above the 3% funded allowance. Sustained demand, escalation capacity and patient-flow pressures constrain staffing resilience and have increased bank and agency expenditure. • **Emergency and urgent care vacancies remain a key risk.** The report identifies 29 WTE RN vacancies across these areas. Medicine risk 3329, relating to acute sickness and unfilled vacancies, has a residual score of 12 and an Amber action plan. Recruitment plans indicate progress towards a more stable staffing position across all nursing areas, although continued oversight remains essential.
ADVISE	• **Establishment and assurance reviews remain underway.** Annual staffing reviews will inform 2027/28 workforce plans and the April 2027 safer staffing report, with work to align review and reporting cycles across the Group. The current review identified no additional nursing establishment investment requirements for inpatient wards, paediatrics or ED. Developing Workforce Safeguards reassessment is due in November 2026.
ASSURE	• **Staffing risks are subject to established oversight.** Senior nurse-led staffing meetings take place at least twice daily, seven days a week, reviewing acuity, dependency and skill mix, with out-of-hours oversight by site and patient-flow teams. Red flags are monitored in

	real time, supported by monthly Nursing, AHP and Midwifery Workforce Group oversight chaired by the Chief Nursing Officer. • **Workforce deployment and retention provide positive assurance.** Nursing turnover remains low; inpatient rosters have been aligned to agreed establishments. The Trust achieved level 4 against NHSE E-rostering meaningful use standards and was recognised within the top 10% nationally for effective E-rostering. • **External and self-assessment evidence shows progress.** The report records full compliance with 11 of 12 Developing Workforce Safeguards recommendations and partial compliance with the remaining workforce planning recommendation. NQB self-assessed compliance improved from 33 of 37 recommendations in June to 35 of 37 in September 2026. • **Quality assurance remains qualified.** The review identified no specific safety themes or current correlation between nursing staffing levels and quality metrics. Falls reduced by 9% compared with the preceding six months. However, 96 pressure ulcers were reported, including 24 in ICU, with multifactorial learning and ongoing action plans. These findings do not remove the risks of safer staffing levels as a contributing factor; continued triangulation of quality outcomes, sickness absence and below-planned fill rates remains necessary. • **Enhanced care provision has been strengthened.** The substantive Enhanced Care Team has improved continuity and personalised care while reducing reliance on bank and mental health agency staffing. Further development will align with the NHSE Enhanced Therapeutic Observations of Care programme over the next 12 months.

1.3 Salisbury NHS Foundation Trust (SFT)

Overall, the safer staffing position remains well governed but under sustained workforce and operational pressure. Current controls and external assurance provide confidence in the Trust's staffing governance arrangements; however, the gap between funded headroom and actual staff unavailability, alongside increasing acuity, complexity, enhanced care and patient-flow demands, continues to place pressure on staffing resilience. The 2026 review identifies targeted establishment and skill-mix changes to address areas of greatest need, with proposed investment subject to final validation and affordability.

1.3.1 SFT Alert Advise Assure Nursing

● **ALERT**	• Workforce availability is the principal driver of staffing pressure. Average reported staff unavailability is approximately 32%, compared with 24% funded headroom, alongside rising acuity, complexity, escalation, patient-flow pressures and enhanced-care demand. Workforce sustainability challenges are particularly evident within the HCA workforce, where vacancies and turnover continue to present operational risk. • CHPPD has reduced and remains in the lower national quartile. It is not interpreted as a standalone measure of staffing safety and is triangulated with acuity and dependency, fill rates, nurse-to-patient ratios, quality outcomes, and professional judgement. • Appendix 3 contains 13 quantified proposals totalling 60.19 WTE and £2.632 million recurrent investment. Implementation remains conditional on final divisional validation, confirmation of WTE and banding, recurrent affordability, and completion of required quality and equality impact assessments. ICU remains under review, and the Longford proposal requires further assessment and validation. • Temporary staffing availability remains constrained, including during transition to Bank Partners, and operational pressures continue to affect the ability to consistently achieve planned Ward Leader supervisory time.
ADVISE	• RN day and night fill rates were broadly stable at or above 100% and were close to planned levels by September 2026. HCA night fill was generally around or above plan, reflecting additional deployment for enhanced care requirements. HCA day fill remained below 100% throughout the period, reaching its lowest point in August before partially recovering in September; this is consistent with sustained HCA vacancies and requires continued monitoring alongside focused actions to reduce avoidable sickness and improve workforce availability. • The review supports targeted establishment and skill-mix changes rather than a uniform uplift, prioritising emergency and acute medicine, frailty, older people's services, enhanced care, patient flow, palliative care and specialist rehabilitation. • Forecast population growth and an ageing population are expected to increase demand, particularly within services supporting frailty, older people and complex care pathways. Workforce planning therefore needs to be considered alongside pathway redesign, productivity, acuity and future registered nurse workforce supply requirements. • The recurrent investment should be considered alongside opportunities to reduce temporary staffing expenditure, improve workforce sustainability and mitigate quality risks associated with workforce shortages, increasing patient dependency and operational pressures.

ASSURE	• NHS England South West confirmed compliance with 11 of 12 safer staffing domains. The remaining action relates solely to the online accessibility of monthly actual-versus-planned staffing reports and does not indicate a deficiency in the Trust's staffing governance arrangements. • The Trust has maintained a near-zero ward RN vacancy position and RN turnover within target, supported by Nursing Associate, apprenticeship and internal development pathways. However, HCA vacancies, turnover, and workforce availability continue to present operational risks in several areas. • Agency and RMN utilisation have reduced, supported by strengthened ETOC governance and multidisciplinary oversight. Forecast additional-duty expenditure of £636,000 is lower than each of the previous three years. • Several staffing proposals are targeted at services caring for patients with higher levels of dependency, frailty, dementia and delirium and are intended to support safer care delivery, enhanced observation and falls prevention, particularly during evening periods when falls incidence is higher. • Risks are managed through daily SafeCare assessments, three-times-daily staffing meetings, weekly senior review, strengthened bank approval processes and established monthly governance arrangements, providing ongoing ward-to-Board assurance. Sustained operational pressures continue to impact achievement of planned Ward Leader supervisory time, and this remains subject to ongoing monitoring through safer staffing governance.

BSW Hospitals Group Board

Agenda item	4.2.4
Report title	Six-Monthly Integrated Perinatal Workforce and Capacity Report: MIS Year 8 Safety Action A • Great Western NHS Foundation Trust • Salisbury NHS Foundation Trust
Date of meeting	5 November 2026
Sponsor	Luisa Goddard Chief Nursing Officer Jo Howarth Chief Nursing Officer Jason Lugg Chief Nursing Officer
Prepared by	Kat Simpson, Director of Midwifery and Neonatal Services Vicki Marston Director of Midwifery and Neonatal Services
Approval Process:	Care Organisation's Quality and Safety Committee

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

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

BOARD ASSURANCE FRAMEWORK LINK	
BAF risk ID	**Principal risk title**

KEY MESSAGES

GWH

ALERT

- The funded neonatal nursing establishment remains below the workforce requirement identified through BAPM modelling, with continuing pressure relating to Qualified in Specialty capacity and supernumerary nurse-in-charge provision.
- The neonatal medical model does not yet fully meet BAPM recommendations for Tier 1 evening and Tier 2 afternoon, evening and night cover.
- Perioperative vacancies increased during the reporting period and the current maternity theatre workforce model does not meet Association for Perioperative Practice standards.
- The current workforce model is not always enabling a timely review by a senior doctor during triage care episodes.

ADVISE

- Midwifery staffing was above funded establishment at the end of August 2026; however, establishment figures do not fully reflect operational availability, acuity, sickness, maternity leave, skill mix and deployment. Delivery Suite and Hazel Ward acuity data therefore remain important components of assurance.
- Planned caesarean birth activity has increased beyond the capacity supported by the recurrent workforce model. Additional obstetric, anaesthetic and perioperative capacity is being progressed through workforce planning, risk management and business planning.
- Turnover remained relatively low across maternity services from March to July 2026, while neonatal nursing turnover was higher at 10.71% to 12.84% and will continue to be monitored alongside recruitment and workforce development.

ASSURE

- Established systems are in place to monitor workforce, acuity and capacity pressures, with escalation through maternity, neonatal, workforce and risk-governance arrangements.
- The midwifery establishment remains aligned with the May 2025 Birthrate Plus assessment. The next review will be brought forward to April 2027, with preparatory work commencing in January 2027.
- Obstetric anaesthetic rota compliance was maintained throughout the reporting period, with appropriately trained staff available to support obstetric activity. Current mitigations have supported continuity of maternity and neonatal services.

OVERALL ASSURANCE

Workforce risks are recognised, monitored and actively managed, but sustainable workforce gaps remain against neonatal and perioperative standards and in the recurrent capacity required to support planned caesarean birth activity.

SFT

ALERT

- The neonatal medical workforce does not currently meet British Association of Perinatal Medicine (BAPM) workforce standards. This is recorded as a divisional risk, has been escalated to Trust Board and a Business Case is being progressed.
- The neonatal nursing workforce is no longer BAPM compliant. A specific, measurable, achievable, relevant and time-bound (SMART) action plan is being developed to provide a trajectory towards compliance.
- Assurance over medical rostering is limited because current systems do not provide consistent, auditable workforce data.
- Increasing maternity activity, acuity and complexity continue to place pressure on capacity and timely care.

ADVISE

- Twenty-four-hour clinical cover was maintained across all workforce groups throughout the reporting period.
- Midwifery vacancies increased to 7.40 WTE, or 6.72%, by August 2026. Posts were being held for recruited Band 5 preceptee midwives, with bank staff used to support safe staffing.
- Anaesthetic recruitment is expected to bring the service to full establishment by January 2027.
- Reported delays in care relate mainly to elective caesarean sections, induction of labour pathways and reviews of urgent ultrasound scans.
- No staffing-related harm to patients was identified through the review of Datix incidents during the reporting period.
- Whilst Obstetric staffing is stable ability to meet increasing demand is a risk.

ASSURE

- The obstetric medical workforce remained stable, with no reported vacancies or turnover and temporary consultant maternity leave cover in place.
- The midwifery establishment is funded in line with the Birthrate Plus® assessment accepted by the Trust Board in May 2024. Staffing and acuity are monitored through the Birthrate Plus® acuity tool and reported through established oversight arrangements.
- Neonatal nursing vacancies improved following the recruitment of 1.6 WTE Band 5 nurses during July and August 2026.
- Perioperative cover for obstetric theatres continued to be provided through the wider Trust theatre workforce, with no maternity-specific vacancies or gaps reported.

Identified workforce risks are being managed through established escalation processes, temporary staffing, active recruitment, the neonatal medical workforce business case and the development of a neonatal nursing SMART action plan.

RECOMMENDATION

The Group Board is asked to:

The Board is asked to:

1. **Receive and discuss the six-monthly integrated perinatal workforce and capacity reports for Salisbury and Great Western Hospitals.**
2. **Note the areas of compliance and the controls in place to manage workforce and capacity pressures.**
3. **Note the areas where partial assurance remains, particularly neonatal workforce compliance, operational midwifery availability, maternity triage responsiveness, perioperative workforce sustainability and recurrent capacity for planned caesarean birth activity.**
4. **Support continued development of sustainable workforce models through established workforce, risk-management and business-planning processes.**
5. **The Board to note that the RUH perinatal workforce paper was included in Quarter 2 Perinatal Safety Report that was received by the Board in September 2026.**

Six-Monthly Integrated Perinatal Workforce and Capacity Report

1. Purpose and scope

This six-monthly report provides the Group Board with integrated assurance regarding workforce and capacity across maternity and neonatal services for the period March to August 2026. It supports assurance against Safety Action A of the NHS Resolution Maternity Incentive Scheme Year 8, which requires effective multidisciplinary workforce and capacity planning aligned with nationally recognised workforce standards.

The report provides assurance across midwifery, obstetric, neonatal medical and nursing, anaesthetic and perioperative staffing, together with the workforce implications of planned caesarean birth capacity. It summarises the workforce position, compliance with relevant professional standards, material staffing risks, current controls and improvement trajectory.

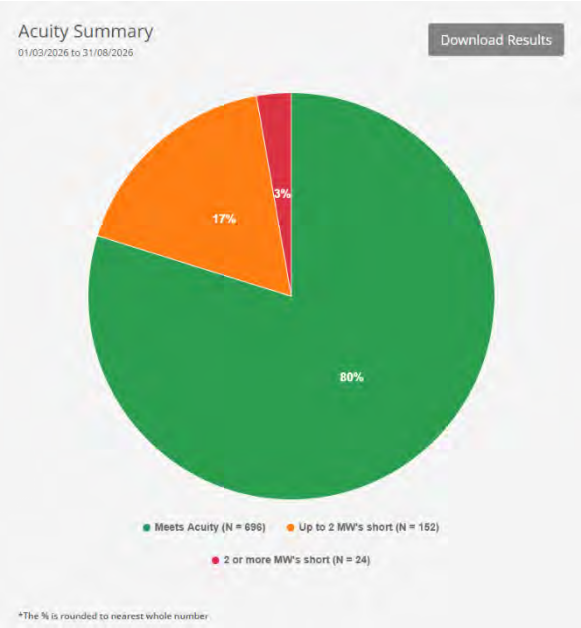
2. Midwifery staffing and Birthrate Plus assurance

At the end of August 2026, 184.30 WTE midwives were in post against a funded establishment of 181.37 WTE, representing an apparent over-establishment of 2.93 WTE. This does not fully reflect operational availability because some staff were unavailable through maternity leave or sickness and because activity, acuity, skill mix and deployment requirements vary across the service. Turnover remained relatively low across the maternity workforce between March and July 2026, reducing from 7.48% to 4.38% for inpatient midwifery, from 7.48% to 6.25% within the Maternity Care Centre, and from 8.70% to 6.25% for community midwifery. Up to 14.5 WTE staff were on maternity leave at any one time across the service.

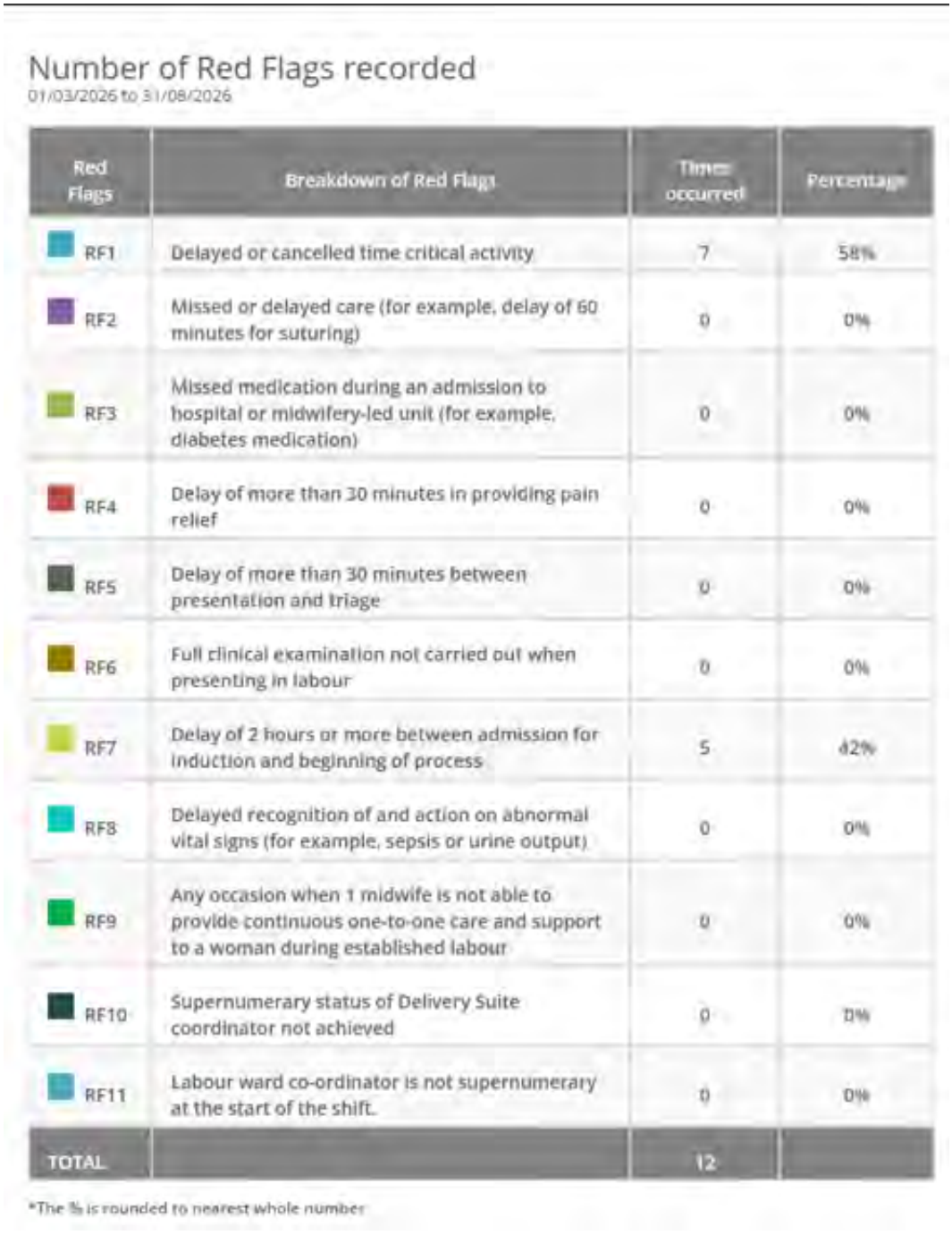
2.1 Acuity Delivery Suite

Between March and August 2026, staffing met assessed acuity in 80% of the time on Delivery Suite. Staffing was up to two midwives below assessed need 17% of the time and two or more midwives below assessed need was 3%. Therefore, 20% of recorded assessments identified a staffing shortfall against assessed acuity.

No Birthrate Plus red flags were recorded for failure to provide one-to-one care in established labour or failure to maintain the supernumerary Delivery Suite coordinator. However, Birthrate Plus recording compliance was not 100%; separate monthly reporting identified one-to-one care compliance below 100% in three months, with documentation accuracy identified as the principal contributory factor. This is monitored through the Perinatal Quality Oversight Model.



Delivery Suite acuity summary, March-August 2026



Number of Red Flags recorded

01/03/2026 to 31/08/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	7	58%
RF2	Missed or delayed care (for example, delay of 60 minutes for suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	0	0%
RF5	Delay of more than 30 minutes between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	5	42%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Supernumerary status of Delivery Suite coordinator not achieved	0	0%
RF11	Labour ward co-ordinator is not supernumerary at the start of the shift.	0	0%
TOTAL		12	

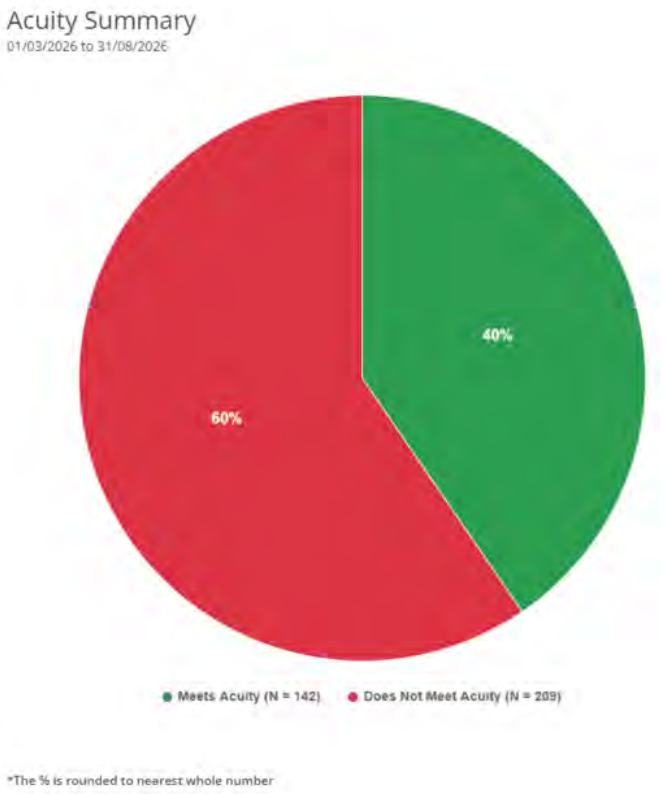
*The % is rounded to nearest whole number

Delivery Suite red flags, March-August 2026

2.2 Acuity Hazel Ward

The available Hazel Ward data indicates greater staffing pressure. Staffing met assessed acuity in 40% of recorded assessments and did not meet assessed acuity in 60%. Principal recorded factors included unexpected midwifery and maternity support worker absence, coordinator non-supernumerary status, skill-mix pressures, redeployment and unfilled shifts.

Compliance with recording and uploading Birthrate Plus data on Hazel Ward has been poor. An improvement plan is in place and the dataset should not be treated as complete. However, the available data is considered representative of the staffing pressures experienced and will be triangulated with roster, incident, patient-experience and wider quality evidence.



Hazel Ward acuity summary, March-August 2026

Number of Staffing Factors

01/03/2026 to 31/08/2026

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	24	14%
SF2	Unexpected MSW absence/sickness	27	16%
SF3	Unable to fill vacant MW shift	11	7%
SF4	Unable to fill MSW shift	15	9%
SF5	Staff on transfer duties	0	0%
SF6	MW redeployed to other area	16	9%
SF7	MSW redeployed to other area	4	2%
SF8	No ward clerk available	4	2%
SF9	No Co-ordinator on duty	0	0%
SF10	Support staff less than rostered numbers	8	5%
SF11	2 or more band 5 midwives on duty	21	12%
SF12	No NIPE midwife on duty	13	8%
SF13	Coordinator not supernumerary	26	15%
TOTAL		169	

*The % is rounded to nearest whole number

Hazel Ward recorded staffing factors, March-August 2026

2.3 Acuity Outpatients

There is no acuity tool in place across the outpatient areas which include maternity triage, day assessment unit, antenatal clinical community services. Staffing is monitored via daily staffing huddles at 09.15 and 12.00 with redeployment of staff considered from other areas of the services in line with the escalation policy. Staffing models across all areas of outpatients meet the current local BirthRate Plus recommendations.

2.4 Workforce position and establishment assurance

At the end of August 2026, the funded midwifery establishment was 181.37 WTE against 184.30 WTE in post, a gap of 2.93 WTE (1.62%). The position of over recruitment accounts for staff on maternity leave and therefore is not representative of staff available to work. This has impacted on the fill rate of rostered shifts which may be further impacted by short-term absence, supernumerary requirements, skill mix and deployment across specialist and non-frontline functions which continue to affect operational availability.

Measure	March–August 2026 position
Funded establishment	181.37 WTE
Staff in post	184.30 WTE
Position against funded establishment	2.93 WTE / 1.62%
Temporary shifts requested	2,264
Temporary shifts filled	1,890

Unfilled temporary shifts	374
Temporary shift fill rate	83.48%
Delivery Suite Coordinator supernumerary at shift start	100%

The maternity service has a limited bank-only workforce and is largely reliant on substantive staff undertaking additional shifts. This provides flexibility but creates an ongoing fatigue, burnout and absence risk if prolonged.

2.5 Specialist and non-frontline midwifery capacity

Specialist and non-frontline roles form part of the maternity establishment and support statutory, safety-critical and improvement functions. The current Birthrate Plus review identifies 18.89 WTE across specialist, leadership and management roles. These functions support statutory requirements, clinical safety, education, governance and service improvement, while also contributing to clinical escalation arrangements where appropriate.

Internal redeployment of specialist and non-frontline midwifery staff form part of the escalation policy with the expectation that all staff maintain their skills in the clinical setting. The Perinatal Leadership team are reviewing the opportunity for all specialist roles to contribute regularly to the clinical rota. Specialist operational resilience is being considered as part of a wider business continuity plans for the perinatal services to ensure that wider staff groups have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available.

2.6 Workforce controls and improvement

Risk 593 records the risk that insufficient midwifery staffing to fill rosters may compromise patient safety. Controls include bank and agency escalation, daily matron review and redeployment, recruitment to turnover and maternity leave, the maternity staffing escalation plan, and bi-monthly recruitment and retention review. Senior assurance is provided through the fortnightly Chief Nurse bank and agency spend huddle, with the wider workforce review progressing through the 10-point maternity action plan.

Workforce capacity across inpatient and intrapartum services is reviewed every 4–6 hours through the Birthrate Plus® acuity app. The Maternity Clinical Escalation Policy and the OPEL maternity framework are embedded in daily operational practice, with daily status reporting to NHS England. These arrangements support timely escalation, deployment decisions and organisational oversight of workforce, acuity, flow and capacity.

Recruitment continues to mitigate turnover and maternity leave. Retention remains comparatively strong, with turnover reported at 5.5% in August 2026. The dedicated Preceptorship Lead Midwife strengthens support for newly qualified midwives and reduces the supervisory and educational burden on experienced clinical staff. Fortnightly senior oversight of vacancies and temporary staffing expenditure, alongside bi-monthly recruitment and retention review, provides a structured route for monitoring workforce stability and emerging pressure.

2.8 Birthrate Plus review cycle

The last full Birthrate Plus assessment was completed in May 2025. The funded midwifery establishment therefore remains within the required three-year review cycle. The next assessment will be brought forward to April 2027, with preparatory work commencing in January 2027, to provide earlier assurance that the funded establishment remains aligned with current activity, acuity and service configuration.

Midwifery assurance conclusion

The Board can take assurance that the midwifery establishment is currently funded in line with a Birthrate Plus assessment completed within the required review period. Partial assurance is provided regarding operational workforce availability because acuity data demonstrates periods when staffing did not match assessed need, particularly on Hazel Ward. Assurance is further limited by poor Hazel Ward data-upload compliance, for which an improvement plan is in place.

3. Obstetric medical workforce

The obstetric and gynaecology medical workforce vacancy position increased across the reporting period. Against a funded establishment of 45.97 whole-time equivalent, the reported vacancy increased from 1.60% in March 2026 to 17.67% in August 2026. The principal driver was gaps within the resident doctor workforce following the August deanery rotation. Consultant vacancies remained comparatively stable. The figures cover the integrated obstetrics and gynaecology medical cost centre and should not be interpreted as an obstetrics-only establishment measure.

3.1 Workforce position and rota resilience

The service requested 224 temporary obstetric medical shifts during the reporting period. Of these, 222 were filled through bank arrangements and two remained unfilled, giving a fill rate of 99.11%. The two unfilled shifts were risk assessed with oversight from the Clinical Lead or Clinical Director and Divisional Medical Director. This provides assurance that core rota gaps were identified and actively managed, but it also demonstrates continued reliance on additional duties and temporary staffing to maintain service delivery.

Resident doctor gaps are affected by deanery allocations, rotations and less-than-full-time placements. These allocations may not match the service establishment and are not automatically backfilled by the deanery. Local controls include active rota management, recruitment to resident doctor vacancies, use of substantive staff for additional duties, temporary staffing and senior medical oversight.

Workforce data demonstrates low sickness absence of 0.22% and turnover of 9.76% in August 2026. It is recognised that the system in place for resident doctors reporting sickness absence was not capturing all absences accurately. A revised system for reporting sickness absence has been introduced which is anticipated to be associated with a perceived rise in sickness as the system is embedded.

Measure	March 2026	August 2026	Supporting data
Funded establishment	45.97 WTE	45.97 WTE	Integrated obstetrics and gynaecology cost centre
Contracted workforce	41.20 WTE	37.85 WTE	Reduction reflects resident rotation gaps
Reported vacancy	1.60%	17.67%	Material deterioration during the reporting period
Temporary shift fill	Not reported monthly	222 of 224; 99.11%	Core rota maintained with local mitigation

3.2 Clinical standards and service impact

The consultant rota meets the Royal College of Obstetricians and Gynaecologists requirements for on-site support for a unit of this size. Consultant attendance at defined “Consultant Must Attend” events and timely consultant review of postnatal readmissions continue to be monitored through perinatal governance. No episodes of consultant non-attendance at defined ‘must attend’ events were reported between March and August 2026. All

exceptions are investigated and exception reports to be brought to Perinatal Governance cross referenced against patient safety events via Datix.

Current resident doctor working patterns provide maternity triage cover, but doctors also cover other clinical areas. A recent audit undertaken in response to the Amos report (2026) which considers triage attendances demonstrated that 56% of women attending received a medical review within the timeframe required. This was due to competing clinical needs across the service, which can delay the medical assessments in triage. A revised working model is being developed to provide dedicated Tier 1 and Tier 2 cover for maternity triage and the Day Assessment Unit, with improved consultant oversight.

Increasing planned caesarean birth demand creates an additional obstetric workforce requirement. Temporary additional lists are in place, while the maternity theatre proposal identifies a requirement for 0.52 additional consultant whole-time equivalent. This proposal is being considered through senior leadership and 2027/28 business-planning arrangements.

The fetal medicine service at GWH has a specialist consultant with no operational resilience due to the specialised skill set. A service review with Oxford University Hospitals is under way to inform a sustainable longer-term model.

Obstetric medical workforce conclusion

The Board can take partial assurance regarding the obstetric medical workforce. Core rotas were largely maintained and gaps were actively managed, with 99.11% of requested temporary shifts filled. However, the reported vacancy position deteriorated materially during the reporting period, the service remained reliant on local mitigation, and further work is required to provide dedicated maternity triage cover and sustainable capacity for increasing planned caesarean birth activity.

4. Neonatal medical and ANNP workforce

The August 2026 neonatal medical position was 50.40 WTE in post against a funded establishment of 50.36 WTE. These figures include the integrated neonatal and paediatric medical workforce and do not demonstrate compliance with the British Association of Perinatal Medicine (BAPM) standards for medical staffing model required for the Local Neonatal Unit.

4.1 Compliance with neonatal medical workforce standards

A workforce review identified that the current model does not fully meet the applicable British Association of Perinatal Medicine recommendations which were released in November 2025. Tier 1 cover met the recommended level during daytime and night shifts but not during the evening period from 17:00 to 20:45. Tier 2 cover met the recommended level on weekdays from 08:30 to 12:30 but not during weekday afternoons, evenings or nights. Tier 3 cover met the recommended level.

4.2 Rota resilience and temporary staffing

The neonatal and paediatric medical rota is supported by resident doctors in specialty training, substantive specialty doctors and fixed-term staff-grade appointments. Forecast gaps are actively reviewed, and fixed-term appointments provide Tier 2 rota cover through to March 2027. During the reporting period, 113 temporary neonatal medical shifts were requested; 111 were filled through bank arrangements and two remained unfilled, a fill rate of 98.23%.

This provides assurance that immediate rota gaps were actively managed. However, the reliance on temporary and fixed-term solutions does not close the underlying establishment gap against the BAPM model.

4.3 Advanced Neonatal Nurse Practitioner workforce

At the end of August 2026, the Advanced Neonatal Nurse Practitioner establishment was 7.00 WTE, with 6.36 WTE in post and a vacancy of 0.64 WTE (9.14%). The team have three qualified ANNPs and four practitioners in training. ANNP development is a central component of the neonatal medical workforce strategy because appropriately experienced practitioners can contribute to Tier 1 and Tier 2 activity and strengthen rota resilience.

Recruitment of qualified ANNPs remains challenging. The service has therefore adopted a grow-your-own approach, supporting experienced neonatal nurses through ANNP training. Succession planning is also required because anticipated retirements and changes in contracted hours may affect this small specialist workforce. All ANNPs receive 25% non-clinical time for leadership, education, governance and service development; and the workforce model accounts for the difference between funded WTE and available clinical rota capacity.

4.4 Safety, quality and service impact

The principal risks associated with the workforce gap are reduced resilience, delays in clinical assessment or decision-making, reduced clinical supervision and increased reliance on temporary staffing. Perinatal quality reporting identified occasions of near misses associated with the absence of dedicated Tier 2 Local Neonatal Unit cover at night, although no direct harm was reported in the source evidence.

The Trust was an alert-level outlier for two-year follow-up within the National Neonatal Audit Programme which has impacted the ability to provide consistent outpatient follow-up for high-risk infants Funding was reallocated for a dedicated neonatal follow-up service, planned to commence at reduced capacity in November 2026 and become fully operational in February 2027.

Risk 1686 records the insufficient neonatal medical staffing capacity to meet the revised BAPM workforce standards. Current controls include rota review, senior cover, escalation arrangements, temporary staffing and review of workforce metrics and standards compliance.

Workforce planning is underway to determine how a hybrid model of specialty doctors and Advanced Neonatal Nurse Practitioners could support sustainable Tier 2 cover. The model recognises the greater workforce stability offered by developing and retaining experienced ANNPs alongside the clinical flexibility provided by specialty doctors.

Neonatal medical and ANNP workforce conclusion

The Board can take partial assurance regarding neonatal medical and ANNP staffing. Immediate rota gaps were actively managed and temporary-shift fill was high; Tier 3 provision met the recommended level, and there is an established ANNP development pipeline. However, the current model does not fully meet the revised (November 2025) BAPM recommendations for Tier 1 evening and Tier 2 afternoon, evening and night cover. Full assurance is dependent on approval and delivery of a sustainable, fully funded mixed medical and ANNP workforce model, supported by validated safety-impact evidence and measurable milestones.

5. Neonatal nursing workforce

At the end of August 2026, the neonatal nursing workforce stood at 44.32 WTE in post against a funded establishment of 44.84 WTE, with a vacancy of 0.52 WTE (1.16%). Recruitment has commenced to address 7 WTE of the 9.44 WTE requirement identified using the BAPM nursing calculator (2020) workforce modelling tool.

5.1 Compliance with neonatal nursing standards

Workforce capacity is monitored through BAPM metrics, Operational Delivery Network workforce returns and the Perinatal Quality Oversight Model, taking into account cot occupancy, dependency levels and acuity. During the

reporting period, compliance with BAPM staffing requirements based on cot occupancy ranged from 40.9% to 76.1%, demonstrating that the funded workforce did not consistently match service demand.

Measure	Reported position	Required standard / expectation
Funded versus required establishment	9.44 WTE below BAPM workforce-calculator requirement	Funded establishment aligned with BAPM 2020 nursing calculator
Staffing compliance based on cot occupancy	40.9%-76.1% during reporting period	>90%
Qualified in Specialty workforce	69.5% of overall workforce in August 2026	At least 70% of patient-facing staff
Shift skill mix	80.9% of shifts met the required skill-mix standard	>90%
Supernumerary nurse in charge	29.5%-56.6% of shifts	100%

5.2 Qualified in Specialty capacity and skill mix

BAPM standards require at least 70% of patient-facing neonatal nursing staff to hold Qualified in Specialty status. The reported overall workforce position was 69.5% in August 2026. Active deployment of experienced staff enabled 80.9% of shifts to meet the required skill-mix standard, but the position remained vulnerable to turnover, newly appointed staff entering the development pathway and short-term absence. Recruitment has therefore focused on Band 5 nurses supported to progress through the Qualified in Specialty pathway, because experienced Band 6 neonatal nurses remain difficult to recruit nationally. Cohorts of nurses are allocated to the programme through two intakes each year. The number of staff attending at any one time is limited due to the study leave requirement of the course.

5.3 Supernumerary nurse-in-charge provision

Compliance with the requirement for a supernumerary nurse in charge ranged from 29.5% to 56.6% of shifts. During periods of high occupancy or acuity, the nurse in charge was required to provide direct clinical care to maintain bedside staffing. This reduced leadership capacity for coordination, escalation, oversight and staff support and represents the material operational gap against the expected staffing model. Current recruitment is expected to improve supernumerary nurse-in-charge compliance over the next six months.

5.4 Rota resilience, temporary staffing and capacity impact

During the reporting period, 874 temporary neonatal nursing shifts were requested. Of these, 751 were filled through bank arrangements, 20 through agency and 103 remained unfilled, giving an overall fill rate of 88.22%. Current controls include proactive roster management, bank and agency escalation, acuity-based deployment, senior operational review and use of the neonatal escalation policy.

Where workforce availability does not support activity safely, the service may restrict external admissions or temporarily reduce cot capacity. These measures protect immediate safety but reduce system resilience and may result in babies being cared for outside the local area, with associated family separation and travel burden. There were episodes of the neonatal service restricting access to both external and internal admissions during the reporting period due to high cot occupancy and acuity.

5.5 Risk, recruitment and improvement trajectory

Risk 1627 records the patient-safety risk arising from the neonatal nursing workforce model not meeting BAPM standards. The September quality report recorded a risk score of 11. Current controls include daily escalation, senior review, acuity-based staffing, cross-cover and transfer arrangements when required. These controls

support the delivery of safe care but do not remove the underlying establishment, skill-mix and supernumerary leadership gaps.

Seven additional neonatal nursing WTE were approved using the Maternity Incentive Scheme rebate. 5.16 WTE have been recruited to and are awaiting start dates, with the remaining 1.84 WTE advertised. This recruitment reduces the immediate gap but does not provide recurrent funding for the full 9.44 WTE requirement which will be considered through business planning 2027/28. A combined, risk-based workforce business case for the neonatal nursing and medical workforce is under development.

Neonatal nursing workforce conclusion

The neonatal nursing workforce was close to its existing funded establishment, staffing pressures are monitored and current controls supported safe delivery during the reporting period. However, the funded establishment remained 9.44 WTE below the BAPM workforce-calculator requirement; staffing did not consistently meet occupancy-based standards; Qualified in Specialty compliance was marginally below the required level; and supernumerary nurse-in-charge provision was achieved on only 29.5% to 56.6% of shifts. Full assurance is dependent on recurrent approval and delivery of a sustainable establishment, skill-mix and leadership model aligned with BAPM standards. Neonatal nursing turnover remained higher, ranging between 10.71% and 12.84% from March to July 2026, and will continue to be monitored alongside recruitment, retention and the Qualified in Specialty workforce trajectory.

6. Anaesthetic and perioperative workforce

This section provides maternity-specific assurance regarding anaesthetic and perioperative support. Whole-department workforce figures are included only where they help explain resilience; they do not, in isolation, demonstrate that the obstetric service has sufficient staff with the required competencies at the relevant time.

6.1 Obstetric anaesthetic cover

Consultant anaesthetic vacancy levels remained stable throughout the reporting period. Resident doctor capacity varied following the August deanery rotation, reflecting centrally determined training allocations, including less-than-full-time placements. These variations were managed effectively through roster management, temporary staffing and support from the substantive team. The service maintained 100% compliance with the obstetric anaesthetic rota, with appropriately trained trainees, specialty doctors and consultants providing cover and 19 senior clinicians available to support obstetric activity. Compliance is monitored monthly through the Perinatal Quality Oversight Model.

6.2 Anaesthetic capacity for planned maternity care

The funded anaesthetic model supports five half day elective caesarean birth lists each week. Increasing demand has required additional sessions that are not included within the current establishment. A forecast requirement of 5.5 additional anaesthetic sessions per week was identified to support an all-day elective list and additional perinatal pre-operative clinics and is being considered through 2027/28 business planning.

Where additional obstetric anaesthetic activity cannot be absorbed, obstetric care is prioritised and there is a risk that other elective surgical activity is delayed or cancelled. Current mitigation includes Waiting List Initiative payments either to cover obstetric activity directly or to release an anaesthetist from other elective work. This maintains immediate maternity cover but is not a sustainable substitute for recurrent capacity.

6.3 Perioperative workforce position, maternity theatre staffing model and service impact

The perioperative anaesthetic-practitioner workforce remained under sustained pressure during the reporting period. In August 2026, 34.87 WTE were in post against a funded establishment of 41.73 WTE, representing a vacancy of 6.86 WTE or 16.43%. This was a deterioration from the 8.61% vacancy reported in March 2026 and reflects that recruitment did not keep pace with the increase in funded establishment.

Temporary staffing continued to support service delivery. Of 327 additional shifts requested during the reporting period, 269 were filled and 58 remained unfilled, an overall fill rate of 82.26%. Current controls include proactive roster management, recruitment, bank and overtime arrangements, and prioritisation of maternity activity where competing demands arise. These measures have supported continuity of care but leave the service reliant on substantive staff undertaking additional duties, with associated risks to resilience and workforce sustainability.

The maternity theatre staffing model remains recorded on Risk 1691 because it does not meet Association for Perioperative Practice staffing standards. The workforce model provides emergency and planned maternity theatre cover but has limited resilience when planned and emergency activity occur simultaneously. This creates a risk of delayed access to theatre, reliance on cross-cover and additional shifts, and displacement of other elective activity because emergency maternity care is prioritised.

A multidisciplinary review has been undertaken, informed by workforce and compliance analysis, incident review, demand-and-capacity assessment and an obstetric theatre risk assessment. This has identified the need for a recurrent workforce model aligned with Association for Perioperative Practice standards and clearer operational accountability for maternity theatres. The proposed model is being progressed through the Trust's risk-management and business-planning processes.

Anaesthetic and perioperative workforce conclusion

The Board can take reasonable assurance that anaesthetic and perioperative workforce pressures are recognised, monitored and actively managed. Anaesthetic rota compliance was maintained throughout the reporting period, with appropriately trained staff supporting obstetric activity. Current controls have also supported continuity of maternity theatre provision despite significant perioperative vacancies.

Partial assurance is provided regarding the overall sustainability of the workforce model. The recurrent anaesthetic establishment does not fully reflect the additional planned maternity activity, while the perioperative workforce remains below funded establishment and the current maternity theatre staffing model does not meet Association for Perioperative Practice standards. Full assurance is dependent on approval and implementation of a recurrently funded anaesthetic and perioperative workforce model capable of supporting planned and emergency maternity activity.

7. Planned caesarean birth capacity: workforce implications

Planned caesarean birth activity has increased, with demand exceeding the capacity supported by the current recurrent workforce model. The service is funded to provide five planned caesarean birth lists each week, with additional temporary capacity currently supporting demand.

Demand and capacity review has identified additional workforce requirements across obstetric, anaesthetic and perioperative staffing, including 0.52 WTE consultant obstetric capacity, additional anaesthetic sessions and an uplift in perioperative staffing to support a model aligned with Association for Perioperative Practice standards. These requirements are being considered alongside the wider maternity theatre workforce model through business-planning and risk-management processes. Capacity pressures and delays are monitored through operational and governance arrangements, with escalation where demand exceeds available capacity.

The Board can take partial assurance that the workforce implications of increased planned caesarean birth demand are understood and subject to active workforce planning; full assurance is dependent on agreement and implementation of the recurrent workforce model.

8. Conclusion

Overall, the Board can take partial assurance regarding the sustainability of the multidisciplinary perinatal workforce. Established systems are in place to monitor workforce, acuity and capacity pressures, escalate concerns and implement operational controls. These arrangements have supported continuity of maternity and neonatal services during the reporting period.

Reasonable assurance is available regarding the funded midwifery establishment and current obstetric anaesthetic cover. However, material gaps remain in neonatal medical and nursing staffing against BAPM standards, operational midwifery availability, maternity triage responsiveness, perioperative staffing against professional standards and recurrent workforce capacity for planned caesarean birth activity.

Area	Board assurance	What prevents full assurance
Midwifery and Birthrate Plus	Reasonable assurance regarding funded establishment; partial assurance operationally	Periods of mismatch between staffing and acuity, particularly on Hazel Ward, and incomplete Hazel Ward data submission.
Obstetric medical workforce	Partial assurance	Resident-doctor vacancies, cross-cover within triage, and fetal medicine resilience.
Neonatal medical and ANNP workforce	Partial assurance	Tier 1 evening and Tier 2 afternoon, evening and night gaps against the applicable BAPM model; final funded trajectory not approved.
Neonatal nursing workforce	Limited / partial assurance	Funded establishment remains 9.44 WTE below the BAPM calculator requirement; inconsistent occupancy-based compliance and insufficient supernumerary nurse-in-charge provision.
Anaesthetic and perioperative workforce	Partial assurance	Additional maternity activity is not recurrently funded; perioperative vacancies remain material; the hybrid theatre model does not meet AfPP standards.
Planned caesarean capacity	Partial assurance	The annual demand-and-capacity assessment identifies the need for increased capacity, while the recurrent workforce, theatre and estates response remains in development.

Salisbury NHS Foundation Trust Perinatal services Bi-Annual Integrated Workforce Report

Maternity Incentive Scheme (MIS) Year 8 Safety Action A

Executive Summary

This report provides assurance to the Trust Board on workforce capacity and safe staffing across maternity, neonatal, obstetric, anaesthetic and perioperative services between March and August 2026, in support of Maternity Incentive Scheme (MIS) Year 8, Safety Action A. It evidences that arrangements are in place to monitor, escalate and mitigate workforce risks, and 24-hour clinical cover was maintained throughout the reporting period.

The obstetric medical workforce remained stable, with no reported vacancies or turnover and temporary consultant backfill in place for maternity leave. Midwifery staffing remained broadly stable, supported by bank cover and planned recruitment, although vacancies and sickness absence increased during the period. Neonatal nursing vacancies improved following recruitment, and anaesthetic staffing is expected to reach full establishment by January 2027. Perioperative cover continued to be provided through the wider Trust theatre workforce.

The principal residual risks relate to neonatal medical and nursing compliance with British Association of Perinatal Medicine (BAPM) workforce standards, availability of neonatal nurses who are Qualified in Specialty (QIS), and increasing maternity activity, complexity and acuity. These risks are recognised and are being managed through established escalation arrangements, temporary staffing, active recruitment, a neonatal medical workforce business case and development of a specific, measurable, achievable, relevant and time-bound (SMART) action plan for neonatal nursing compliance.

There is a recognised risk of lack of assurance for the processes for medical workforce rostering, which has not led to reduced outcomes, but has limited the level and quality of the assurance able to be given.

No harm associated with staffing-related delays was identified during the reporting period. Delays were mainly associated with elective caesarean sections, induction of labour pathways and review of urgent ultrasound scans, reflecting operational capacity and acuity pressures. The Board is asked to note the assurance provided, the residual workforce risks and the actions in progress, and to record the required evidence of compliance in the Trust Board minutes.

1. Purpose

The aim of this report is to provide assurance to the Trust Board that there was an effective system of monitoring workforce and capacity risks in the medical, midwifery, neonatal, anaesthetic and perioperative teams related to safe staffing levels from March 2026 to August 2026. This is a requirement of the year 8 NHS Resolution Maternity Clinical Negligence Scheme Trusts (MIS) Maternity Incentive Scheme and relates to Safety Action A.

2. Background

It is a requirement, that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing, midwifery and medical staffing in line with the National Quality Board (NQB) requirements.

Safety Action A requires the demonstration of an effective system of clinical workforce and capacity planning to nationally recognised workforce standards. This report gives a summary of all the measures in place to achieve this related to the following workforce groups in line with safety action A:

- Obstetric medical workforce
- Midwifery workforce
- Neonatal Medical workforce
- Neonatal Nursing Workforce
- Anaesthetic medical workforce
- Perioperative staffing

3. Staffing Levels and Workforce Sustainability

This section provides assurance on staffing levels and workforce sustainability across the maternity, neonatal, obstetric, anaesthetic and perioperative workforce groups. It presents funded establishment and substantive staffing levels alongside vacancy, turnover and absence data, where available, to identify workforce pressures, demonstrate how these are being monitored and set out the recruitment, retention and mitigation actions in place to support safe and sustainable staffing.

3.1 Medical workforce: obstetrics, paediatrics/neonates and anaesthetics

Workforce outcomes for obstetrics, paediatrics/neonatal and anaesthetics were non-alerting during the reporting period. Twenty-four-hour clinical cover was maintained across all staff groups at all times, and no staffing-related harm was identified through Datix review.

Obstetric staffing, operated through a joint obstetrics and gynaecology rota, remained stable with maternity leave backfill in place. Paediatric and neonatal medical staffing continued to provide neonatal cover, although it remained below British Association of Perinatal Medicine (BAPM) workforce standards. Anaesthetic staffing levels improved through recruitment, with appointments expected to bring the service to establishment by January 2027.

Assurance over medical rota management remains limited. Medical rotas are not consistently managed through a single electronic rostering system, with local Excel spreadsheets and paper rotas still in use. Sickness and annual leave are recorded electronically but do not map directly to shifts, limiting assessment of their impact on rota coverage. Locum shifts are managed through a separate system that is not integrated with substantive rota arrangements.

Consequently, planned and filled shifts, rota gaps, locum use, skill mix and escalation decisions cannot be routinely reconciled and reported from a single reliable source. There is also no consistently applied and auditable process across the three services for prospective rota approval, competency and seniority checks, management of gaps and locum use, escalation, and routine governance reporting.

The absence of national guidance defining safe medical staffing standards for obstetrics further limits prospective assurance compared with the more established approach to midwifery workforce analysis.

Overall, assurance is limited with regard to fill rates due to inadequate data, however assurance regrading safety is robust due to interrogation of Datix, incidents and risk. The reported staffing position is thus reassuring, but it is not yet supported by a sufficiently robust, consistent and auditable control framework.

Actions in repsonse:

The following actions are to be taken to develop assurance frameworks:

- Work with erostering and CMO's office to agree a minimum standard for monitoring of management of medical rotas.
- Introduce more detailed rota reporting for medical workforce to fill current assurance gaps.
    - Planned, Filled and Unfilled shifts based on substantive rotas
    - Gaps identified before and after rota publication (6 weeks)

    - Number of sickness-related changes with reporting period
    - Number of consultant or senior escalations for rota or workforce caps
- To work with the E-rostering team and CMO's office to introduce and develop e-rostering within medical workforce

3.1.1 Obstetric medical workforce

Salisbury NHS Foundation Trust (SFT) operates a joint obstetrics and gynaecology rota; therefore, the funded establishment covers both services. Temporary backfill is currently in place to cover maternity leave and maintain safe staffing levels.

Consultant obstetric medical workforce

Month	Funded establishment WTE	Vacancy %	Turnover %
March	**12.98**	**0%**	**0%**
April	**11.63**	**0%**	**0%**
May	**11.63**	**0%**	**0%**
June	**11.63**	**0%**	**0%**
July	**11.63**	**0%**	**0%**
August	**11.63**	**0%**	**0%**

3.1.1.2 Registrar (ST3+) obstetric medical workforce

Month	Funded establishment WTE	Vacancy %	Turnover %
March	**8.30**	**0%**	**0%**
April	**8.13**	**0%**	**0%**
May	**8.13**	**0%**	**0%**
June	**8.13**	**0%**	**0%**
July	**8.13**	**0%**	**0%**
August	**8.13**	**0%**	**0%**

3.1.1.3 Medical workforce absence

Month	Absence %	Absence Days Lost (days)
March	**0.55%**	**1.45**
April	**0.69%**	**8.26**
May	**2.01%**	**9.00**
June	**2.53%**	**6.66**
July	**2.22%**	**2.00**
August	**0.77%**	**7.40**

The tables above demonstrate a stable obstetric medical workforce across the reporting period. Following a reduction in funded establishment between March and April, consultant and registrar staffing remained consistent through to August 2026, with no reported vacancies or turnover. Medical workforce absence remained low overall, fluctuating between 0.55% and 2.53%, and reduced to 0.77% in August.

3.1.2 Paediatric and Neonatal medical workforce

The Neonatal and Paediatric medical workforce are not delivered via separate rotas. The numbers below represent this joint workforce. The Neonatal medical workforce is not currently compliant to the workforce standards set out by the British Association of Perinatal Medicine (BAPM). A business case is currently being progressed to achieve this in line with CNST standards for compliance. Non-compliance to BAPM standards is currently being held as a divisional level risk.

Month	Funded establishment WTE	In Post WTE	Vacancy WTE	Vacancy %	Turnover %	Absence %
March	**24.92**	**28.04**	**+3.12**	**0**	**0**	**0.45**
April	**29.45**	**28.59**	**0.86**	**2.92**	**0**	**2.09**
May	**29.45**	**27.68**	**1.76**	**5.97**	**0**	**1.72**
June	**29.45**	**28.59**	**0.86**	**2.92**	**0**	**0.74**
July	**29.45**	**27.68**	**1.76**	**5.97**	**7.13**	**0.22**

August	**29.45**	**26.39**	**3.06**	**10.39**	**6.95**	**0.00**

The table shows that the funded establishment for the joint neonatal and paediatric medical workforce increased from 24.92 whole-time equivalent (WTE) in March to 29.45 WTE from April onwards. Although staffing was initially above establishment, the in-post workforce reduced to 26.39 WTE by August, resulting in a vacancy of 3.06 WTE (10.39%). Turnover increased in July and August, while absence remained low throughout the reporting period and was 0% in August.

3.1.3 Anaesthetic medical workforce

Month	Funded establishment WTE	In Post WTE	Vacancy WTE	Vacancy %	Turnover %	Absence %
March	*	*	*	*	***not available**	**2.37%**
April	**34.62**	**33.31**	**1.31**	**3.78%**	***not available**	**1.28%**
May	**33.95**	**35.31**	**-1.36**	**-4.01%**	***not available**	**2.25%**
June	**33.95**	**35.16**	**-1.21**	**-3.56%**	***not available**	**2.53%**
July	**33.95**	**35.18**	**-1.23**	**-3.62%**	***not available**	**1.40%**
August	**33.95**	**36.23**	**-2.28**	**-6.72%**	***not available**	**1.38%**

*data collected for March 26' is currently being validated due to inconsistencies across financial years. Due to challenges with financial data, as well as limited consultant implementation on e-rostering systems, absence data is not valuable to be shared.

3.2 Midwifery workforce

3.2.1 Birthrate Plus® workforce planning and staffing levels

A formal Birthrate Plus® assessment was carried out through October to December 2023, as per NICE (2017) national recommendation for repeat assessment timeframes, which reviewed the acuity of women who used maternity services. It was formally reported in February 2024; recommended changes to Midwifery establishment were presented to and accepted by Trust board on 2nd May 2024 with an uplift to staffing agreed. Current funded midwifery establishment reflects birthrate plus recommended staffing levels.

The current midwifery establishment at SFT is calculated using a midwife/birth ratio of 1:24 as recommended by the SFT Birthrate Plus® report in February 2024. Birthrate Plus® is the national workforce tool recommended by NICE (2014). Current funded establishment is based upon a projected total of 2200 births per annum. To monitor the safety of this approach we also use the Birthrate Plus® acuity tool, inputting precise data detailing risk and acuity of inpatients on Labour Ward 4 hourly, and Beatrice Ward 6 hourly. This gives up to date feedback on the level of safe staffing against the acuity and activity of the day. The tool also measures, by exception, where 1:1 care is not possible for labouring women, and when the labour ward coordinator is not able to maintain supernumerary status. These metrics are reported monthly via perinatal Quality Oversight Model slide set to ensure robust oversight.

Birthrate Plus® is the only recognised national tool for calculating midwifery staffing levels and provides a robust and proven methodology for determining midwifery staffing establishments and is thus the recommended tool that MIS CNST stipulates to be used.

The below demonstrates current Midwifery funded establishment (including Director of midwifery and Neonatal services, Head of Midwifery and Neonatal services and Matrons) against vacancy, turnover and absence rates.

Month	Funded establishment WTE	In Post WTE	Vacancy WTE	Vacancy %	Turnover %	Absence %
March	**110.05**	**106.46**	**3.59**	**3.26**	**9.96**	**3.54**
April	**110.05**	**107.21**	**2.84**	**2.58**	**9.21**	**3.91**
May	**110.05**	**107.08**	**2.97**	**2.69**	**10.99**	**3.97**
June	**110.05**	**105.27**	**4.78**	**4.34**	**9.84**	**4.96**
July	**110.05**	**102.85**	**7.20**	**6.54**	**9.88**	**6.44**
August	**110.05**	**102.65**	**7.40**	**6.72**	**10.31**	**6.55**

Overall midwifery staffing numbers remain stable and although the vacancy rates have increased over the reporting period this has been to ensure that posts are held for the recruited Band 5 preceptee midwives who will join the service in October. Backfill has been provided by bank usage to ensure appropriate safe staffing levels.

Sickness absence rates have increased over the summer due to a combination of increased long term sickness absence. The absence rates are reported monthly through the Perinatal Surveillance Oversight Model (PSOM) and are managed closely in line with the Trust Attendance Management policy by the leadership team.

3.3 Neonatal nursing workforce

The neonatal nursing establishment is determined in accordance with British Association of Perinatal Medicine (BAPM) workforce standards. The annual staffing requirement is confirmed by the local Operational Delivery Network (ODN), based on the previous year's cot occupancy and acuity, and includes all staff providing direct clinical care. The funded establishment met BAPM requirements in Quarter 1 of 2026/27; however, the required establishment has subsequently increased following the annual review of activity presented to the ODN and is now reported as an additional 1.54 WTE required. The staffing position is being reviewed and a specific, measurable, achievable, relevant and time-bound (SMART) action plan is being developed to provide a clear trajectory towards compliance.

Month	Funded establishment WTE	In Post WTE	Vacancy WTE	Vacancy %	Turnover %	Absence %
March	**25.29**	**22.20**	**3.09**	**12.21**	**10.37**	**4.99**
April	**25.29**	**22.20**	**3.09**	**12.21**	**7.04**	**3.94**
May	**25.29**	**22.20**	**3.09**	**12.21**	**9.67**	**2.79**
June	**25.29**	**21.59**	**3.70**	**14.63**	**6.22**	**6.36**
July	**25.29**	**22.31**	**2.98**	**11.78**	**6.10**	**7.50**
August	**25.29**	**23.11**	**2.18**	**8.62**	**6.15**	**1.69**

Sickness absence rates are variable month on month due to the relatively small numbers in the team. The absence rates are reported monthly through the Perinatal Surveillance Oversight Model (PSOM) and are managed closely in line with the Trust Attendance Management policy by the leadership team.

3.4 Perioperative workforce

Month	Funded establishment WTE	In Post WTE	Vacancy WTE	Vacancy %	Turnover %*	Absence %*
March	15.68	15.68	0	0	N/A	N/A
April	15.68	15.68	0	0	N/A	N/A
May	15.68	15.68	0	0	N/A	N/A
June	15.68	15.68	0	0	N/A	N/A
July	15.68	15.68	0	0	N/A	N/A
August	15.68	15.68	0	0	N/A	N/A

*The perioperative workforce who staff obstetric theatres are provided from the main Trust theatre team and are not a standalone team. There are not applicable turnover and absence rates as this team is not a single unit and is always provided to cover maternity theatres. Absence and turnover do not therefore impact the safe staffing levels for maternity.

4. Rota Gaps and Workforce Capacity

Across the reporting period, 24/7 obstetric, neonatal medical, anaesthetic and perioperative cover was maintained, with maternity and neonatal services prioritised

because of their acute and time-critical nature. There is, however, a lack of assurance for the process of medical workforce rostering, with actions to be taken to fill this gap in the next reporting cycle. Formal fill-rate data are not available for these groups because they are not recorded on the Allocate rostering platform; however, no workforce gaps affecting the delivery of care were reported, and review of Datix incidents identified no related safety concerns. Any obstetric medical gaps were mitigated through consultant cover within the shared obstetrics and gynaecology rota, neonatal medical gaps through the paediatric consultant workforce, and anaesthetic and perioperative cover through established Trust-wide arrangements.

Staff Group	Total Planned Shifts (March-August 2026)	Unfilled Shifts	Fill Rate % (including use of locum/agency/bank)	Escalations
Midwifery	2726	77	97.1%	None
Neonatal Nursing	1271	80	93%	See table below

Midwifery achieved a 97.1% fill rate across 2,726 planned shifts, with 77 unfilled shifts arising mainly from short-term sickness or emergency leave; these were managed through bank cover and established Tier 1 and Tier 2 escalation pathways, with no recurrent gaps or formal escalations.

Neonatal nursing achieved a 93% fill rate across 1,271 planned shifts, with 80 unfilled shifts. The principal risk remains achieving four staff on each shift, including a supernumerary nurse in charge, and maintaining a minimum of two nurses who are Qualified in Specialty (QIS) trained when acuity exceeds the staffing assumptions based on 80% cot occupancy. This is mitigated through bank staffing and escalation arrangements, with the new Bath, Swindon and Wiltshire (BSW) Bank Partners model expected to improve access to QIS-trained temporary staff and reduce reliance on substantive staff.

Workforce	**Risk Identified**	**Mitigation Implemented**	**Progress**
Neonatal nursing	Paucity of QIS trained temporary (bank) staff	BSW Group introduction of Bank partners	Neonatal Matron to meet bank partners

			in September 2026 to agree pathways
Neonatal Nursing establishment	Neonatal nursing workforce not funded in line with BAPM standards	Activity and Accuity monitored daily against BAPM standards and reported via PQOM monthly slides	SMART action plan in progress
Neonatal Medical workforce	Neonatal medical workforce not funded in line with BAPM standards	Clinical care is covered by the consultant paediatric team	Trust board sighted on risk and business case being written.

5. Impact on Safety and Quality

5.1 Red flag incidents

Red flags are warning indicators that staffing capacity, workforce availability or increased clinical acuity may be affecting the safe and timely delivery of care across the maternity, red flag neonatal, obstetric, anaesthetic and perioperative services described in this report. Where a is identified, it is escalated to the relevant clinical lead to determine the contributory factors and implement appropriate mitigation. Red flags are monitored through established operational reporting and escalation processes, including the live Birthrate Plus® acuity tool for midwifery.

The following tables demonstrate red flag events for the 6-month period from 1st March 2026 to August 31st, 2026:

Number of Red Flags recorded

01/03/2026 to 31/08/2026

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	2	33%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	0	0%
RF5	Delay of 30 minutes or more between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	2	33%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Supernumerary status of labour ward coordinator not achieved	2	33%
TOTAL		6	

*The % is rounded to nearest whole number

5.2 Delays in care

Most reported delays relate to elective caesarean sections, induction of labour pathways and review of urgent ultrasound scans. No associated harm has been identified; however, these delays may adversely affect the experience of women and families and present a potential risk to timely care.

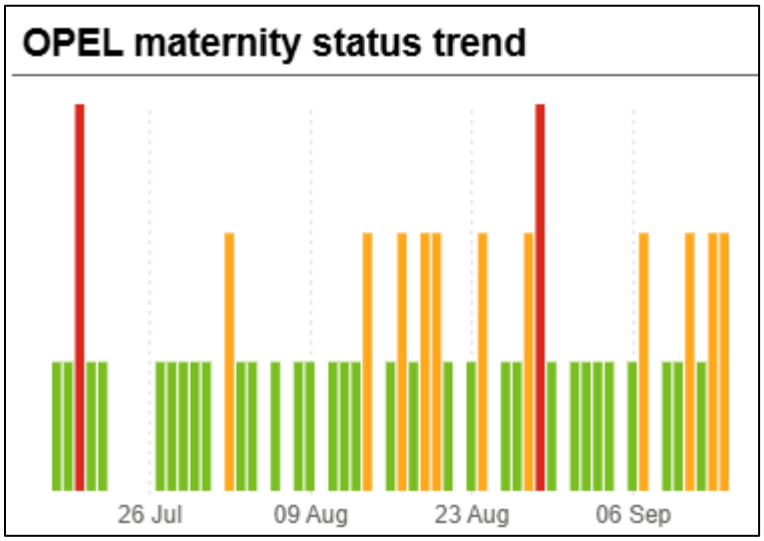
Delays are primarily attributable to operational capacity and acuity pressures. Midwifery capacity may constrain progression of induction pathways, while urgent clinical demands can limit timely obstetric review of scan results. Although staffing is maintained at the

agreed establishment, increasing activity and complexity of Obstetric patients continue to place pressure on workforce capacity.

5.3 Escalation events

The launch of the National Maternity and Neonatal sitrep in December 2025 has ensured that our Opel status is reported at least once daily to the national team. The Opel status is based on a variety of operational parameters including stating the operational status and safety of the midwifery, obstetric, anaesthetic and neonatal workforce. The Opel status has been published on a National dashboard since July 2026.

The below table is extracted from the national Maternity and Neonatal sit rep and demonstrates SFT OPEL status from its start on 26tgh July to end of this reporting period.



The Operational Pressures Escalation Level (OPEL) status is reported through Trust-wide capacity meetings, together with any required mitigation, providing Trust oversight of operational pressures. Staffing gaps are managed in accordance with the Safe Staffing Levels in Maternity Services and Operational Escalation Policy and the Neonatal Unit Escalation Standard Operating Procedure (SOP).

To support consistent OPEL assessment and reporting, a standardised status calculator will be implemented for use by the maternity and neonatal leadership team by the end of September.

6. Recruitment, Retention and Succession Planning

Recruitment, retention and succession planning are actively managed across the perinatal workforce to maintain safe staffing, address identified vacancies and support a sustainable future workforce. Key actions by workforce group are summarised below.

6.1 Obstetric medical workforce

One whole-time equivalent (WTE) consultant has been appointed from March 2026 to January 2027 to provide maternity leave cover and maintain safe staffing. Retention and succession actions include registrar and Specialty Training Years 1–2 rota changes informed by deanery feedback from September 2026, review of consultant job plans and medical workforce capacity, staff listening and survey action plans, and strengthened feedback arrangements for rotating doctors.

6.2 Midwifery workforce

Four newly qualified Band 5 midwives have been recruited to commence in November 2026, with NHS England funding supporting recruitment of a further two. Two midwifery apprentices are also expected to join as Band 5 preceptee midwives in January 2027. Retention and succession measures include flexible working, exit interviews, a dedicated 1 WTE preceptorship and retention role, development opportunities across education, safeguarding and labour ward leadership, Professional Midwifery Advocate support, training needs analysis and continuing professional development funding, team engagement and delivery of the staff survey action plan.

6.3 Neonatal medical workforce

No recruitment took place during the reporting period. Subject to approval of the business case at Trust and Integrated Care Board level, recruitment will commence to support compliance with British Association of Perinatal Medicine (BAPM) standards. Tier 1 and Tier 2 resident doctors rotate through training posts; the proposed workforce model will therefore include Advanced Neonatal Nurse Practitioners (ANNPs) to provide a stable workforce and support longer-term retention and succession planning.

6.4 Neonatal nursing workforce

Recruitment of 1.6 WTE Band 5 nurses in July and August has improved the vacancy position, with further recruitment planned in Quarter 3 and the remaining Band 7 vacancy under review. Retention and succession measures include flexible working, exit interviews, service development roles, Band 6 leadership workstreams, Professional Nurse Advocate support, training needs analysis and continuing professional development funding, regular team meetings and delivery of the staff survey action plan.

6.5 Anaesthetic and perioperative workforces

Anaesthetic recruitment during Quarters 1 and 2, together with further confirmed appointments, is expected to achieve full establishment by January 2027. The perioperative workforce supporting obstetric theatres is drawn from the main Trust theatre team; no maternity-specific vacancies or gaps are reported, and wider recruitment, retention and succession planning is managed through the Trust theatre workforce arrangements.

7. Recommendations

The Trust Board is asked to receive the report and take assurance that effective systems are in place to monitor and manage perinatal workforce capacity and safe staffing; note the residual workforce risks and associated mitigating actions; and formally record in the Trust Board minutes its review of the required workforce metrics as evidence of compliance with Maternity Incentive Scheme (MIS) Year 8, Safety Action A.

BSW Hospitals Group Board

Agenda item	4.3
Report title	Month 6 Group Financial Report
Date of meeting	5th November 2026
Sponsor	Simon Wade, Group Chief Financial Officer
Prepared by	John Ridler, Associate Director of Finance
Approval Process: (where has this paper been reviewed and approved)	

☒ FOR ASSURANCE	☒ FOR DECISION	☐ FOR INFORMATION

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R5	Increasing sustainability

KEY MESSAGES

The Month 6 financial report highlights:

- **Position –** The Group reported a £6.5m deficit in September and a £41.3m deficit for the first six months of the year.
- **Efficiency –** £31.1m has been delivered to September against a £38.8m plan. Forecast delivery is £87.5m against the £117.1m annual target, with £61.9m of this being recurrent.
- **Workforce –** Total Workforce was 15,725 WTE, which is 472 above plan, driven by operational pressures, the pace of efficiency delivery and recruitment challenges.
- **Cash –** Closing cash at the end of September was £39.5m.
- **Capital –** Spend to September was £18.7m, £18.2m below plan. The majority of the underspend is driven by nationally funded strategic schemes, including the Electronic Patient Record (EPR) programme.

RECOMMENDATION

The Board is asked to:

- **Note** the £41.3m deficit for the first half of the year.
- **Require** further action to close the reported £29.7m efficiency shortfall and complete the recurrent and non-recurrent classification.
- **Delegate** ongoing scrutiny of delivery, cash and residual financial risk to the Financial Sustainability Committee, with material issues escalated to the Group Board.

APPENDICES

The attached Month 6 Group Financial Report provides the detailed evidence base and public appendix.	
Appendix 1	Month 6 Group Financial Report – Board presentation (pages 2–8)

Group Financial Report

Monthly finance report from Simon Wade, Group CFO

September 2026

Public Group Board finance report

Great Western Hospitals (GWH), Salisbury (SFT), Royal United Hospitals Bath (RUH)

26th October 2026

Group financial position and outlook

DEFICIT TO SEPTEMBER

(£41.3m)

£29.2m adverse to plan

SAVINGS DELIVERY

£31.1m

£38.8m planned to September

CAPITAL PROGRAMME DELIVERY

£18.7m

£36.9m planned to September

Key highlights in Month 6 position

1. There is a deficit in month totalling £6.5m
2. The I&E deficit for April–September totals £41.3m, which is £29.2m adverse to plan.
3. Savings forecast £87.5m against £117.1m target. Mitigations being worked on for current £29.7m shortfall.
4. Capital programme delivery remains behind plan, mainly in relation to nationally funded schemes.
5. Cash balance of £39.5m at end of month.

Financial position by Care Organisation

Care Organisation	Month 6 Planned position £'m	Month 6 Actual position £'m	Variance from plan £'m
Great Western Hospitals	(4.2)	(21.4)	(17.2)
Salisbury	(2.8)	(2.8)	0.0
Royal United Hospitals Bath	(5.1)	(17.1)	(12.0)
Group total	**(12.1)**	**(41.3)**	**(29.2)**

Group outlook

Challenging financial position with a number of efficiency schemes not delivering planned levels .

Recovery depends on acceleration of schemes identified but not delivering full value.

Deficit Support Funding (DSF) received at SFT but not GWH

Material constraints

Demand and escalation capacity increase costs.

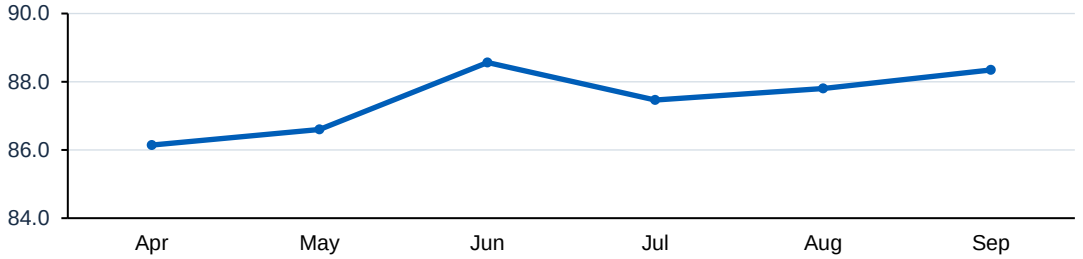
Savings delivery has been delayed due to operational pressures in first half of year.

Cash support requirements moving into latter months of the year at both SFT and RUH.

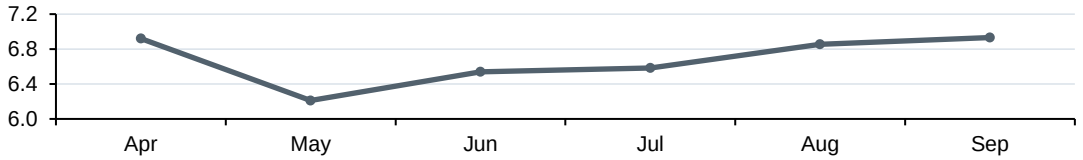
Staff costs and workforce position

Monthly pay spend • £m

Total pay (£m)

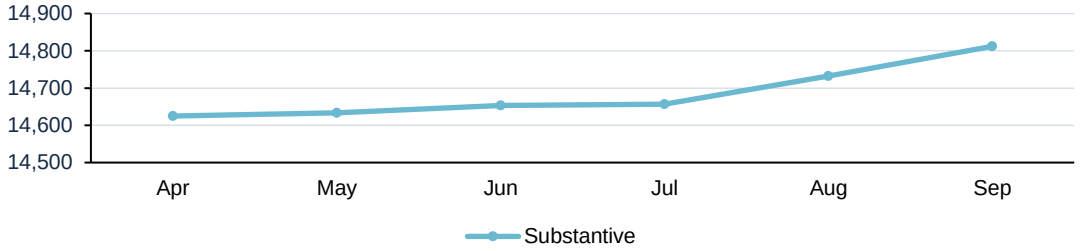


Bank + agency pay (£m)

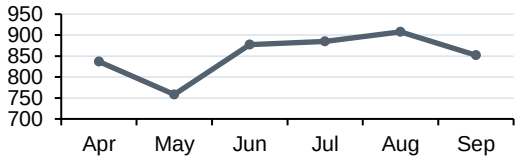


Monthly workforce, full-time equivalents

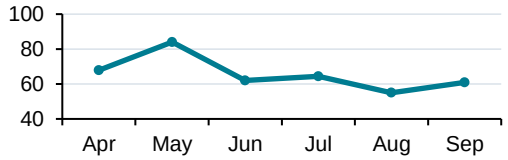
Permanent staff



Bank / temporary staff



Agency staff



Current month	Pay actual £m	Pay v Plan £m	Actual WTE	WTE vPlan
Substantive	81.2	(2.3)	14,812	307 above
Bank / other temporary	6.0	(1.8)	852	159 above
Agency	1.0	(0.3)	61	6 above
Total	**88.3**	**(4.0)**	**15,725**	**472 above**

Workforce and cost drivers

Workforce remains over plan due to a number of factors including:

- Operational pressures
- Pace of Efficiency delivery
- Recruitment challenges

Efficiency Programme Delivery

DELIVERED TO SEPTEMBER
£31.1m
YTD plan £38.8m

SAVINGS FORECAST
£87.5m
£117.1m annual target

RECURRENT SAVINGS
£61.9m

FORECAST SHORTFALL
(£29.7m)
£117.1m annual target

Trust / programme	Apr–Sep actual	Savings forecast	Forecast vs plan	Recurring forecast
GWH	10.7	25.8	(21.3)	17.0
SFT	11.3	32.5	0.0	23.0
RUH	9.0	29.2	(8.4)	21.9
Group total	**31.1**	**87.5**	**(29.7)**	**61.9**

Delivery and classification

£87.5m full year efficiency forecast.
£29.7m reported efficiency shortfall.
£61.9m recurrent savings projected in year

Capital programme delivery and forecast

£m	Expenditure to September	Underspend to September	Full-year forecast	Forecast against plan
Great Western Hospitals	4.0	**4.5**	20.9	**5.6 over**
Salisbury	6.0	**5.4**	25.9	**On plan**
Royal United Hospitals Bath	8.7	**8.4**	50.9	**0.8 under**
Group total	**18.7**	**18.2**	**97.7**	**4.8 over**

Proposed prioritisation and delivery assurance

£18.2m underspend to September alongside a £4.8m forecast overspend for the year.

Mitigations for overspend in development including rephasing of schemes, deprioritisation and exploring alternative funding options.

Expenditure on nationally funded schemes, including EPR, accelerates in the latter half of the year

BSW Hospitals Group Board

Report from	Financial Sustainability Committee. Item 2.2.2
Report to	Group Board
FSC meeting date	14th October 2026
Board meeting date	5th November 2026
Author	Chair – Paul von der Heydfe
Status	Information / Discussion
Reporting period	To end of September
Linked Strategic Priority(s)	
Linked BAF principal risk(s)	

Purpose of this report.

This report is the Financial Sustainability Committee's assurance report to the Group Board.

1. Executive summary

The meeting's main topic was the challenges with the financial performance of the group for the period up to date, the groups overall cash position and the national concern with the Group's performance.

2. Alert, Advise, Assure

2.1 Alert

There continues to be a very substantial challenge for the group and its three care organisations in delivering its plan and the half year review papers submitted to NHSE SW region indicate they break even will not be delivered even if the planned deficit support funding were to be given.

The Committee received its first substantive update on the turnaround programme which emphasised the magnitude of the challenge and the plans to improve the operational and financial performance. The committee recognises the need for constant encouragement and persistent determination to deliver the improvements required, to reimagine ways of service delivery and proactive engagement with partners.

The committee was encouraged to understand the essential increased grip and control developing and looked forward to the improved reporting of activities and outcomes.

As regards the committee's cash committee role, the immediate challenges were explained and some comfort was provided that cash management was in hand but substantial concerns were raised as to the urgency of the need for solutions to the forecast cash flow challenges

2.2 Advise

The committee received its regular update on performance and forecasts for each care organisation which supported the need for the turnaround efforts and the need for cooperation across the three care organisations.

The committee considered the NHSE submission and challenged the risk of its deliverability.

2.3 Assure

The committee received the appropriate update on capital programmes.

It also considered the key risks presented and urged action for improved controls where possible.

3. Items for Board attention

As set out above, the committee urges the whole Board to proactively engage with the turnaround work.

It also urges each member of the Board to own their own part in the delivery of even better performance than the plan as submitted to NHSE recognising that the expectation from NHSE to do all in our power to move back to delivering our original submissions.

4. Forward look

The committee will continue to monitor closely the performance of the group, the individual care organisations and the turnaround team.

BSW Hospitals Group Board

Agenda item	4.4.1
Report title	CPO Report Sept 2026
Date of meeting	5 November 26
Sponsor	Jude Gray – Group Chief People Officer
Prepared by	Jude Gray – Group Chief People Officer

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title

KEY MESSAGES

RECOMMENDATION

Key messages

The Group Executive Committee is asked to note:

1. The M05 workforce position: workforce is 400 WTE above plan, with a £7.8m adverse monthly pay variance and £28.3m adverse year-to-date variance; workforce CIP delivery has improved to £3.10m in August and £9.6m year to date but remains £6.5m behind plan; temporary staffing reduced month on month and agency cap compliance improved, while sickness remains above trajectory at RUH and SFT. Recovery actions have been incorporated into Group and Care Organisation turnaround plans. Overall assurance: Limited

2. Corporate Service Transformation Programme – Overall assurance: Partial

The programme is progressing and assurance remains dependent on:

validation of sustainable financial benefits rather than reliance on vacancies; completion of governance and service-level arrangements across all corporate functions; sufficient HR and

change capacity to support overlapping consultations safely; recovery of temporary staffing fill rates, particularly for clinical roles at RUH and improvement against the outstanding supplier KPIs. PA Consulting are starting a 6week diagnostic The review will test whether the designs create genuinely integrated Group-wide services, deliver the planned 11% cost reduction, identify further savings, exploit digital opportunities and maximise wider organisational value.

3. People and workforce domain within the NOF Framework – Q12026/27 – Quartile1
4. NHS Staff Standards – feeds into NOF assessment, working group being established to respond to the 6 standards
5. Staff Safety Pioneers - £100k investment – application to take part in this programme has been submitted

APPENDICES

Appendix 1	M05 WOM

Section 1: Executive Summary

1.1 Alert | Advise | Assure

Alert

- **Workforce Recovery** - Limited Assurance: At M05, the Group is 400 WTE above plan, comprising 230 substantive WTE and 170 bank WTE above plan, partly offset by agency staffing 3 WTE below plan.

Pay expenditure is £440.1m year to date against a plan of £411.8m, an adverse variance of £28.3m; the monthly adverse variance is £7.8m.

Workforce CIP delivery improved to £3.10m in August and £9.6m year to date, but remains £6.5m behind plan. Stronger scheme ownership and conversion to recurrent savings are required.

Sickness remains above plan at RUH (5.66% vs 5.34%) and SFT (4.39% vs 3.30%); GWH is marginally below plan (4.28% vs 4.32%).

Job planning and rostering: work remains in progress at SFT, and all three trusts are continuing work to ensure agreed job plans are delivered in practice as well as signed off.

Areas requiring focus: above-cap agency use remains concentrated in Medical and Dental; Nursing, and Midwifery has the highest off-framework usage.

Spend controls: agency cap compliance improved from 50% to 60%. Agency shifts reduced from 1,224 to 1,095; above-cap agency shifts fell by 171 and off-framework shifts by 9.

Temporary staffing: overall temporary staffing reduced by 12 WTE month on month. Agency use fell from 64 WTE to 55 WTE and bank use reduced from 871 WTE to 868 WTE.

- **Corporate Service Transformation Programme – Partial Assurance**

The Corporate Services Transformation programme continues to progress, with consultations and appointments moving forward across the Group's corporate functions. Across the wider programme, the maturity of governance arrangements and service-level agreements remains variable, with some functions still developing their future arrangements.

The programme risk relating to financial savings and benefits realisation has a residual score of 12 and is reported as improving. However, forecasting and benefits tracking remain a challenge. The digital enablement risk remains stable at 15, reflecting the affordability and unresolved scope of the digital investment required to support future corporate service models. A separate workforce risk, scored 12, concerns the HR and change-management capacity needed to support concurrent consultations and organisational change while maintaining business-as-usual services.

Temporary Staffing

GWH maintained the strongest position, with overall fill of 90% in August and 89% in September. SFT reported 80% and 81% respectively in the detailed data tables, supported in part by agency use. RUH remains the principal area of concern, with overall fill declining from 71% to 65%; in September, Nursing and Midwifery fill was 52% and Healthcare Assistant fill was 59%. Targeted supply interventions, clinical bank growth and focused recruitment are therefore required, particularly at RUH and in the identified clinical hotspots.

Supplier performance is mixed. Compliance is reported for safer recruitment, professional-body notifications, safeguarding concerns, booking-response times and complaint handling. However, a number of contractual measures were not achieved, including the 80% overall fill target, provision of a real-time reporting dashboard, price-cap compliance and the 20-working-day time-to-hire standard. The August management-information pack also did not meet the timeliness or quality requirements.

The immediate priorities are to strengthen recruitment to the bank, introduce site- and department-level reporting, undertake focused reviews of high-demand and hotspot areas, and validate the financial opportunities and benefits arising from the new model.

Escalation meeting with the Bank Partners Managing Director has been arranged.

BSW Hospitals Group is commissioning PA Consulting for a six-week, independent review of proposed corporate services designs across the eight functions.

- The review will test whether the designs create genuinely integrated Group-wide services, deliver the planned 11% cost reduction, identify further savings, exploit digital opportunities and maximise wider organisational value.
- Particular emphasis is placed on ensuring savings do not simply transfer workload, cost or risk to clinical, operational or managerial teams.
- Each function will receive an evidence-based "retain, refine or rethink" conclusion, supported by function assessment cards, an opportunities and benefits register, and a prioritised roadmap.
- The work is an assurance and diagnostic exercise—not detailed redesign or implementation—with final findings and recommendations due at the end of Week 6.

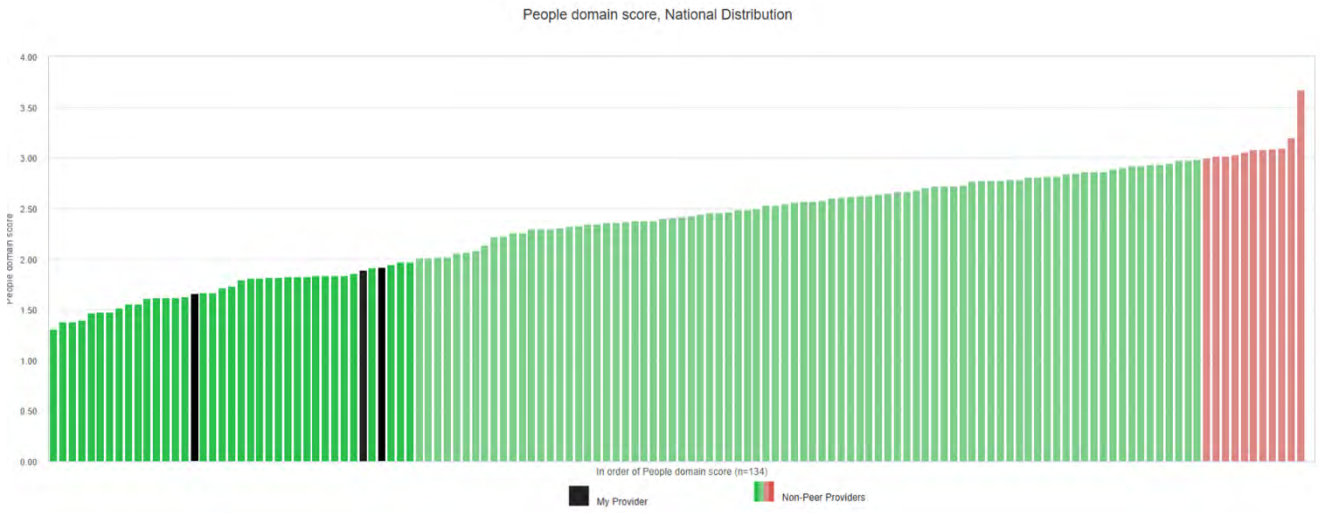
Advise

- **People and workforce domain within the NOF Framework – Q12026/27**

The People and Workforce domain within the NHS Oversight Framework (NOF) is intended to assess whether an organisation has the workforce capacity, capability and culture to deliver

safe, effective and sustainable services. The framework explicitly includes People and Workforce as one of the five scored domains used to determine a provider's overall segment.

Trust	Advise
GWH	Overall People domain quartile 1; sickness below national average; all survey and training metrics above national average; strongest flu uptake; agency below average and on track.
RUH	Overall People domain quartile 1; strongest education and training experience; engagement and flu vaccination above national average; bank expenditure below average and on track.
SFT	Strongest overall People domain score; strongest engagement and Staff Standards results; sickness below national average; education and training experience and flu uptake above national average.



Metric	Period	Performance				NHS OF Score		
		GWH	RUH	SFT	National Avg.	GWH	RUH	SFT
People domain score	**Q1 2026/27**	**1.89**	**1.92**	**1.66**	**-**	**1**	**1**	**1**
Sickness absence rate	Mar-26	4.16%	5.70%	4.30%	5.54%	1.09	2.73	1.12
NHS staff survey engagement theme sub-score score	2025	6.81	6.83	6.87	6.80	2.44	2.38	2.04
National Education and Training Survey overall experience sub-score score	2025	80.84%	83.74%	81.12%	78.16%	1.81	1.33	1.73
NHS staff standards sub-score score	Q3 2025/26	7.61	7.45	7.62	7.52	1.97	2.98	1.90
Percentage of frontline healthcare workers to receive a flu vaccination score	Q1 2025/26	63.70%	63.10%	61.30%	49.35%	1.06	1.09	1.19
Temporary staffing cost relative band score	Bank Q1 2026/27	4	1	2	2	3	1	2
	Agency Q1 2026/27	1	2	2	2			

Quartile 1	Quartile 2	Quartile 3	Quartile 4

- **Staff Standards and how we are responding**

The UK government and NHS England published a mandatory national framework of NHS Staff Standards in July 2026 to hold secondary care employers accountable for workforce treatment and improve staff retention.

The framework establishes minimum employment requirements across six priority areas:

- Line management: Compassionate, fair, and developmental management with regular appraisals.
- Health and wellbeing: Organizational protection for physical and mental safety at work.
- Violence prevention and reduction: Safe environments designed to prevent and reduce abuse.
- Championing sexual safety: Workplaces strictly free from sexual harassment and abuse.
- Tackling racism: Sustained, measurable action against racial discrimination.
- Promoting flexible working: Making flexibility the everyday norm rather than an exception.

Performance is measured via the NHS Oversight Framework and tracked through public league tables.

Site-level survey data and information on existing work programmes have been collected, the next step is to review this information per priority area and be clear on impact of workstreams ensuring we focus on activity that delivers meaningful improvement for colleagues within BSW Hospital's group. The proposed approach therefore combines delivery of agreed improvement plans with assurance on progress and impact, alongside escalation of risks and barriers. To support this programme of work a Staff Standards Group will bring together the six subgroup leads to coordinate delivery of the NHS Staff Standards across BSW Hospitals Group.

It's role will be to develop and oversee a Group-wide delivery plan, monitor performance, challenge variation and share good practice, ensuring that staff voice informs improvement. The Group will align this work with workforce, culture, equality, wellbeing and organisational development priorities, receive escalations from Care Organisation. It will provide information and assurance to each care organisation around progress and component workstreams People and Culture Committee.

Success will be assessed through improved compliance with the standards, positive trends in staff survey results and other measures aligned to each standard, reduced variation between organisations, and better staff experience, engagement and inclusion.

- **Staff Safety Pioneers Bid submitted - £100k**

BSW Hospitals Group has applied to participate in the NHS England Staff Safety Pioneers Programme, a national improvement initiative aimed at strengthening how staff safety is understood, measured and improved across the NHS. The programme takes a broad view of staff safety, encompassing physical safety, psychological safety, wellbeing, inclusion and speaking up culture. Participation will provide access to national learning, development of emerging best practice, and opportunities to contribute to the design of future staff safety approaches, including data standards and improvement methodologies. For BSW, the

programme aligns closely with our ambition to create consistently safe, supportive workplaces and will support further integration of our work across health and safety, wellbeing, Freedom to Speak Up, EDI and organisational development

If successful this work would be overseen by the Staff standards group.

Assure

- BSWHG People Plan Development – People Plan proposal coming to GEC 10 November 2026

1.2 Key achievements and good news

Section 2: Group-wide Workforce

2.1 Group-wide workforce initiatives

	Initiative	Benefits	Demand on resources/update
GWW01	**Staffing/Availability Reviews** **Workforce Modelling registered/unregistered** **Purpose:** To support an analysis of staff use against need, understand the drivers for any variance, identify opportunities to deliver greater resilience and/or efficiency within resource, and to identify opportunities for improvement	Strategic Workforce Planning Potential opportunity to reduce workforce costs missed. **Benefits:** the reviews will improve the alignment of workforce to need, deliver improved resilience within resource, and identify clear evidence-based actions for improvement	SFT reviewing Simon Fuller Report and Recommendations. GWH & RUH initiating the work.
GWW02	**Fairer Deal For Nurses** **Nursing Profiles – Starting with B5 Registered Nursing**	Taking our People with us	Working group in place, and initial benchmarking provided to regional and national teams,
GWW04	**Group Staff Survey Working Group**	Taking our People with Us	Launches 21 Sept 26 and Ends 27 Nov 26 w/c 5 oct 26: RUH 1647 completed; 25.6%; GWH 1488 completed; 26.49% and SFT 1165 completed; 25.0%
GWW06	**Corporate Services Employer Model**	Becoming an effective Group, enabling shared corporate services	First workshop held 4 Aug Paper coming to GEC.

Section 4: Risk Escalation

Four risks arising from CST, scoring 12 or above are contained in the CST presentation

Risk Register

Risk Ref	Date Opened	Risk Title	Risk Type	Risk Statement (one sentence)	Causes (facts, one per line, numbered)	Consequences (one per line, numbered)	Controls in Place (numbered, mapped to causes)	Evidence of Control Effectiveness	Residual Score (L+I+C)	Direction of Travel	Status this Period	Control Gaps	Actions (numbered, with dates)	Action Owner	Action Due Date	Action RAG	Risk Owner	Date Last Reviewed	Next Review Due
		Workforce Plan Delivery	Workforce	At M05 400 WTE above plan, with a £7.8m adverse monthly pay variance and £28.3m adverse year-to-date variance Temporary staffing remains above trajectory, with bank utilisation above plan and continuing risks to workforce cost control and delivery of workforce-related savings.			Turnaround Measures in place		**12**	Worsening	Score increased			Ian Crowley			Ian Crowley	09/10/2026	Turnaround Governance

BSW HOSPITALS GROUP

NHS

Workforce Oversight

BSW Hospitals Group

M05 2026/27

NHS Great Western Hospitals NHS Foundation Trust

NHS Royal United Hospitals Bath NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

CIP Planning by Category

	Operational productivity	Bed rationalisation	Workforce efficiencies	Service transformation	Transactional savings
GWH Target £47.2M	**£5.4m** Elective Productivity and outpatient productivity.	**£2.0m** Drivers are NCTR reduction and demand management.	**£6.8m** Agency and bank reduction within NHSE limits.	**£11.6m** Clinical Services and corporate redesign.	**£21.2m** Procurement, specialty productivity challenge, commercial opportunities.
RUH Target £37.6M	**£6.0m** Theatre, endoscopy, cath lab and outpatient productivity to upper decile.	**£2.6m** Drivers are NCTR reduction and demand management.	**£2.9m** Agency and bank reduction within NHSE limits.	**£2.5m** Clinical Services and corporate redesign.	**£23.5m** Procurement, specialty productivity challenge, commercial opportunities.
SFT Target £32.5M	**£3.1m** Theatre, endoscopy, cath lab and outpatient productivity to upper decile.	**£1.6m** NCTR to 40, LoS down 0.5d, second ward closure Aug–Nov.	**£5.4m** Agency and bank reduction within NHSE limits.	**£9.6m** Clinical and corporate redesign. CDC endoscopy, group plastics/OMFS, dermatology.	**£12.8m** Procurement, specialty productivity challenge, commercial opportunities.
		Total £6.2M	Total £15.1M	Total £23.7M	

CIP Workforce Plan

Pay Efficiency Schemes

			M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27	*Full year effect*
Group Total	Total	Plan £	2,530,333	2,832,333	2,508,333	4,058,111	4,253,111	4,174,111	4,016,667	4,741,667	4,346,667	4,526,667	4,674,667	4,754,667	*47,417,334*
		Actual £	**1,240,230**	**1,366,560**	**1,615,570**	**2,230,110**	**3,180,750**								*9,633,220*
		Variance £	-1,290,103	-1,465,773	-892,763	-1,828,001	-1,072,361								*-6,549,003*

CIP delivery strengthened further in August, with savings increasing to £3.10m compared with £2.23m in July, representing the strongest month of delivery achieved year to date. Although delivery remains behind plan, the sustained improvement in the monthly run rate provides increased confidence that savings momentum is building across the Group.

Year to date, £9.6m of savings have been delivered. The cumulative position remains adverse to plan (-£6.5m YTD), and work continues to strengthen scheme assurance, ownership and delivery planning, with a particular focus on converting identified opportunities into sustainable recurrent savings and improving performance over the remainder of the financial year.

Data Source: Care Organisation CIP Efficiency Trackers

WTE Performance Against Plan (Group)

Progress against plan

			M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27	Current vs Mar-26
Group Total	Substantive	Plan WTE	14,571	14,559	14,586	14,510	14,499	14,505	14,561	14,554	14,550	14,468	14,451	14,431	-21
		Actual WTE	**14,615**	**14,624**	**14,644**	**14,648**	**14,729**								
	Bank	Plan WTE	728	732	720	702	698	693	686	675	674	670	667	647	1
		Actual WTE	**834**	**810**	**835**	**871**	**868**								
	Agency	Plan WTE	68	66	65	57	56	55	51	48	47	40	36	29	36
		Actual WTE	**68**	**84**	**62**	**64**	**55**								
	Total	Plan WTE	15,367	15,357	15,370	15,269	15,253	15,253	15,298	15,277	15,271	15,178	15,154	15,107	16
		Actual WTE	**15,517**	**15,519**	**15,540**	**15,584**	**15,653**								
		Variance WTE	150	162	170	314	400								
		Plan £	83,445,300	83,256,300	83,211,300	80,965,500	80,921,500	80,890,500	81,015,600	81,060,600	81,062,600	79,553,600	79,347,600	79,082,600	
		Actual £	**86,595,807**	**87,700,373**	**88,907,828**	**88,106,198**	**88,766,085**								
		Variance £	3,150,507	4,444,073	5,696,528	7,140,698	7,844,585								

At M05, the Group is 400 WTE above plan, resulting in an adverse pay variance of £7.8m for the month. The position continues to be driven primarily by substantive staffing levels, at 230 WTE above plan, and bank utilisation, at 170 WTE above plan. This is partially offset by agency usage remaining 3 WTE below plan.

There was a positive movement in temporary staffing during August, with agency utilisation reducing from 64 WTE to 55 WTE and bank utilisation reducing slightly from 871 WTE to 868 WTE. Overall temporary staffing reduced by 12 WTE month-on-month, while substantive staffing increased by 81 WTE. Total workforce therefore increased by 69 WTE, indicating that workforce growth during August was driven by substantive staffing rather than temporary staffing

Year to date, pay expenditure is £440.1m against planned expenditure of £411.8m, resulting in a cumulative adverse variance of £28.3m. The underlying drivers remain consistent with previous months, including sustained operational pressures, workforce requirements associated with critical incident arrangements, and continued reliance on bank staffing in key services. Workforce controls remain in place, supported by establishment reviews, vacancy management processes and CIP delivery programmes, with continued focus on reducing temporary staffing reliance and improving alignment to planned workforce trajectories.

Data Source: Care Organisation PWR and PFR

SFT Performance

Salisbury NHS Foundation Trust 2026/27 Workforce Plan

			M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27	Mar-27 vs Apr-26
SFT Total	Substantive	Plan WTE	4194	4187	4185	4112	4110	4111	4194	4202	4204	4127	4115	4098	-96
		Actual WTE	**4,160**	**4,182**	**4,176**	**4,176**	**4,194**								
	Bank	Plan WTE	198	207	207	191	189	189	189	186	186	185	185	185	-14
		Actual WTE	**238**	**211**	**240**	**226**	**260**								
	Agency	Plan WTE	36	36	35	28	28	27	23	22	21	14	10	5	-31
		Actual WTE	**38**	**38**	**28**	**30**	**26**								
	Total	Plan WTE	4,428	4,429	4,427	4,332	4,327	4,326	4,406	4,410	4,411	4,326	4,309	4,287	-141
		Actual WTE	**4,436**	**4,431**	**4,444**	**4,432**	**4,480**								
		Variance WTE	8	2	17	101	153								
		Plan £	23,280,000	23,239,000	23,184,000	22,603,000	22,547,000	22,525,000	22,999,000	22,970,000	22,919,000	22,360,000	22,167,000	21,900,000	-1,380,000
		Actual £	**23,258,000**	**23,445,000**	**23,936,000**	**23,441,000**	**23,998,000**								
		Variance £	-22,000	206,000	752,000	838,000	1,451,000								

SFT Pay Efficiency Schemes

				M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27	FYE
Efficiency Programme Area	Project	Total	Plan £	433,000	735,000	794,000	880,000	925,000	843,000	925,000	920,000	945,000	1,031,000	1,120,000	1,183,000	*10,734,000*
			Actual £	**539,000**	**686,000**	**575,000**	**722,000**	**895,000**								*3,417,000*
			Variance £	106,000	-49,000	-219,000	-158,000	-30,000								*-350,000*

GWH Performance

Great Western Hospitals NHS Foundation Trust 2026/27 Workforce Plan

			M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27	Mar-27 vs Apr-26
GWH Total	Substantive	Plan WTE	4,905	4,896	4,920	4,910	4,900	4,890	4,883	4,873	4,864	4,854	4,844	4,834	-71
		Actual WTE	**4,964**	**4,966**	**4,985**	**4,999**	**5,036**								
	Bank	Plan WTE	285	280	268	266	264	259	259	251	250	247	245	225	-60
		Actual WTE	**309**	**298**	**306**	**335**	**319**								
	Agency	Plan WTE	24	24	23	23	22	22	22	21	21	21	21	19	-5
		Actual WTE	**16**	**24**	**23**	**20**	**17**								
	Total	Plan WTE	5,215	5,199	5,210	5,199	5,187	5,172	5,164	5,146	5,135	5,122	5,110	5,078	-137
		Actual WTE	**5,289**	**5,288**	**5,314**	**5,355**	**5,372**								
		Variance WTE	75	89	104	156	185								
		Plan £	26,892,300	26,892,300	26,892,300	26,102,500	26,102,500	26,099,500	25,743,600	25,802,600	25,864,600	25,864,600	25,864,600	25,864,600	-1,027,700
		Actual £	**28,933,000**	**29,291,000**	**29,798,048**	**29,682,752**	**29,892,200**								
		Variance £	2,040,700	2,398,700	2,905,748	3,580,252	3,789,700								

GWH Pay Efficiency Schemes

				M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27	FYE
Efficiency Programme Area	Project	Total	Plan £	1,145,667	1,145,667	1,145,667	1,909,445	1,909,445	1,909,445	2,291,333	2,291,333	2,291,333	2,291,333	2,291,333	2,291,333	*22,913,334*
			Actual £	**346,000**	**469,000**	**652,000**	**1,033,000**	**1,980,000**								*4,480,000*
			Variance £	-799,667	-676,667	-493,667	-876,445	70,555								*-2,775,890*

RUH Performance

Royal United Hospitals Bath NHS Foundation Trust 2026/27 Workforce Plan

			M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27	Mar-27 vs Apr-26
RUH Total	Substantive	Plan WTE	5,472	5,476	5,481	5,488	5,488	5,504	5,484	5,479	5,482	5,487	5,492	5,499	27
		Actual WTE	**5,491**	**5,476**	**5,482**	**5,473**	**5,500**								
	Bank	Plan WTE	245	245	245	245	245	245	238	238	238	238	237	237	-8
		Actual WTE	**287**	**302**	**288**	**310**	**290**								
	Agency	Plan WTE	7	7	7	6	6	6	6	5	5	5	5	5	-2
		Actual WTE	**13**	**21**	**12**	**14**	**11**								
	Total	Plan WTE	5,724	5,728	5,733	5,739	5,739	5,755	5,728	5,722	5,725	5,730	5,734	5,741	17
		Actual WTE	**5,791**	**5,799**	**5,783**	**5,797**	**5,800**								
		Variance WTE	67	71	50	58	61								
		Plan £	33,273,000	33,125,000	33,135,000	32,260,000	32,272,000	32,266,000	32,273,000	32,288,000	32,279,000	31,329,000	31,316,000	31,318,000	-1,955,000
		Actual £	**34,404,807**	**34,964,373**	**35,173,780**	**34,982,446**	**34,875,885**								
		Variance £	1,131,807	1,839,373	2,038,780	2,722,446	2,603,885								

RUH Pay Efficiency Schemes

				M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27	FYE
Efficiency Programme Area	Project	Total	Plan £	951,667	951,667	568,667	1,268,667	1,418,667	1,421,667	800,333	1,530,333	1,110,333	1,204,333	1,263,333	1,280,333	*13,770,000*
			Actual £	**355,230**	**211,560**	**388,570**	**475,110**	**305,750**								*1,736,220*
			Variance £	-596,437	-740,107	-180,097	-793,557	-1,112,917								*-3,423,113*

WTE Performance Against Actuals

Trust	Staff Type	Mar-26 Baseline	Aug-26 Actual	WTE Change M5 vs Mar-26
GWH	Substantive	5,042	5,036	-7
RUH	Substantive	5,484	5,500	16
SFT	Substantive	4,182	4,194	12
Group	**Substantive**	**14,708**	**14,729**	**21**
GWH	Bank	355	319	-35
RUH	Bank	271	290	19
SFT	Bank	245	260	15
Group	**Bank**	**870**	**868**	**-1**
GWH	Agency	25	17	-8
RUH	Agency	19	11	-8
SFT	Agency	47	26	-20
Group	**Agency**	**91**	**55**	**-36**
GWH	Total	5,422	5,372	-50
RUH	Total	5,773	5,800	27
SFT	Total	4,473	4,480	7
Group	**Total**	**15,669**	**15,653**	**-16**

Trust	Staff Type	Staff Group	Mar-26 Baseline	Aug-26 Actual	WTE Change M5 vs Mar-26
Group	Total	Clinical Non-Medical	10,410	10,444	34
Group	Total	Clinical Medical	2,260	2,334	74
Group	Total	Non-Clinical	2,999	2,875	-124
Group	Total	Registered Nursing, Midwifery and Health Visiting Staff	4,934	4,888	-46
Group	Total	Registered/ Qualified Scientific, Therapeutic and Technical staff	1,750	1,769	19
Group	Total	Support to Clinical Staff	3,705	3,769	64
Group	Total	Total NHS Infrastructure support	2,999	2,875	-124
Group	Total	Medical and Dental	2,260	2,334	74
Group	Total	Any other Staff	20	17	-3

Since the March 2026 baseline, Group workforce numbers have reduced by 16 WTE. This reflects a reduction of 36 WTE in agency staffing and 1 WTE in bank staffing, partially offset by a 21 WTE increase in substantive staffing.

The clinical workforce has increased overall, with Clinical Medical staffing rising by 74 WTE and Clinical Non-Medical staffing increasing by 34 WTE. Within the clinical workforce, reductions in Registered Nursing, Midwifery and Health Visiting staff of 46 WTE have been offset by increases in Medical and Dental staffing of 74 WTE and Support to Clinical Staff of 64 WTE. Registered/Qualified Scientific, Therapeutic and Technical staffing also increased by 19 WTE.

The most significant reduction has been within NHS Infrastructure Support, which decreased by 124 WTE. At Trust level, GWH reduced by 50 WTE, while RUH and SFT increased by 27 WTE and 7 WTE respectively. Workforce controls remain in place across the Group, with continued focus on reducing temporary staffing reliance and aligning workforce growth to areas of greatest clinical need.

Data Source: Care Organisation PWR

Compliance with Spend Cap and Frameworks

			Bank		Agency			
Trust	Staff Group	Total shifts requested	Filled by bank	Bank shifts over £100	Filled by agency	On framework above cap	Off-framework	% of shifts at cap
GWH	Total	7,337	5,794	249	261	21	10	88%
RUH	Total	9,185	5,989	70	336	122	56	47%
SFT	Total	8,640	5,480	180	498	185	43	54%
Group	Administration & Estates	5,013	4,586	0	20	17	0	15%
	Healthcare Assistants & Other Support	6,610	4,747	0	0	0	0	-
	Healthcare Science	439	357	0	42	0	0	100%
	Medical & Dental	4,622	2,310	499	435	257	20	36%
	Nursing, Midwifery & Health Visiting	7,610	4,663	0	461	24	89	75%
	Scientific, Therapeutic & Technical	868	600	0	137	30	0	78%
	Total	25,162	17,263	499	1,095	328	109	60%
Previous month		25,457	18,340	578	1,224	499	118	50%
Variance to previous month		-295	-1077	-79	-129	-171	-9	10%

Compliance with agency spend controls improved during the month, with 60% of agency shifts filled at or below the agency cap, compared with 50% in the previous month. Agency utilisation also reduced by 129 shifts, from 1,224 to 1,095, while above-cap agency shifts reduced by 171 and off-framework shifts reduced by 9.

Bank staffing continued to meet the majority of temporary workforce demand, filling 17,263 shifts during the month, compared with 1,095 agency shifts. Bank-filled shifts reduced by 1,077 month-on-month, while bank shifts paid above £100 reduced by 79 to 499. Above-cap agency usage remained concentrated in Medical and Dental, with 257 shifts, although Nursing, Midwifery and Health Visiting recorded the highest off-framework usage at 89 shifts.

The overall number of shifts requested reduced by 295 to 25,162. Continued focus on substantive recruitment, improved bank fill and targeted specialty workforce plans will be required to sustain the improvement in agency cap compliance, further reduce above-cap and off-framework usage, and limit reliance on premium-rate bank shifts.

Job Planning and Rostering

Job Planning

Trust	Metric	Consultants	SAS Doctors
GWH	Headcount	277	113
	# with a signed off job plan	240	99
	% signed off	**86.6%**	**87.6%**
RUH	Headcount	321	62
	# with a signed off job plan	311	60
	% signed off	**96.9%**	**96.8%**
SFT	Headcount	252	52
	# with a signed off job plan	181	26
	% signed off	**71.8%**	**50.0%**
Group	Headcount	850	227
	# with a signed off job plan	732	185
	% signed off	**86.1%**	**81.5%**

Job planning remains work in progress at SFT, this work is being led by the Deputy Chief Medical Officer and Divisional Medical Directors.

Across all trusts work is ongoing to ensure that job plans are not only signed off, but are also being delivered in accordance with the plan.

Levels of Attainment

Trust	Staff Group	e-Rostering LoA		Job Planning LoA	
		2025/26 (indicative)	2024/25	2025/26 (indicative)	2024/25
GWH	Additional Clinical Services	3	2	0	0
	Additional Professional Scientific and Technical	3	2	0	0
	Allied Health Professionals	3	2	0	0
	Healthcare Scientists	2	2	0	0
	Medical & Dental	2	2	2	1
	Nursing and Midwifery	3	2	0	0
RUH	Additional Clinical Services	3	3	0	0
	Additional Professional Scientific and Technical	3	3	0	0
	Allied Health Professionals	3	3	0	0
	Healthcare Scientists	3	3	0	0
	Medical & Dental	1	0	1	0
	Nursing and Midwifery	4	4	0	0
SFT	Additional Clinical Services	1	1	0	0
	Additional Professional Scientific and Technical	1	0	0	0
	Allied Health Professionals	1	0	0	0
	Healthcare Scientists	1	0	0	0
	Medical & Dental	1	0	1	0
	Nursing and Midwifery	1	1	0	0
Group Average	Additional Clinical Services	2	2	0	0
	Additional Professional Scientific and Technical	2	2	0	0
	Allied Health Professionals	2	2	0	0
	Healthcare Scientists	2	2	0	0
	Medical & Dental	1	1	1	0
	Nursing and Midwifery	3	2	0	0

Sickness Absence

12-month sickness KPI

Trust	M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27
GWH Plan	4.41%	4.39%	4.36%	4.34%	4.32%	4.30%	4.28%	4.26%	4.24%	4.22%	4.20%	4.17%
GWH Actual	4.25%	4.28%	4.25%	4.23%	4.28%							
RUH Plan	5.37%	5.40%	5.41%	5.38%	5.34%	5.26%	5.15%	5.08%	5.02%	4.98%	4.93%	4.90%
RUH Actual	5.55%	5.60%	5.65%	5.67%	5.66%							
SFT Plan	3.40%	3.40%	3.30%	3.30%	3.30%	3.30%	3.30%	3.30%	3.30%	3.20%	3.20%	3.30%
SFT Actual	4.13%	4.18%	4.24%	4.33%	4.39%							

Sickness absence performance remains variable across the Group. At M05, GWH remains below plan at 4.28% against 4.32%, although this represents a 0.05 percentage-point increase from July. RUH remains above plan at 5.66% against 5.34%, broadly unchanged from July, while SFT has increased by 0.06 percentage points to 4.39% and remains significantly above the stretching 3.30% plan.

The continued elevation in absence is contributing to workforce pressure across the Group, particularly where high sickness coincides with vacancies and operational escalation requirements. At RUH, front-door services have been identified as areas where high sickness and vacancies are driving temporary staffing demand, reinforcing the need for targeted attendance management and local workforce interventions.

Appendix – CIP scheme delivery

SFT Pay Efficiency Schemes

				M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26
Efficiency Programme Area	Project	Total	Plan £	433,000	735,000	794,000	880,000	925,000
			Actual £	**539,000**	**686,000**	**575,000**	**722,000**	**895,000**
			Variance £	106,000	-49,000	-219,000	-158,000	-30,000
Agency - reduce agency as % of total pay bill	*Agency reduction*	Total	Plan £	74,000	210,000	239,000	190,000	215,000
			Actual £	**144,000**	**129,000**	**121,000**	**119,000**	**283,000**
			Variance £	70,000	-81,000	-118,000	-71,000	68,000
Clinical Service re-design - Elective	*Bed rationalisation*	Total	Plan £	0	30,000	30,000	30,000	30,000
			Actual £	**16,000**	**11,000**	**19,000**	**26,000**	**20,000**
			Variance £	16,000	-19,000	-11,000	-4,000	-10,000
Clinical Service re-design - Outpatient	*Clinical services redesign*	Total	Plan £	0	0	0	0	0
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	0	0	0	0	0
Clinical Service re-design - UEC	*Bed rationalisation*	Total	Plan £	2,000	50,000	75,000	80,000	100,000
			Actual £	**122,000**	**176,000**	**113,000**	**178,000**	**58,000**
			Variance £	120,000	126,000	38,000	98,000	-42,000
Corporate services transformation	*Corporate services redesign*	Total	Plan £	138,000	138,000	138,000	138,000	138,000
			Actual £	**135,000**	**141,000**	**131,000**	**202,000**	**401,000**
			Variance £	-3,000	3,000	-7,000	64,000	263,000
Corporate services transformation	*Temporary staffing model*	Total	Plan £	0	0	0	83,000	83,000
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	0	0	0	-83,000	-83,000
E-Rostering / E-Job Planning	*Bank reduction*	Total	Plan £	116,000	198,000	203,000	250,000	250,000
			Actual £	**31,000**	**62,000**	**47,000**	**99,000**	**24,000**
			Variance £	-85,000	-136,000	-156,000	-151,000	-226,000
Establishment reviews	*Specialty challenges*	Total	Plan £	103,000	109,000	109,000	109,000	109,000
			Actual £	**91,000**	**167,000**	**144,000**	**98,000**	**109,000**
			Variance £	-12,000	58,000	35,000	-11,000	0

GWH Pay Efficiency Schemes

				M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26
Efficiency Programme Area	Project	Total	Plan £	1,145,667	1,145,667	1,145,667	1,909,445	1,909,445
			Actual £	**346,000**	**469,000**	**652,000**	**1,033,000**	**1,980,000**
			Variance £	-799,667	-676,667	-493,667	-876,445	70,555
Agency - eliminate off framework supply	*Workforce Optimisation*	Total	Plan £	62,500	62,500	62,500	104,167	104,167
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	-62,500	-62,500	-62,500	-104,167	-104,167
Agency - reduce agency as % of total pay bill	*Agency reduction*	Total	Plan £	15,000	15,000	15,000	25,000	25,000
			Actual £	**0**	**0**	**65,000**	**0**	**0**
			Variance £	-15,000	-15,000	50,000	-25,000	-25,000
Clinical Service re-design - Elective	*Clinical Services Re-design*	Total	Plan £	33,333	33,333	33,333	55,556	55,556
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	-33,333	-33,333	-33,333	-55,556	-55,556
Clinical Service re-design - Non-Acute	*Divisional Programmes*	Total	Plan £	12,333	12,333	12,333	20,556	20,556
			Actual £	**0**	**0**	**0**	**433,000**	**1,732,000**
			Variance £	-12,333	-12,333	-12,333	412,444	1,711,444
Clinical Service re-design - Outpatient	*Outpatient Productivity*	Total	Plan £	136,500	136,500	136,500	227,500	227,500
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	-136,500	-136,500	-136,500	-227,500	-227,500
Clinical Service re-design - UEC	*Non-elective LOS reduction*	Total	Plan £	86,000	86,000	86,000	143,333	143,333
			Actual £	**0**	**270,000**	**0**	**0**	**0**
			Variance £	-86,000	184,000	-86,000	-143,333	-143,333
Corporate services transformation	*Corporate Group Efficiencies*	Total	Plan £	140,000	140,000	140,000	233,333	233,333
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	-140,000	-140,000	-140,000	-233,333	-233,333
Establishment reviews	*Divisional Programmes*	Total	Plan £	170,000	170,000	170,000	283,333	283,333
			Actual £	**346,000**	**199,000**	**587,000**	**600,000**	**248,000**
			Variance £	176,000	29,000	417,000	316,667	-35,333
Increase bank activity and address costs	*Bank reduction*	Total	Plan £	60,000	60,000	60,000	100,000	100,000
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	-60,000	-60,000	-60,000	-100,000	-100,000
Unidentified	Unidentified	Total	Plan £	430,000	430,000	430,000	716,667	716,667
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	-430,000	-430,000	-430,000	-716,667	-716,667

RUH Pay Efficiency Schemes

				M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26
Efficiency Programme Area	Project	Total	Plan £	951,667	951,667	568,667	1,268,667	1,418,667
			Actual £	**355,230**	**211,560**	**388,570**	**475,110**	**305,750**
			Variance £	-596,437	-740,107	-180,097	-793,557	-1,112,917
Agency - reduce agency as % of total pay bill	Various	Total	Plan £	20,833	20,833	20,833	20,833	20,833
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	-20,833	-20,833	-20,833	-20,833	-20,833
Corporate services transformation	Various	Total	Plan £	83,333	83,333	83,333	83,333	83,333
			Actual £	**0**	**0**	**0**	**47,690**	**17,030**
			Variance £	-83,333	-83,333	-83,333	-35,643	-66,303
Clinical Service re-design - UEC	Various	Total	Plan £	0	0	0	0	0
			Actual £	**196,990**	**0**	**130,000**	**150,000**	**150,000**
			Variance £	196,990	0	130,000	150,000	150,000
Establishment reviews	Various	Total	Plan £	297,500	297,500	344,500	474,500	474,500
			Actual £	**153,000**	**0**	**0**	**17,850**	**4,460**
			Variance £	-144,500	-297,500	-344,500	-456,650	-470,040
Other	Various	Total	Plan £	0	0	0	0	0
			Actual £	**5,240**	**211,560**	**258,570**	**259,570**	**134,260**
			Variance £	5,240	211,560	258,570	259,570	134,260
Unidentified	Unidentified	Total	Plan £	550,000	550,000	120,000	690,000	840,000
			Actual £	**0**	**0**	**0**	**0**	**0**
			Variance £	-550,000	-550,000	-120,000	-690,000	-840,000

BSW HOSPITALS GROUP

NHS

Corporate Services Transformation Programme Update



October 2026

NHS Great Western Hospitals NHS Foundation Trust

NHS Royal United Hospitals Bath NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

Month 5 Finances

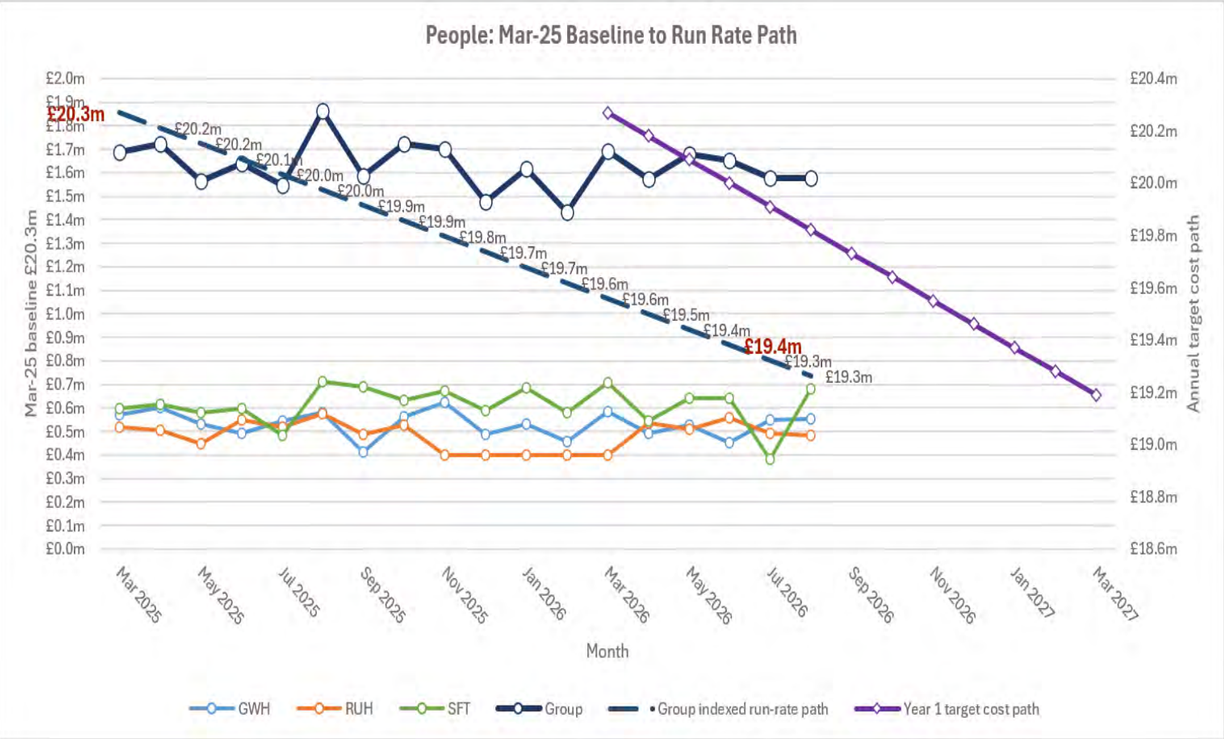
Function	Baseline cost - Mar-25 benchmarking £m	TO-BE cost £m after 11%	11% Target £m	Agreed Target £m	Year 1 Target	Achieved to date - August 2026	Year 1 variance +adverse	Tracker 11% to date - August	Year 2 Target
People	£20.27	£18.11	£2.16	£2.16	£1.08	£1.01	£0.07	**5%**	£1.08
Finance	£9.52	£8.43	£1.09	£0.90	£0.90	£0.10	£0.80	**1%**	£0.00
Procurement	£5.42	£4.86	£0.56	£0.56	£0.28	£0.27	£0.01	**5%**	£0.28
Corp Gov	£1.68	£1.50	£0.18	£0.18	£0.18	£0.28	-£0.10	**16%**	£0.00
Digital	£37.67	£33.53	£4.10	£4.10	£1.50	£2.04	-£0.54	**5%**	£2.60
Communications	£1.37	£1.23	£0.14	£0.14	£0.14	£0.10	£0.04	**7%**	£0.00
TIPS	£5.91	£5.32	£0.59	£0.59	£0.59	£0.61	-£0.02	**14%**	£0.00
Estates	£50.94	£45.34	£5.60	£5.93	£2.97	£2.21	£0.76	**4%**	£2.97
Group leadership	£4.38	£3.90	£0.48	£0.48	£0.48	£0.18	£0.30	**4%**	£0.00
Total	**£137.16**	**£122.22**	**£14.90**	**£15.04**	**£8.12**	**£6.79**	**£1.32**	5%	**£6.93**

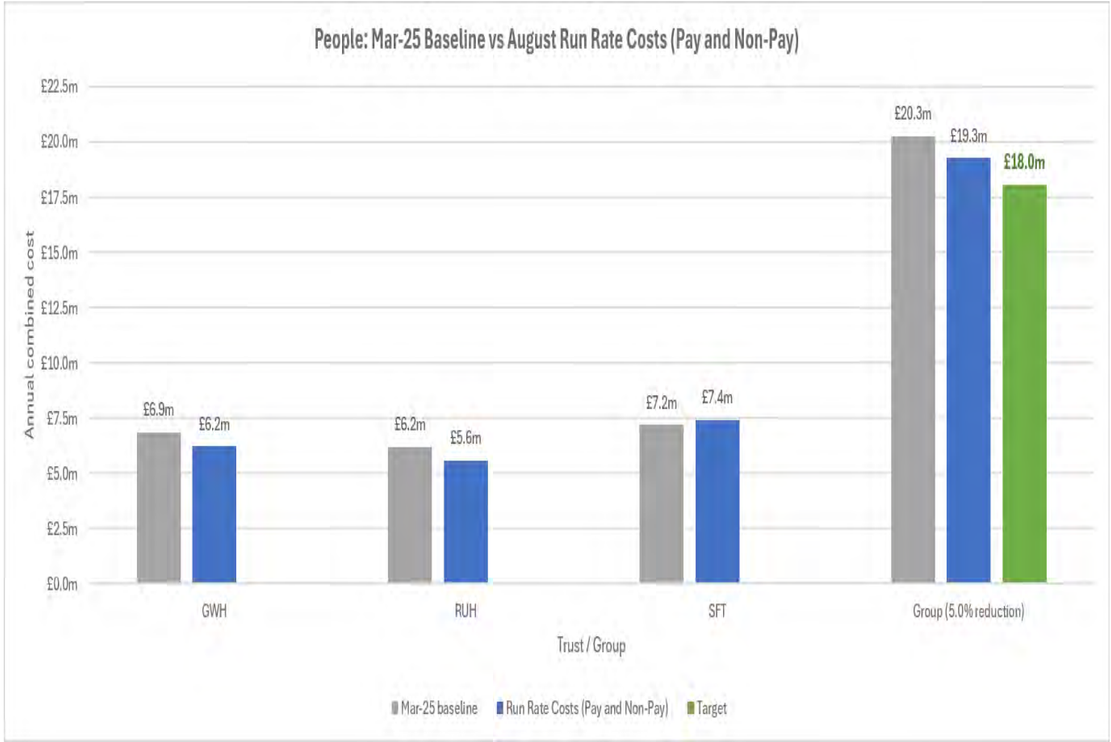
*Achieved to date is predicated on the recurrent vacancies still being met as part of the 11%.
if they are subsequently invested in new designs then the level of saving won't actually be achieved

Finance Update M5 – People

Financial Delivery RAG Rating

SRO – Jude Gray (Chief People Officer)



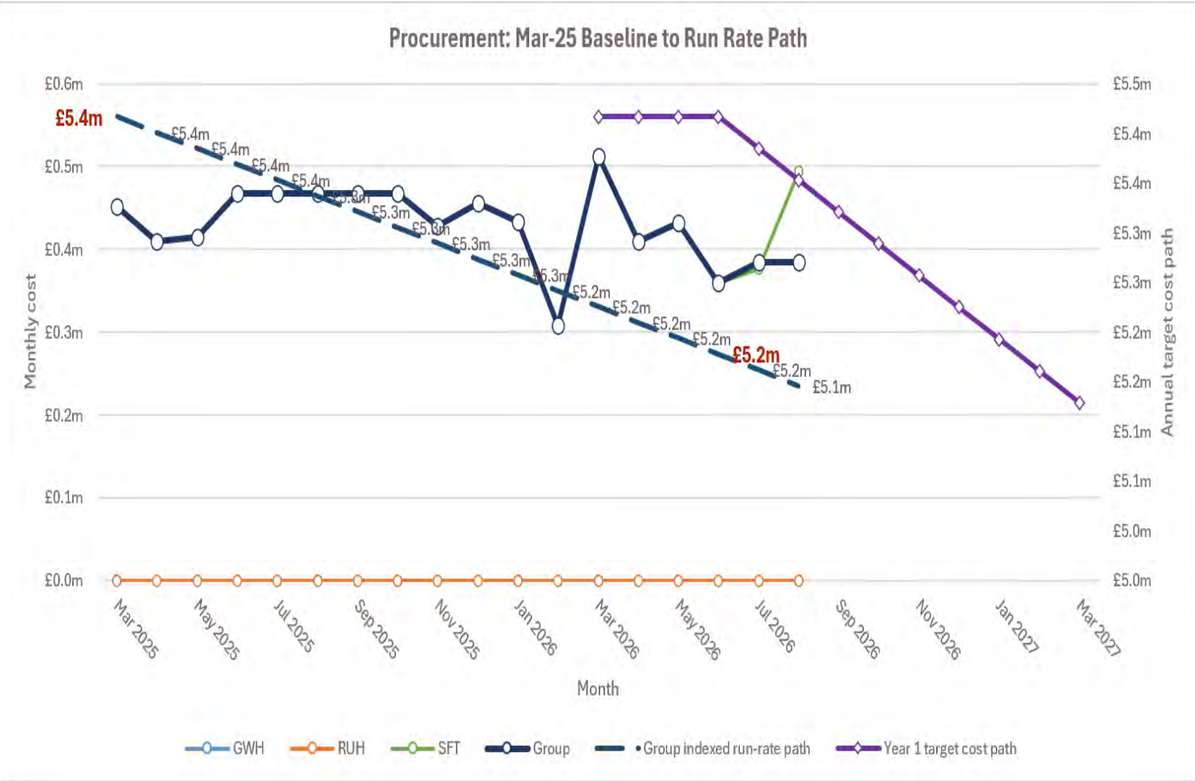


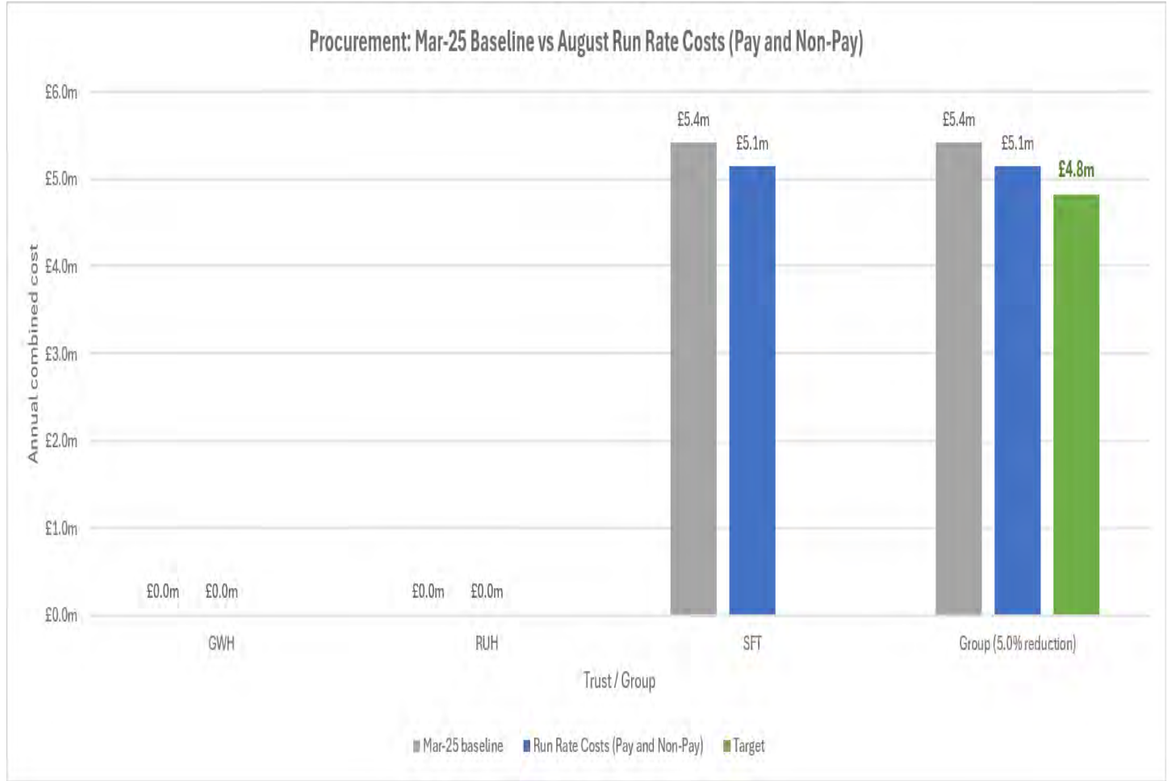
Position summary — The lines show monthly Trust and Group movement against the indexed annual run-rate and Year 1 target path. The latest run rate is £19.3m, 5.0% below the £20.3m baseline but £1.3m above the £18.0m 11% endpoint; SFT remains above baseline while GWH and RUH are lower.

Finance Update M5 – Procurement

Financial Delivery RAG Rating

SRO – Rob Webb – (Director of Procurement)



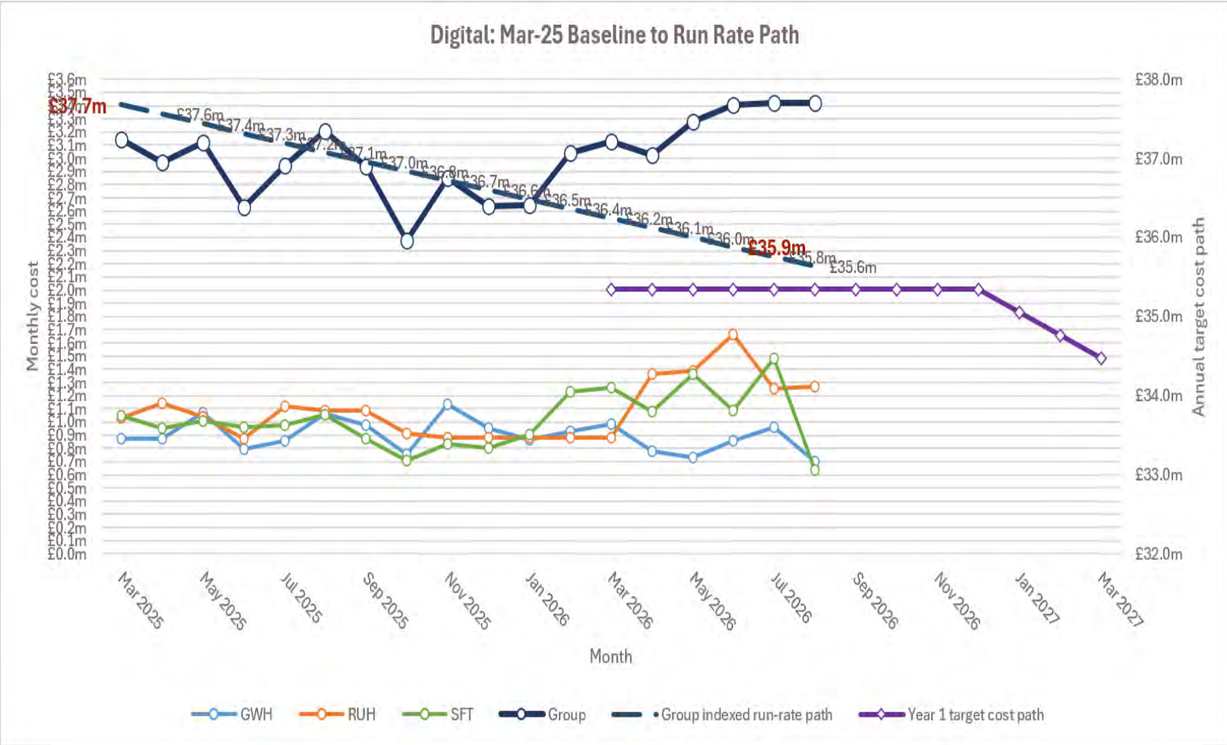


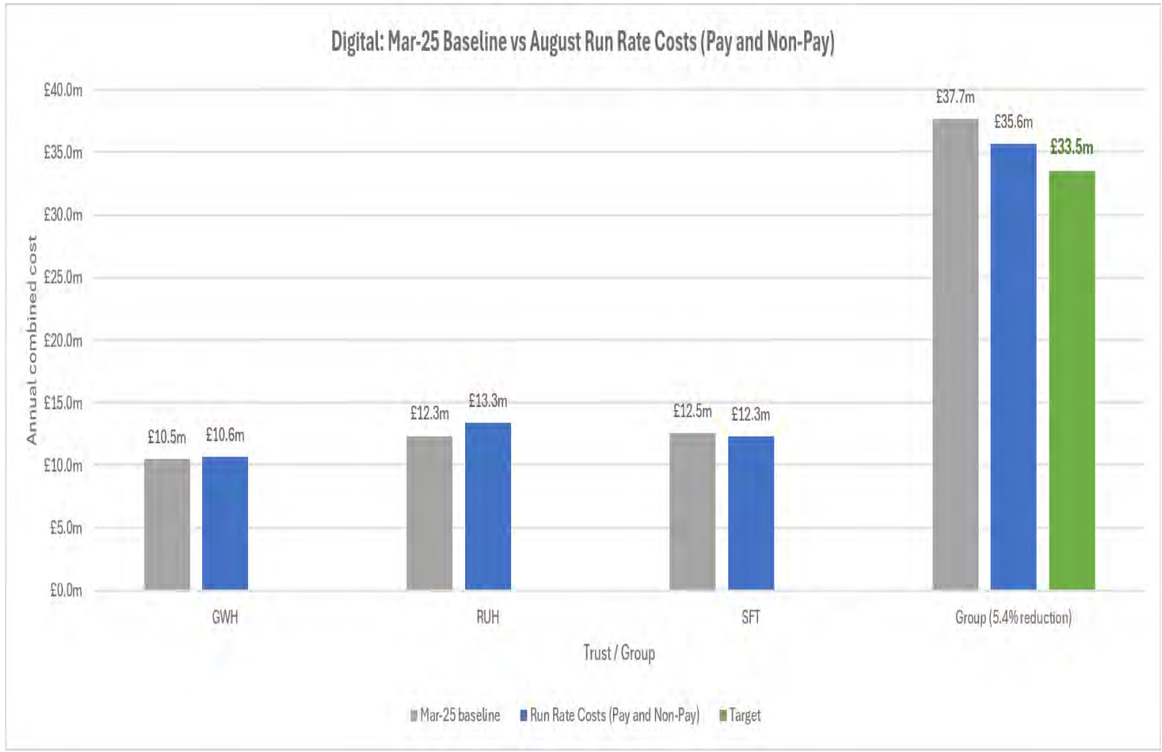
Position summary — The lines show monthly costs and the direction required by the indexed run-rate and Year 1 target paths. Costs are concentrated in SFT; the latest run rate is £5.1m, 5.0% below the £5.4m baseline but still £0.3m above the £4.8m 11% endpoint.

Finance Update M5 – Digital

Financial Delivery RAG Rating

SRO – Jonathan Hinchliffe – (Group Chief Digital and Information Officer)



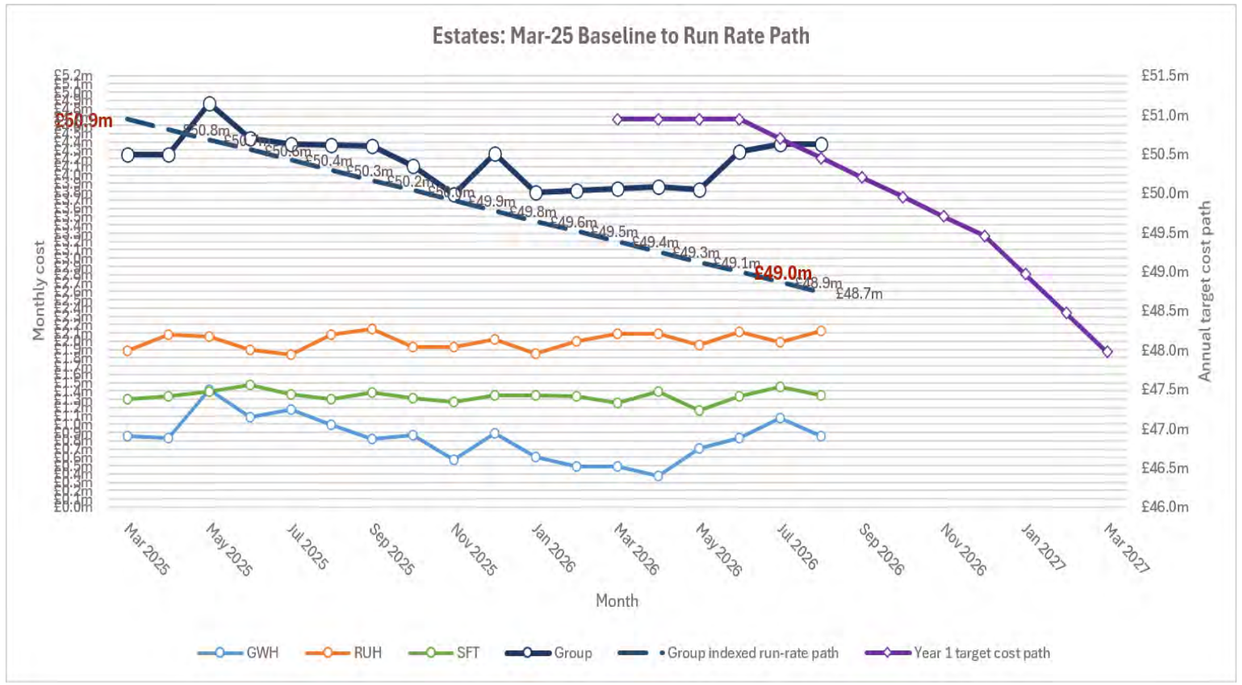


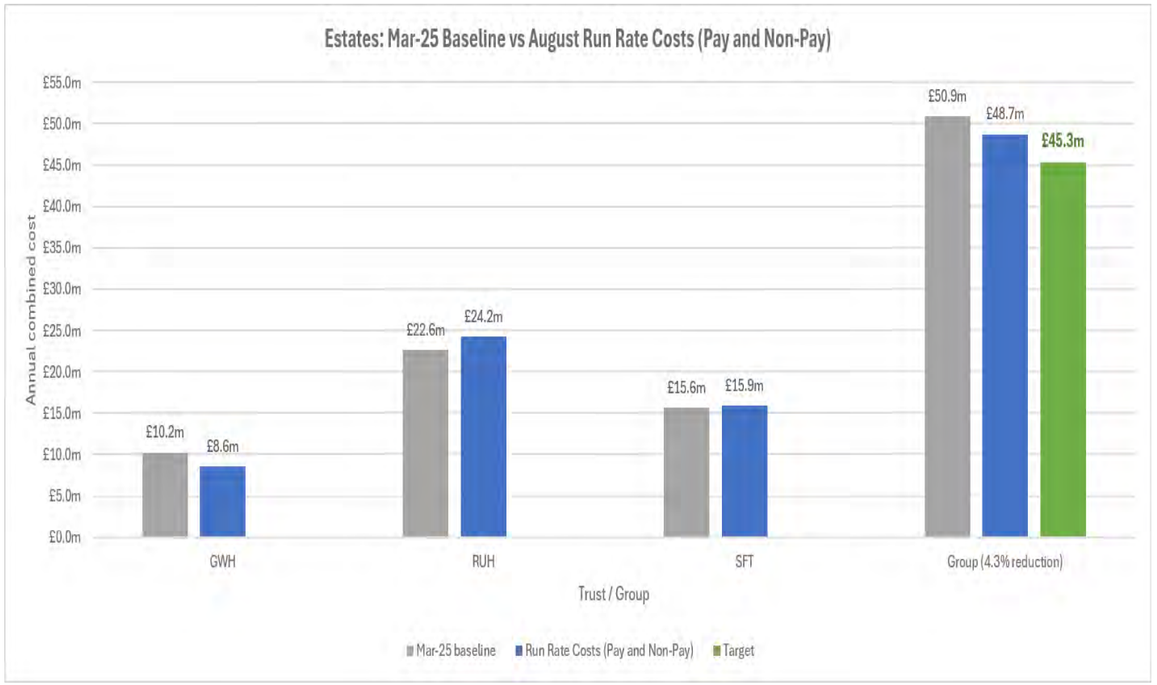
Position summary — The lines show monthly Trust and Group costs against the indexed run-rate and Year 1 target paths. The latest run rate is £35.6m, 5.4% below the £37.7m baseline but £2.1m above the £33.5m 11% endpoint; RUH remains above baseline and is the main pressure.

Finance Update M5 – Capital, Estates and Facilities

RAG Rating

SRO – Simon Wade – (Chief Finance Officer)



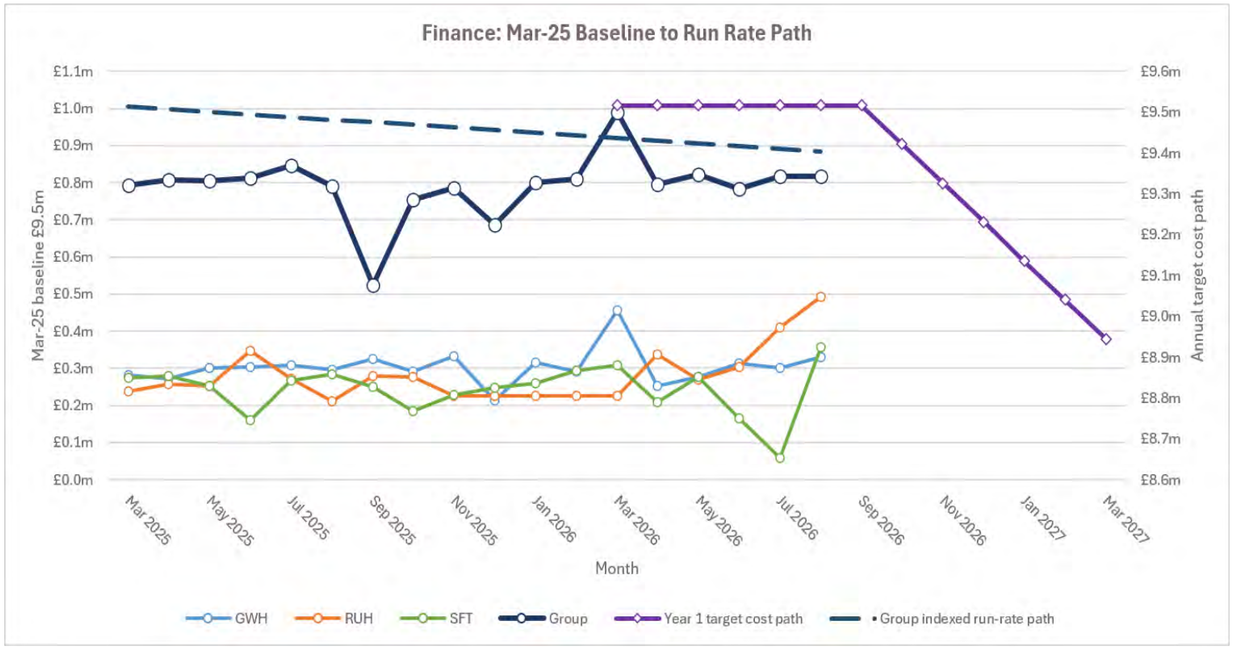


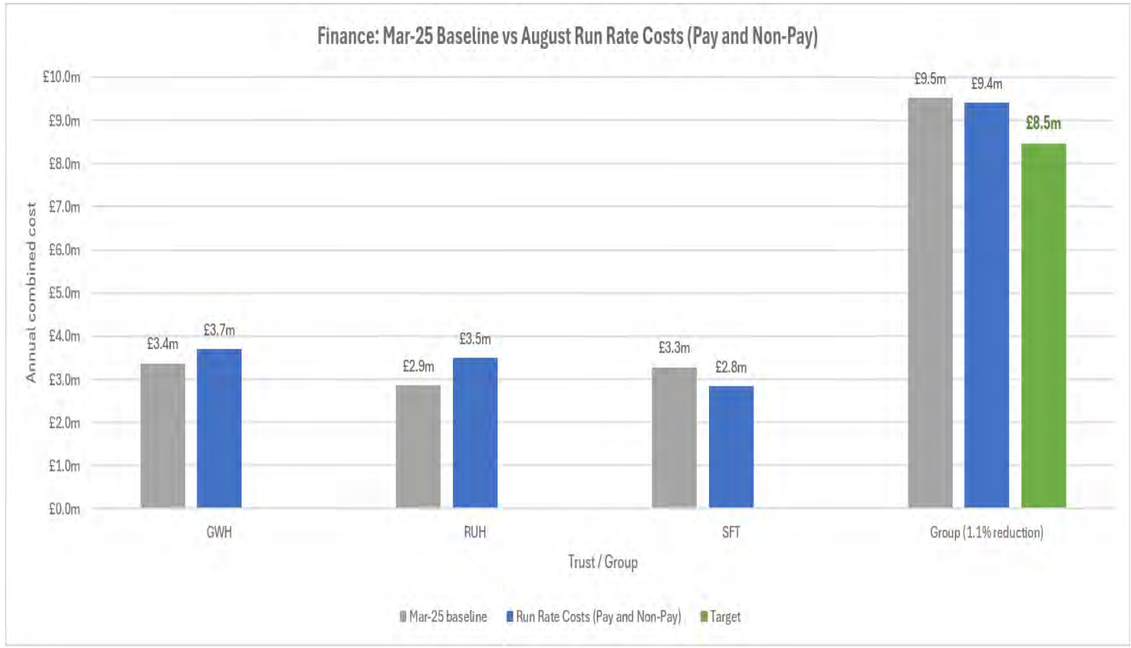
Position summary — The lines show monthly Trust and Group costs against the indexed run-rate and Year 1 target paths. The latest run rate is £48.7m, 4.3% below the £50.9m baseline but £3.4m above the £45.3m 11% endpoint; GWH savings are partly offset by higher RUH and SFT costs.

Finance Update M5 – Finance

Financial Delivery RAG Rating

SRO – Simon Wade – (Chief Finance Officer)



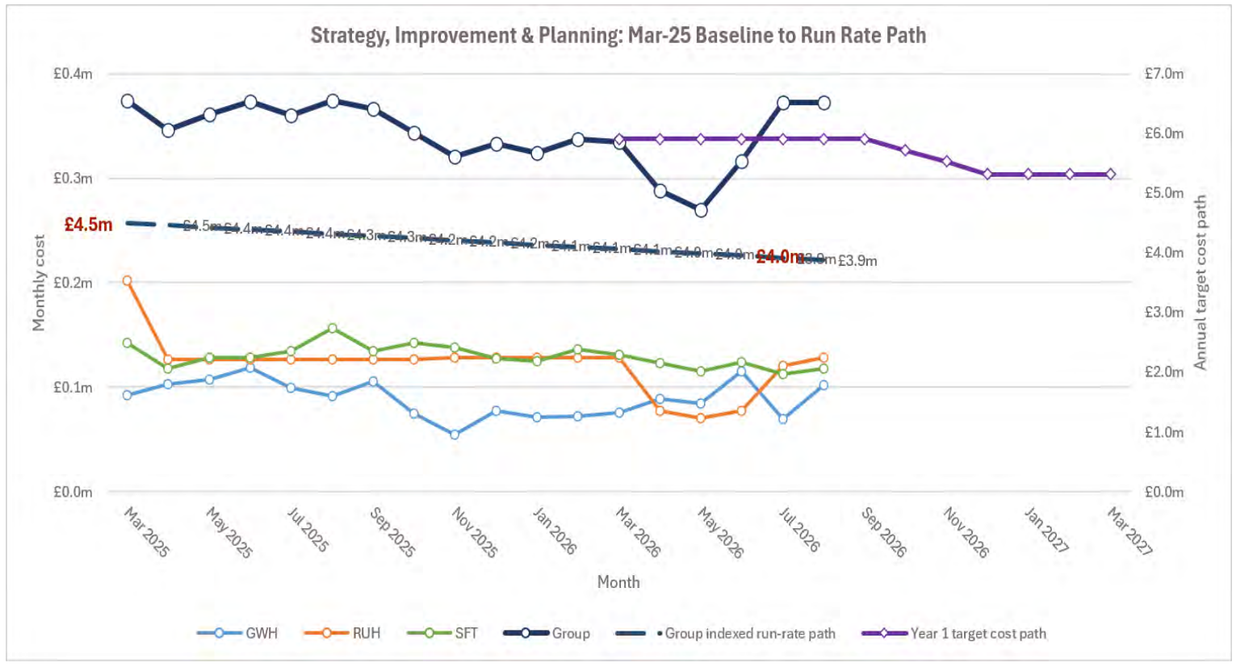


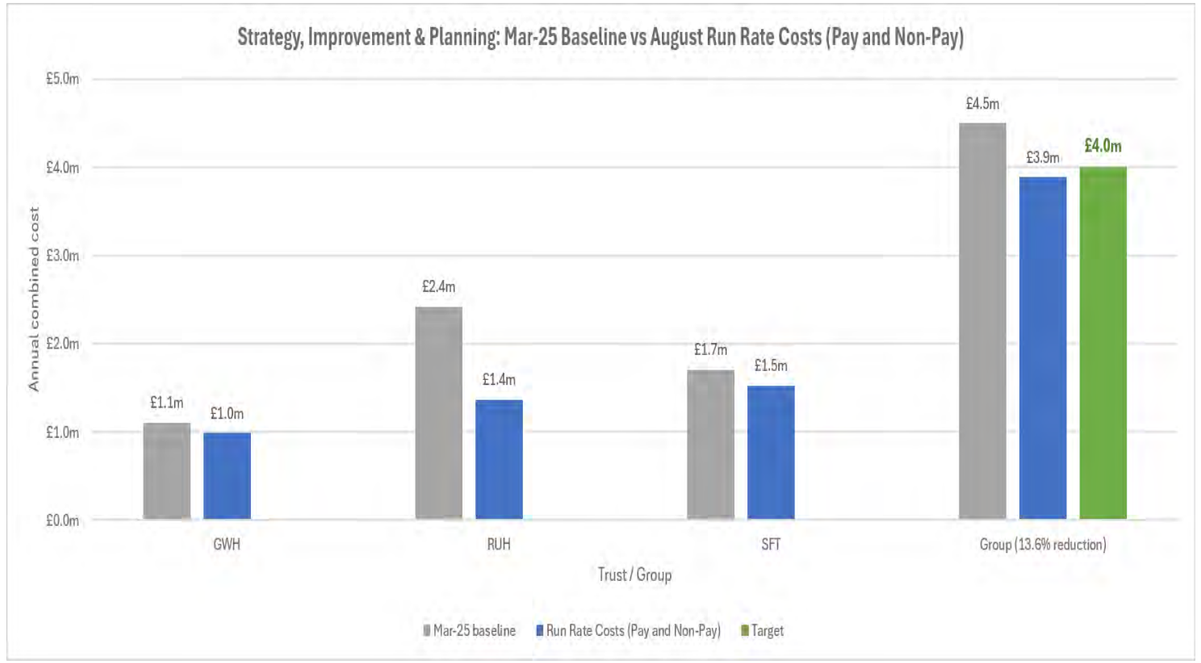
Position summary — The lines track monthly Trust and Group costs, while the indexed annual run-rate and Year 1 target show the required direction. The latest run-rate position is £9.4m, only 1.1% below the £9.5m baseline and still £0.9m above the £8.5m 11% endpoint.

Finance Update M5 – Transformation, Strategy, Improvement and Planning

Financial Delivery RAG Rating

SRO – Judy Dyos – (Chief Strategy Officer)



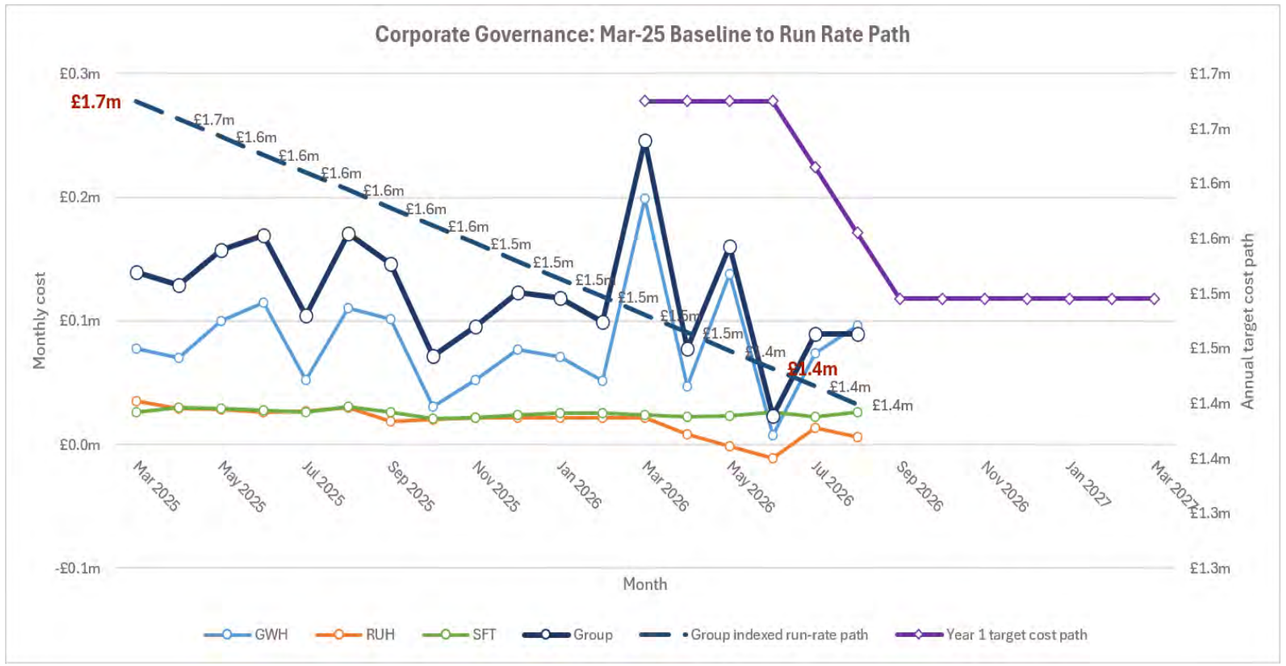


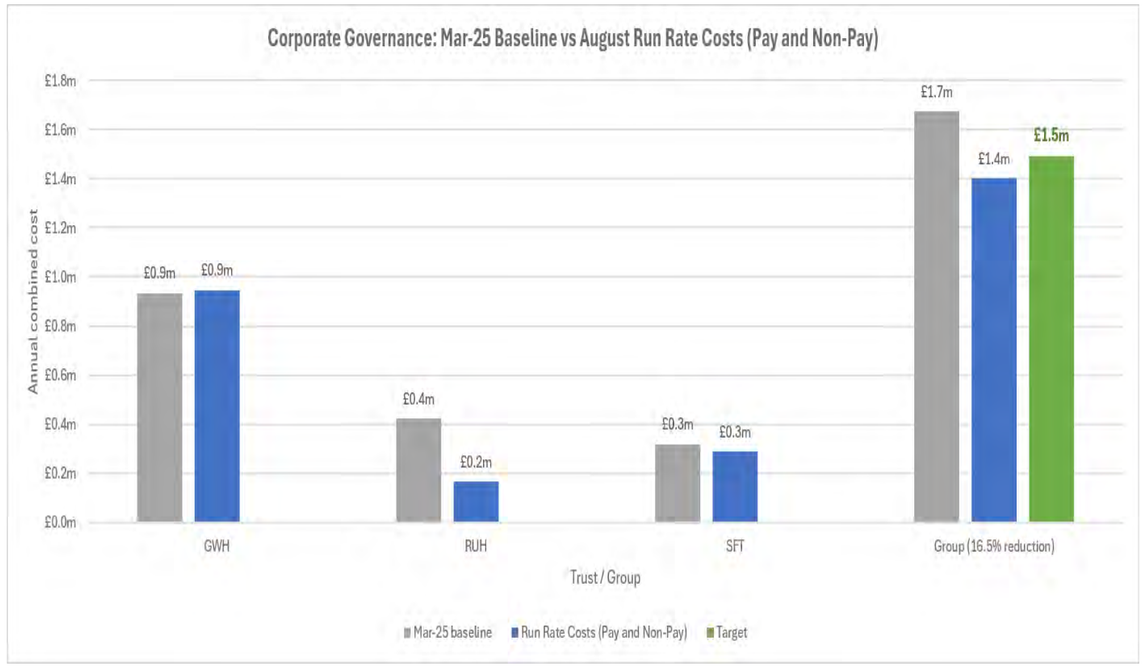
Position summary — The lines show monthly Trust and Group movement against the indexed run-rate and Year 1 target paths. The latest run rate is £3.9m, 13.6% below the £4.5m baseline and around £0.1m better than the £4.0m 11% endpoint, led by the reduction at RUH.

Finance Update M5 – Corporate Governance

Financial Delivery RAG Rating

SRO – Mark Ellis – (Chief Risk Officer)



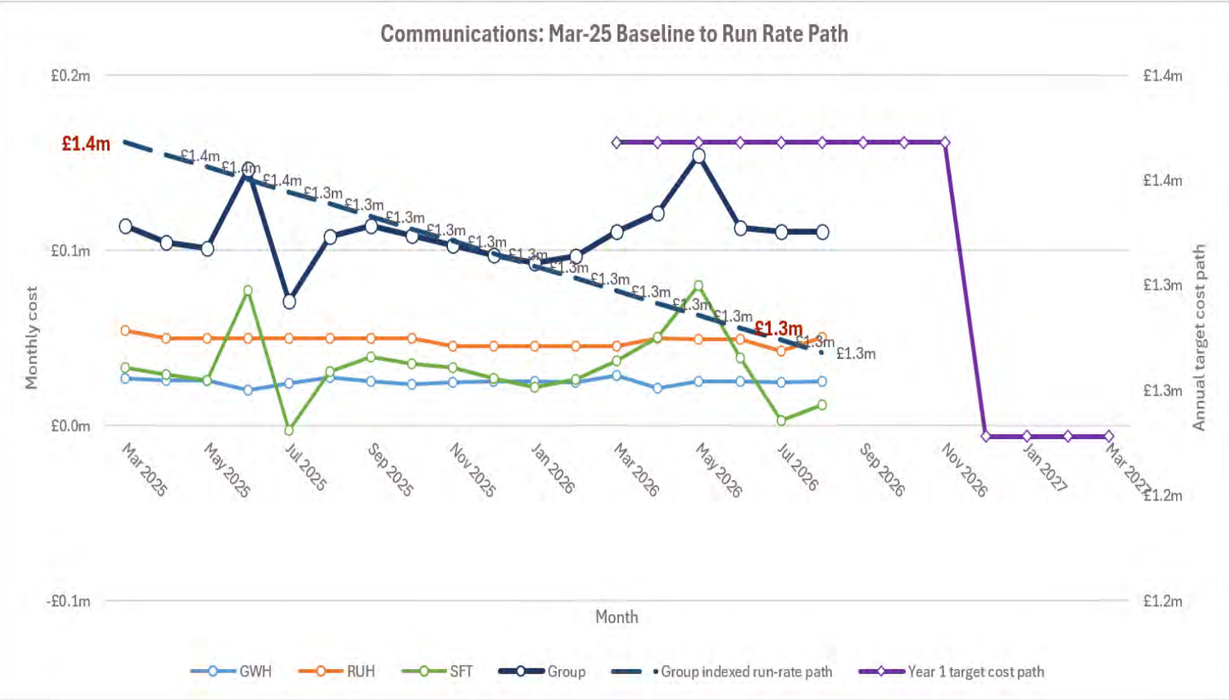


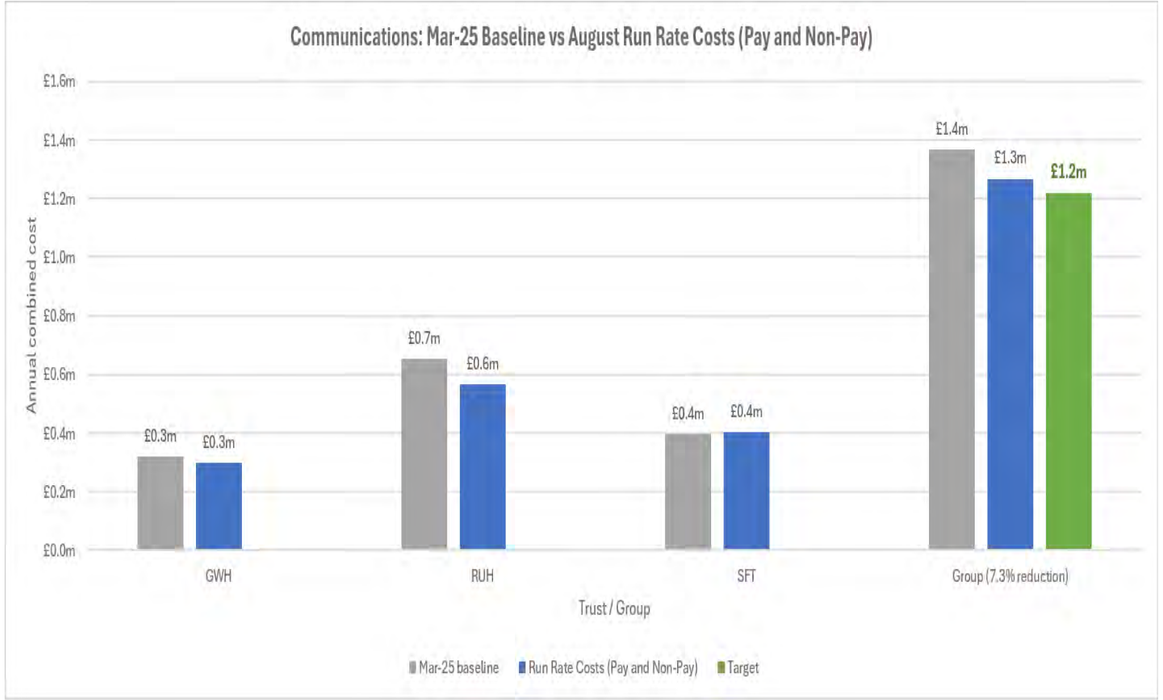
Position summary — The lines show monthly volatility by Trust alongside the indexed run-rate and Year 1 target paths. The latest run rate is £1.4m, 16.5% below the £1.7m baseline and around £0.1m better than the £1.5m 11% endpoint, with the reduction mainly at RUH.

Finance Update M5 – Communications

Financial Delivery RAG Rating

SRO – Emma Mooney – (Director of Communications)





Position summary — The lines show monthly cost movement against the indexed run-rate and Year 1 target paths. The latest run rate is £1.3m, 7.3% below the £1.4m baseline but around £0.1m above the £1.2m 11% endpoint; the overall position is improved but not yet at target.

Consultation Update – Corporate Functions

People	• L4 Consultation closed, working through people impact at Band 8a's / 8b's • Planning for L5 consultation, with change papers to be submitted to staff side in October
Digital	• Senior Digital Team now appointed • Planning for next phase to go live for all employees in October / November
Finance	• Roles 8C and above have been consulted with and appointed into new roles • Planning for next phase to go live for the rest of the structure, date TBC
Capital, Estates and Facilities	• Top level structure now in place • Planning phases for functions across the wider directorate for consultation launch, date TBC
Procurement	• Structure in place • Next steps are to recruit to vacant posts
TIPs	• Change papers have been signed off. Band 9 recruitment taking place in September • In planning for consultation launch for rest of the directorate, date TBC
Corporate Governance	• Consultation closed and finalising appointments in the new structure • Next steps are to recruit to vacant posts
Communications	• Change papers submitted to staff side during Septembet for sign off

Governance Structures and SLA's

Function	Governance Structure	SLA's	Notes
People			SLA's for Resourcing, Employee and Relations and Culture agreed. Awaiting OH, Workforce and Learning and development to be submitted.
Procurement			
Digital			
Capital, Estates/ Facilities			Governance structure to be reviewed with MD's in separate meeting and brought to steering group in November 2026
Finance			SLA in draft
TIPS			Transformation and Strategy SLA's approved, but awaiting Planning to be designed and approved
Corporate Governance			
Communications			Communication do not have a separate governance

Risk Register

Risk Ref	Date Opened	Risk Title	Risk Type	Risk Statement (one sentence)	Causes (facts, one per line, numbered)	Consequences (one per line, numbered)	Controls in Place (numbered, mapped to causes)	Evidence of Control Effectiveness	Residual Score (L+I+C)	Direction of Travel	Status this Period	Control Gaps	Actions (numbered, with dates)	Action Owner	Action Due Date	Action RAG	Risk Owner	Date Last Reviewed	Next Review Due
R019	01/12/2025	Financial Savings - Benefits Realisation	Finance	There is a risk that incomplete financial baselining and forecasting prevent effective tracking of savings and benefits realisation.	1. Financial baseline and forecasting remain in development. 2. A complete forecasting tracker is not yet in place. Group not working from one ledger	1. Savings release cannot be tracked reliably. 2. Benefits realisation cannot be demonstrated. 3. Delivery of the 11% savings requirement is at risk.	Forecasting tracker needs to be built to track finances, release of savings and benefits realisation.	Source status: Escalate. June 2026: No clear plans for 11% delivery.	12	Improving	Score reduced	Monthly finance status by function reported monthly through Givernances routes - CST Steering Group, and Group Board Finance hold deep dive meetings with SROs on current financial position monthly	Update to Group Board (Date TBC) PA Consulting proposal to see if further opportunities to idenitify further savings can be achieved. Decision to be made at CST Steering Group on the 02/10/26	Eugenie Mellon	31/10/2026	Amber	John Ridler	22/09/2026	22/10/2026
R021	01/12/2025	Digital Enablement	Digital and Cyber	There is a risk that unaffordable investment in digital enablers prevents corporate services from achieving their future service states.	1. New corporate-service models require digital investment. 2. Required investment is not currently affordable. 3. Scope and dependencies for a single corporate front door remain unresolved.	1. Future service states may not be achieved. 2. Benefits from new corporate-service models may be delayed or lost.	Digital-enabler task and finish group established; request made at Design Authority to capture the baseline digital requirement for services.	Source status: Escalate. April 2026: Ongoing Design Authority discussions about a single corporate front door; scope, dependencies and resource implications remain to be defined.	15	Stable	No change	Mapping out each functions requirements for digital enablement	Digital Paper submitted to Group Board in September for consideration, highlighting the digital investment required	Eugenie Mellon	31/10/2026	Amber	SROs Jonathan Luff	22/09/2026	22/10/2026

Risk Register

Risk Ref	Date Opened	Risk Title	Risk Type	Risk Statement (one sentence)	Causes (facts, one per line, numbered)	Consequences (one per line, numbered)	Controls in Place (numbered, mapped to causes)	Evidence of Control Effectiveness	Residual Score (L+I+C)	Direction of Travel	Status this Period	Control Gaps	Actions (numbered, with dates)	Action Owner	Action Due Date	Action RAG	Risk Owner	Date Last Reviewed	Next Review Due
SFT-8780	20/03/2026	Capacity of HR and change management resources to support transformation	Workforce	There is a risk that the Trust does not have the HR and change management capacity, experience and skills needed to complete the corporate service redesign programme effectively, leading to the financial and people outcomes of the changes not being achieved.	1. HR and change management capacity, experience and skills are not at the level needed to complete the corporate service redesign programme effectively. 2. The OD&P function is going through consultation at the same time as other CSR functions. 3. Outline proposals may require the TUPE of large numbers of staff within and from outside the group.	1. Financial outcomes from the changes are not achieved. 2. People outcomes from the changes are not achieved. 3. Delivery of the CSR programme is affected. 4. Loss of oversight and management of business as usual activity.	Allocation of HR Business Partners to cross-Group functions is enabling coverage of the CSR change agenda. CSR programme team reviewing the timelines and dependencies on a weekly basis. CSR Design Authority running bi-weekly chaired by the Group CPO, and the CSR Steering Group running on a monthly basis, chaired by the Group CEO. Templated consultation document provided. Shared Managing Organisational Change policy across the three trusts in the Group. Standardised HR FAQs to be worked up and shared with affected staff to avoid localisation and possible resultant misinformation.	HRBP team is in place until Jun 26 - planning to replace members leaving is ongoing current staff remain in place as of Sept 26, interviews to confirm establishment taking place week 2 Sept.	12			One to ones with HR and OD&P staff who are affected by the CSR Consultation with the affected teams	1. Delivery of line management training support interventions. 2. Recruit and train identified roles to support line managers through change management.	Crowley, Ian	1. 31/03/2027 2. 30/10/2026	Green	Crowley, Ian	01/09/2026	30/10/2026

Risk Register

Risk Ref	Date Opened	Risk Title	Risk Type	Risk Statement (one sentence)	Causes (facts, one per line, numbered)	Consequences (one per line, numbered)	Controls in Place (numbered, mapped to causes)	Evidence of Control Effectiveness	Residual Score (L+I+C)	Direction of Travel	Status this Period	Control Gaps	Actions (numbered, with dates)	Action Owner	Action Due Date	Action RAG	Risk Owner	Date Last Reviewed	Next Review Due
006	01/07/2026	Temporary staffing	Workforce	Outsourcing the temporary staffing model could affect staffing levels across the AFC staff group, potentially reducing fill rates and creating gaps within the service. This may increase workload for permanent staff and impact patient care quality and safety. The service transferred on 1 August 2026 without disruption and is now monitored through monthly contract review meetings.	1. Outsourcing of the temporary staffing model. 2. Public concerns raised via an MP, Governors and Council. 3. Service transferred on 1 August 2026.	1. Outsourcing of the temporary staffing model. 2. Public concerns raised via an MP, Governors and Council. 3. Service transferred on 1 August 2026.	1. Monthly contract review meetings scheduled with CNO/DCNO support 2. Weekly check-in calls with Bank Partners for operational oversight 3. Action plan for hot spot areas to ensure resource in pool 4. Monitoring registrations to the Bank from the existing pool 5. Public engagement with HOSC for BaNES, with an update planned in 2027 6. Regular updates to PWAG and People & Culture 7. Action plan for concerns/hot spot departments 8. Weekly meeting with Bank Partners and Finance colleagues to establish the financial delivery of model starting September.		**13**	Worsening	Score Increased			Rebecca Ackrill			Jude Gray	09/10/2026	Daily

BSW HOSPITALS GROUP

NHS

Temporary Staffing Outsourcing Update



October 2026

NHS Great Western Hospitals NHS Foundation Trust

NHS Royal United Hospitals Bath NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

Temporary Staffing Update – Bank Partners

Resource

- 6,571 active workers are currently registered which represents 73.84% of the active worker pool prior to transfer.
- Since go-live, 245 substantive staff have chosen to join the bank, demonstrating continued workforce engagement.

Governance

- Monthly contract performance meetings scheduled. Chief Nursing officers support delivery and review performance against the agreed measures.
- Weekly governance meetings between Resourcing and Bank Partners to embed the new model and drive improvements will continue for the length of the contract.
- Procurement support in place to enforce SLA where compliance is not achieved.

Analysis

Group fill rate: 77% in August and 75% in September

Over 20,000 shifts requested each month. Administrative & Clerical, AHP and Ancillary roles remain strongest, with fill rates above 90% in most areas.

GWH

Overall fill: 90% in August, 89% in September 2026.

Performance remains broadly stable year-on-year despite rising demand.

Pressures concentrate in Nursing, hot spot areas include ED, UTC & ICU.

Bank performance remains strong, particularly in Administrative & Clerical and Healthcare Assistant roles.

SFT

Overall fill: 80% in August, 81% in September 2026.

Administrative, AHP and Ancillary fill rates consistently exceed 90%.

Nursing & Midwifery and Healthcare Assistants remain under pressure, hot spot areas include AMU & Community Midwifery. Agency use supports higher overall fill than elsewhere in the Group.

September demand and unfilled shifts rose. Continued monitoring is needed ahead of winter

RUH

Overall fill: 71% August, 65% September 2026. Greatest staffing challenge in the Group.

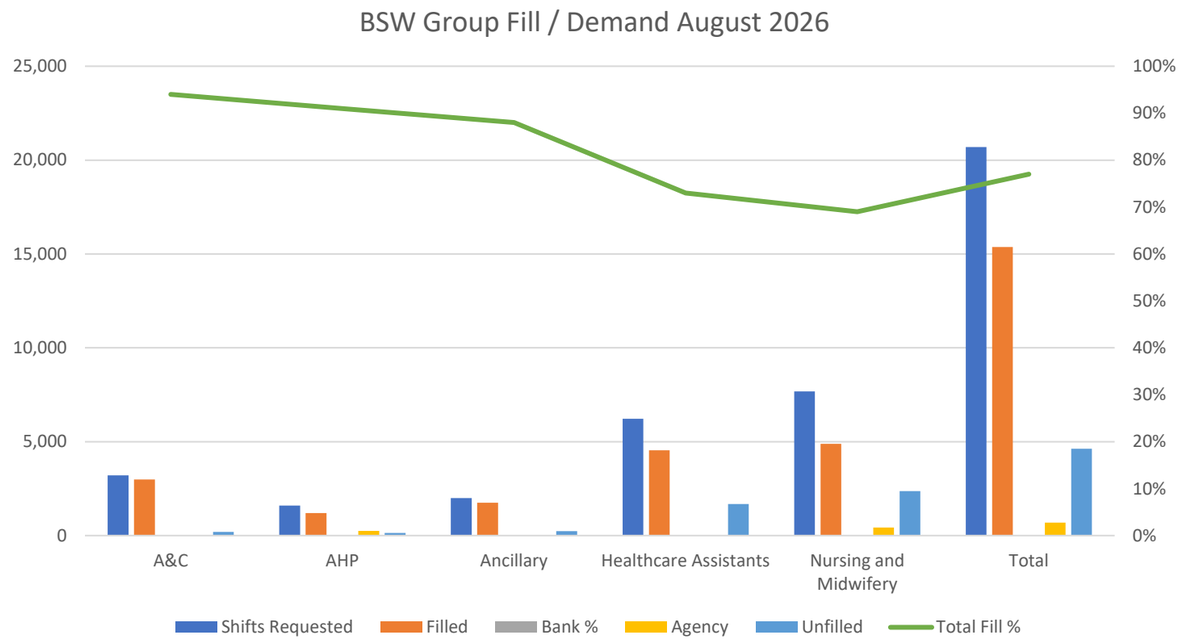
Nursing & Midwifery: 56% August, 52% September. The Group's lowest fill and largest source of unfilled demand.

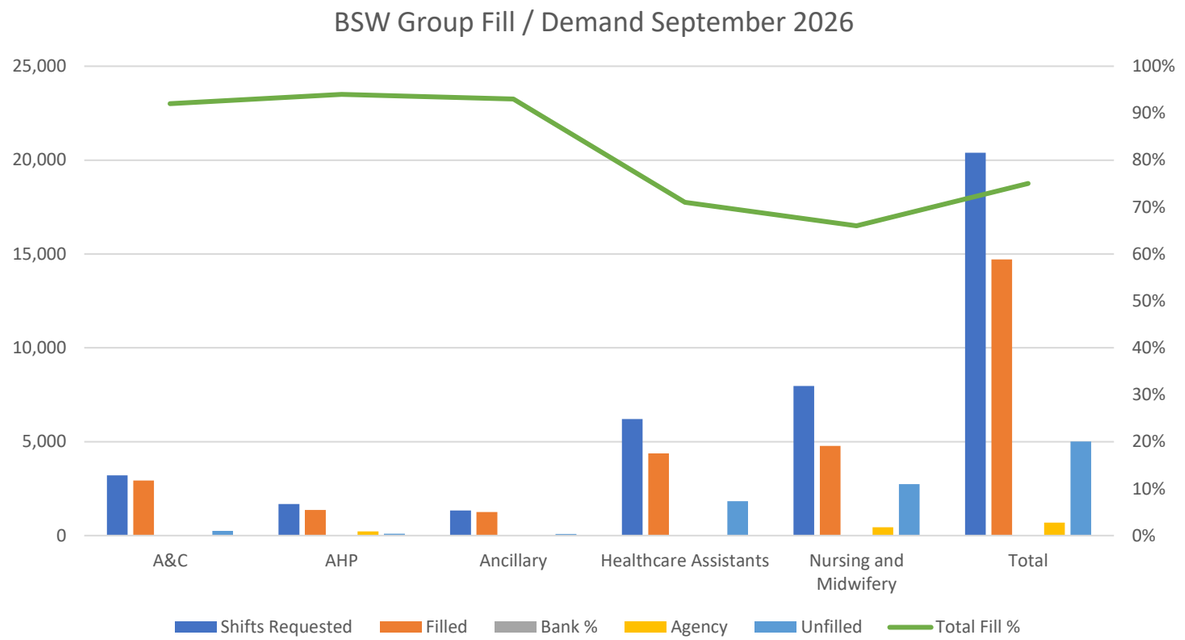
Healthcare Assistants: 68% August, 59% September, with substantial unfilled shifts.

Hot spot areas include Respiratory, Cardiology, Medical Short Say & ED

Priorities: targeted supply interventions, recruitment plans and clinical bank growth

BSW Group Fill / Demand Data for Temporary Staffing for August & September 2026

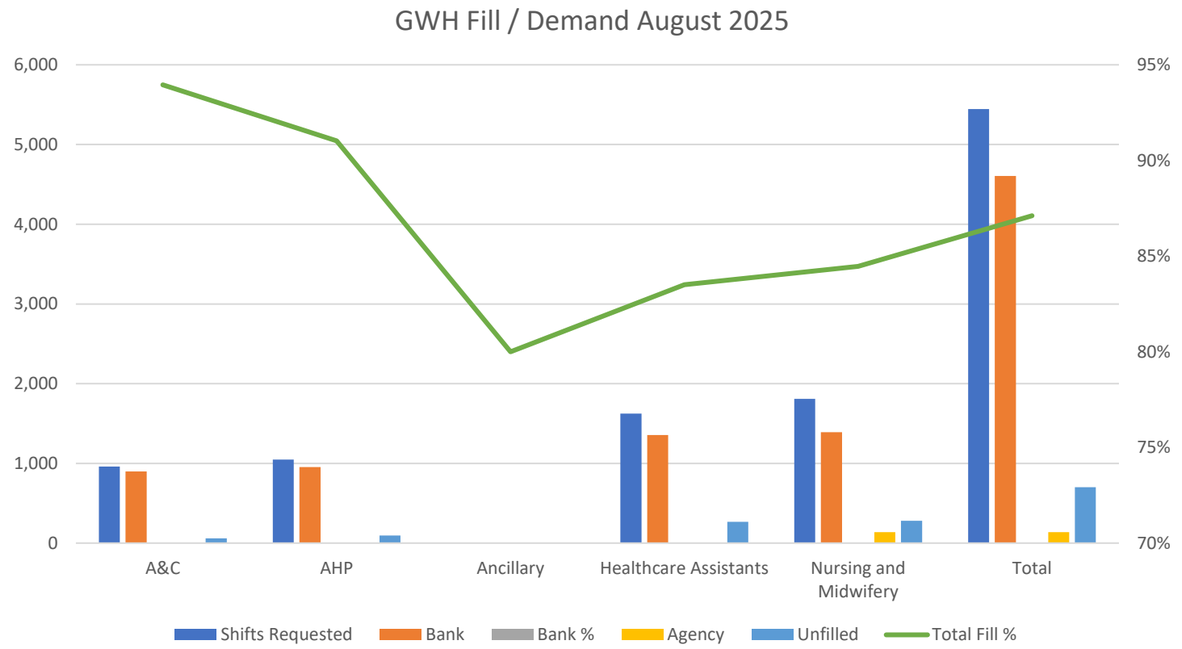


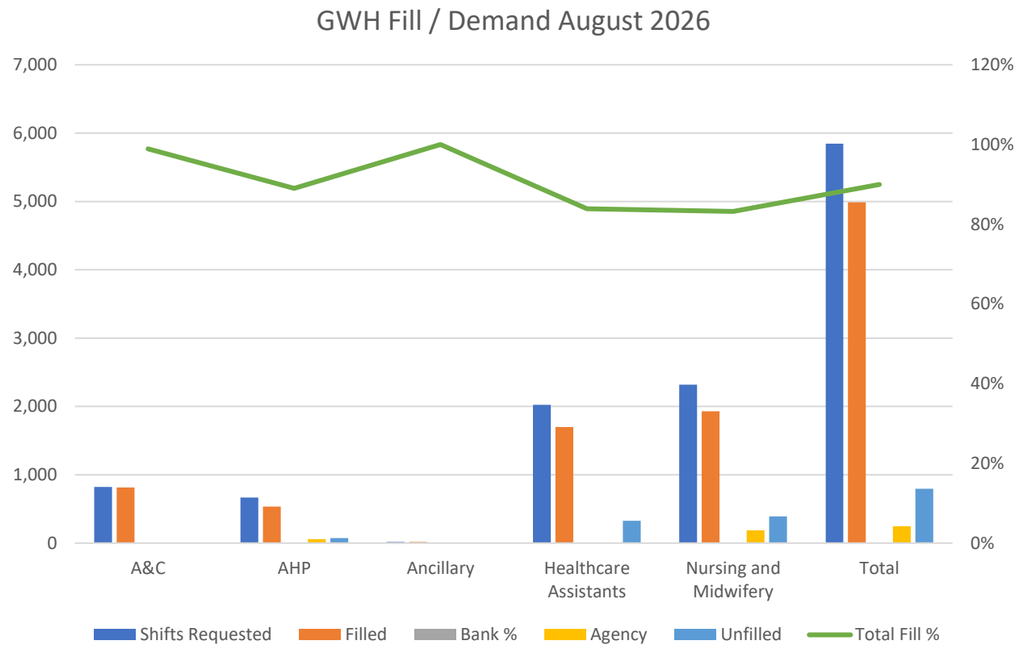


Group	Shifts Requested	Filled	Bank %	Agency	Unfilled	Total Fill %
A&C	3,208	2,990	93%	20	198	94%
AHP	1,594	1,206	76%	250	138	91%
Ancillary	1,995	1,752	88%	0	243	88%
Healthcare Assistants	6,225	4,544	73%	0	1,681	73%
Nursing and Midwifery	7,674	4,882	64%	427	2,365	69%
Total	20,696	15,374	74%	697	4,625	77%

Group September	Shifts Requested	Filled	Bank %	Agency	Unfilled	Total Fill %
A&C	3,212	2,938	91%	20	254	92%
AHP	1,681	1,361	81%	220	100	94%
Ancillary	1,337	1,249	93%	0	88	93%
Healthcare Assistants	6,205	4,379	71%	0	1,826	71%
Nursing and Midwifery	7,962	4,778	60%	446	2,738	66%
Total	20,397	14,705	72%	686	5,006	75%

GWH Fill / Demand for August 2025 / 2026

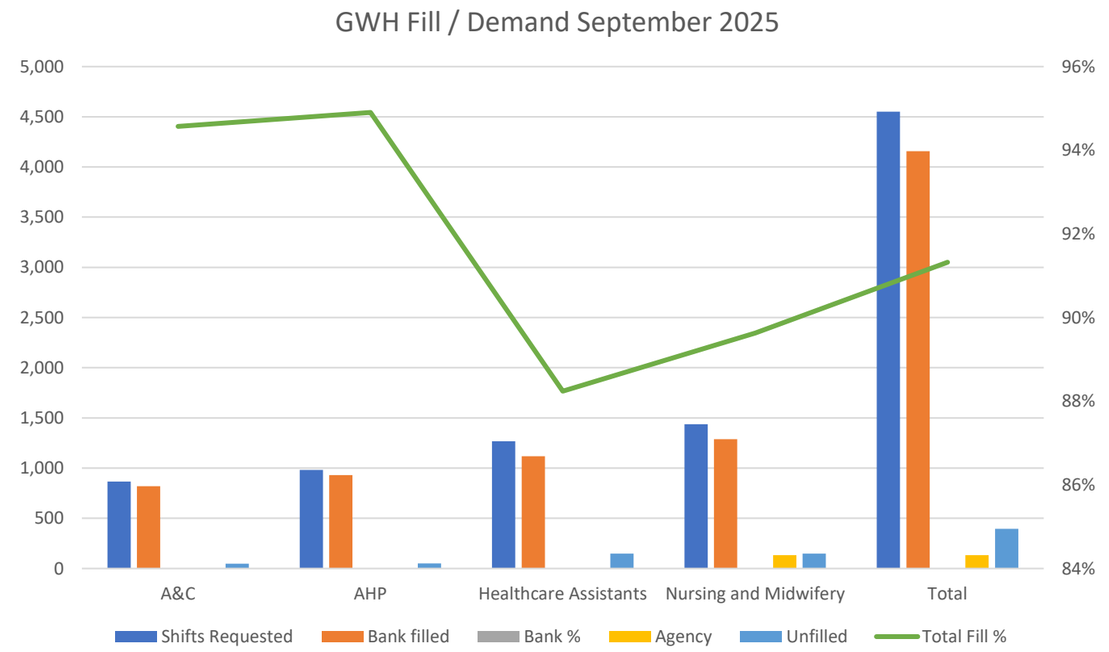


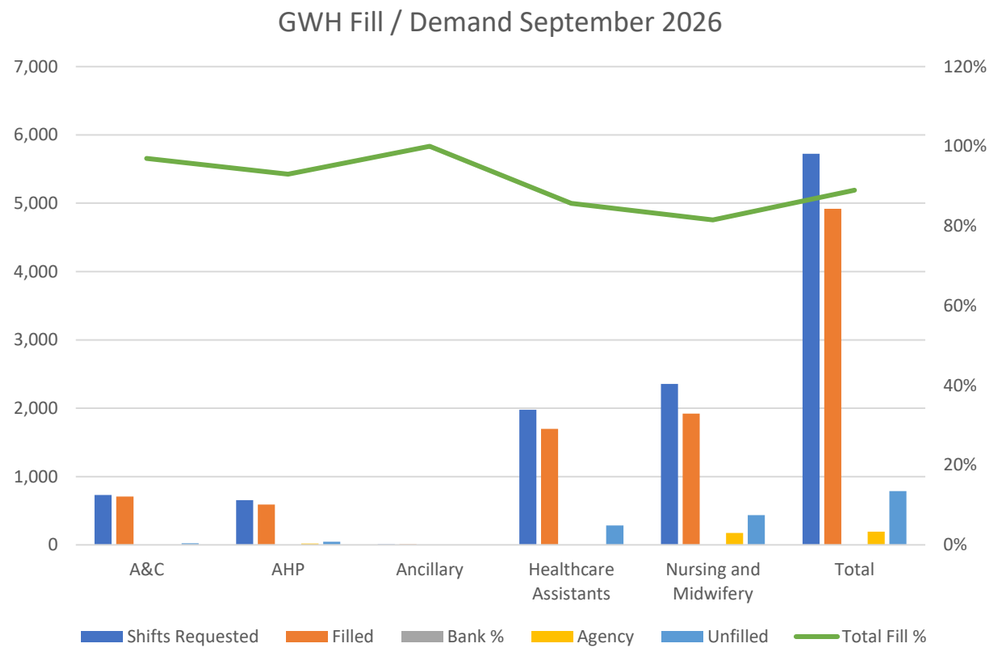


GWH August 2025	Shifts Requested	Bank	Bank %	Agency	Unfilled	Total Fill %
A&C	959	900	94%	1	58	94%
AHP	1,047	953	91%	0	94	91%
Ancillary	5	4	80%	0	1	80%
Healthcare Assistants	1,625	1,357	84%	0	268	84%
Nursing and Midwifery	1,808	1,390	77%	137	281	84%
Total	5,444	4,604	85%	138	702	87%

GWH August 2026	Shifts Requested	Filled	Bank %	Agency	Unfilled	Total Fill %
A&C	822	813	99%	0	9	99%
AHP	665	533	80%	60	72	89%
Ancillary	16	16	100%	0	0	100%
Healthcare Assistants	2,025	1,699	84%	0	326	84%
Nursing and Midwifery	2,317	1,928	75%	186	389	83%
Total	5,845	4,989	83%	246	796	90%

GWH Fill / Demand for September 2025 / 2026

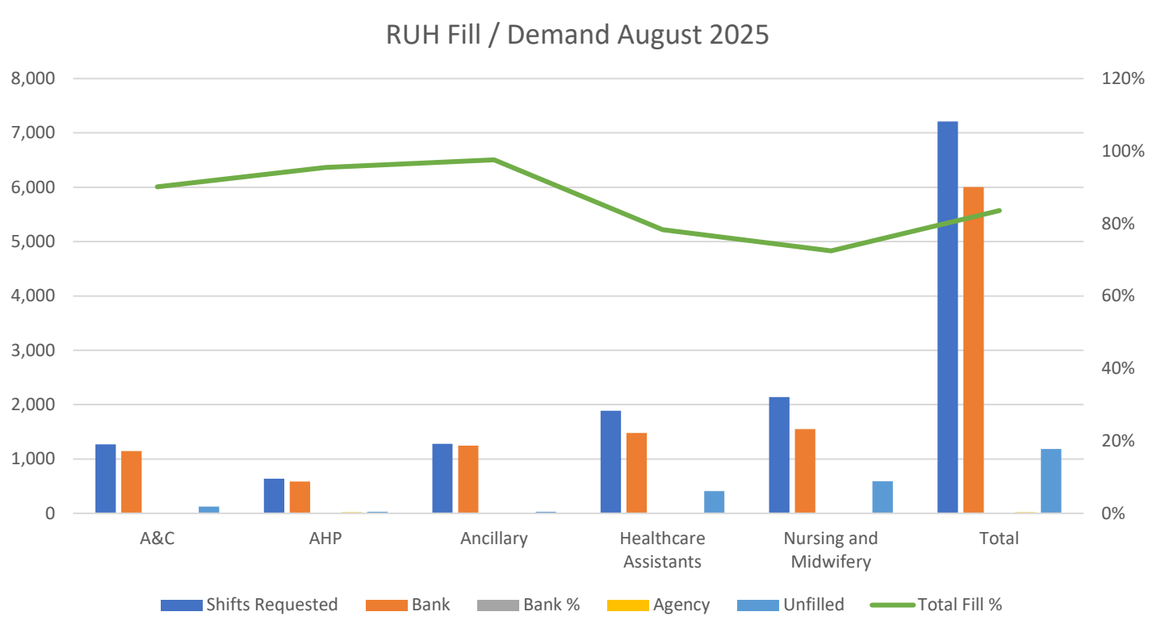


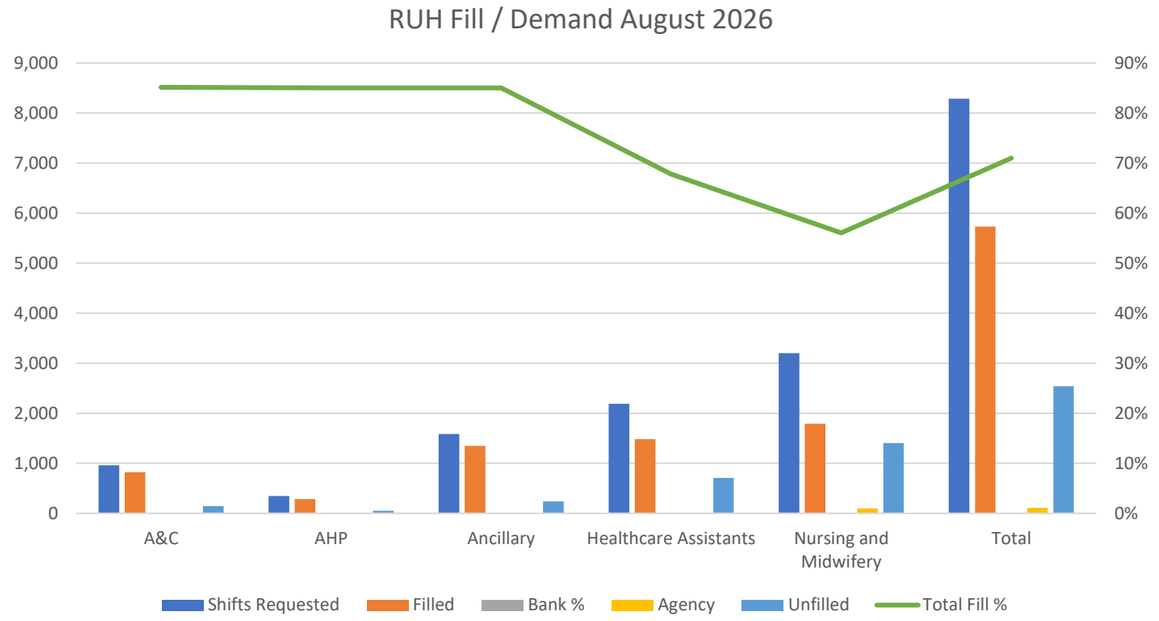


GWH September 2025	Shifts Requested	Bank filled	Bank %	Agency	Unfilled	Total Fill %
A&C	866	819	95%	0	47	95%
AHP	981	931	95%	0	50	95%
Healthcare Assistants	1,267	1,118	88%	0	149	88%
Nursing and Midwifery	1,437	1,288	80%	132	149	90%
Total	4,551	4,156	88%	132	395	91%

GWH September 2026	Shifts Requested	Filled	Bank %	Agency	Unfilled	Total Fill %
A&C	732	706	97%	0	22	97%
AHP	655	589	90%	20	46	93%
Ancillary	7	7	100%	0	0	100%
Healthcare Assistants	1,979	1,696	86%	0	283	86%
Nursing and Midwifery	2,355	1,920	74%	173	435	82%
Total	5,724	4,918	86%	193	786	89%

RUH Fill / Demand for August 2025 / 2026

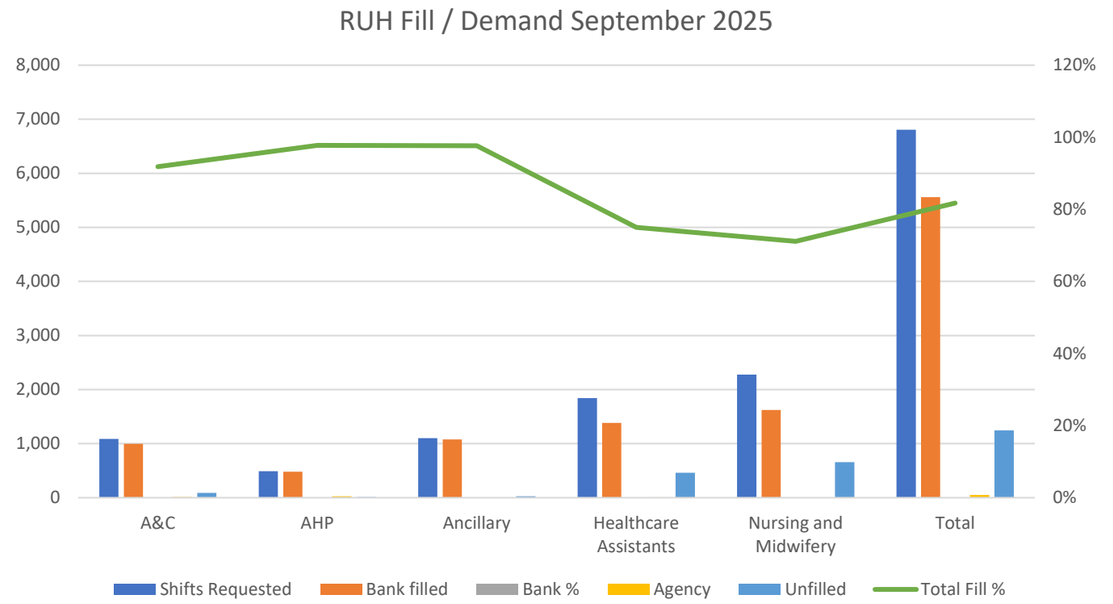


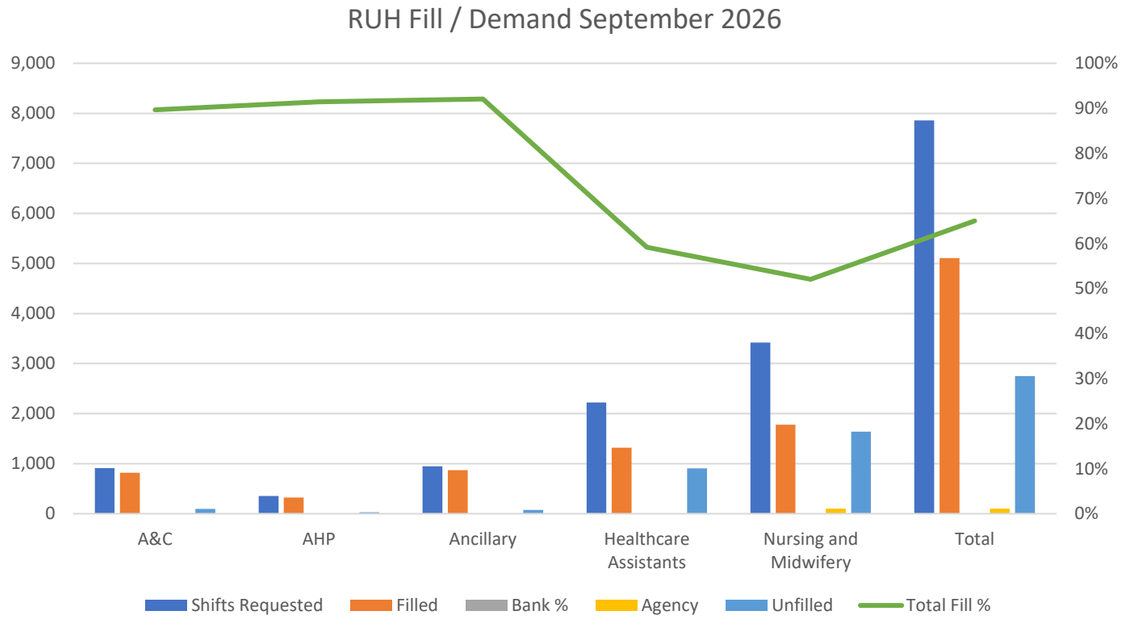


RUH August 2025	Shifts Requested	Bank	Bank %	Agency	Unfilled	Total Fill %
A&C	1,270	1,145	90%	0	125	90%
AHP	636	586	92%	21	29	95%
Ancillary	1,279	1,248	98%	0	31	98%
Healthcare Assistants	1,887	1,477	78%	0	410	78%
Nursing and Midwifery	2,138	1,549	72%	0	589	72%
Total	7,210	6,005	83%	21	1,184	84%

RUH August 2026	Shifts Requested	Filled	Bank %	Agency	Unfilled	Total Fill %
A&C	962	819	85%	0	143	85%
AHP	344	284	83%	10	50	85%
Ancillary	1,586	1,350	85%	0	236	85%
Healthcare Assistants	2,190	1,484	68%	0	706	68%
Nursing and Midwifery	3,201	1,794	53%	101	1,407	56%
Total	8,283	5,731	69%	111	2,542	71%

RUH Fill / Demand for September 2025 / 2026

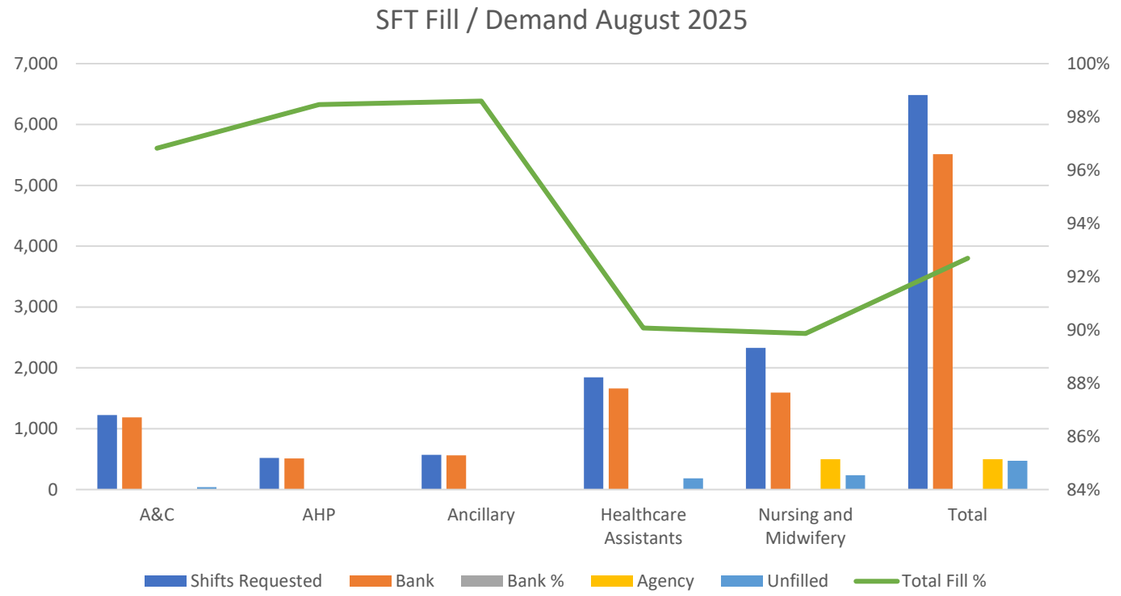


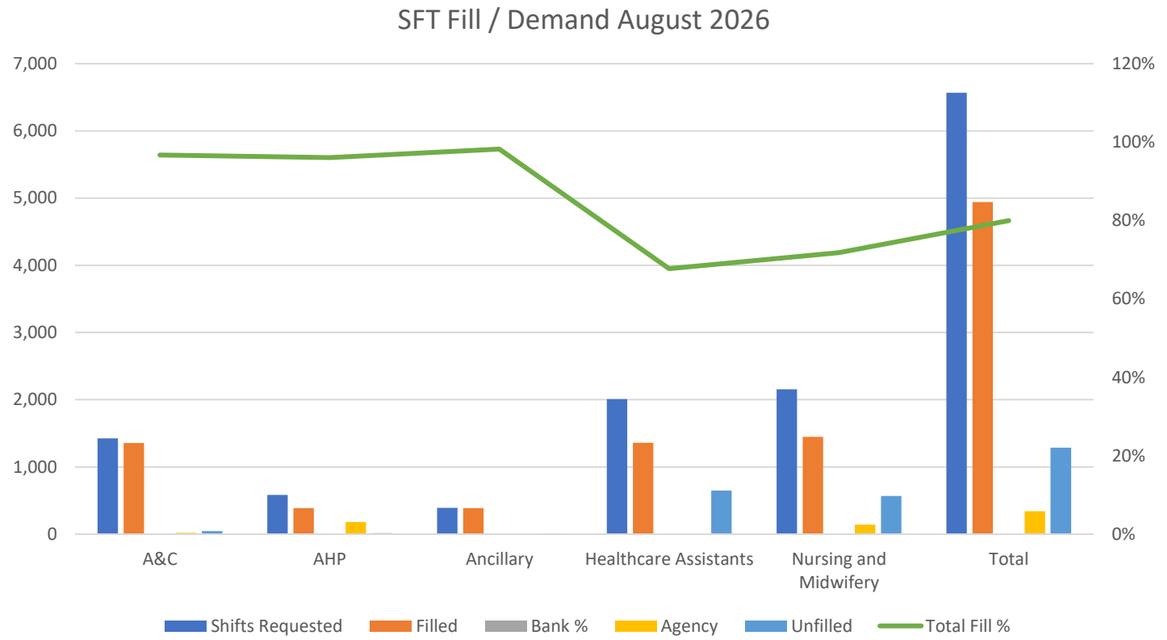


RUH September 2025	Shifts Requested	Bank filled	Bank %	Agency	Unfilled	Total Fill %
A&C	1,088	999	91%	14	89	92%
AHP	491	480	93%	25	11	98%
Ancillary	1,103	1,077	98%	0	26	98%
Healthcare Assistants	1,844	1,383	75%	8	461	75%
Nursing and Midwifery	2,279	1,621	71%	2	658	71%
Total	6,805	5,560	81%	49	1,245	82%

RUH September 2026	Shifts Requested	Filled	Bank %	Agency	Unfilled	Total Fill %
A&C	912	818	90%	0	94	90%
AHP	352	322	91%	0	30	91%
Ancillary	947	872	92%	0	75	92%
Healthcare Assistants	2,225	1,317	59%	0	908	59%
Nursing and Midwifery	3,422	1,781	49%	99	1,641	52%
Total	7,858	5,110	64%	99	2,748	65%

SFT Fill / Demand for August 2025 / 2026

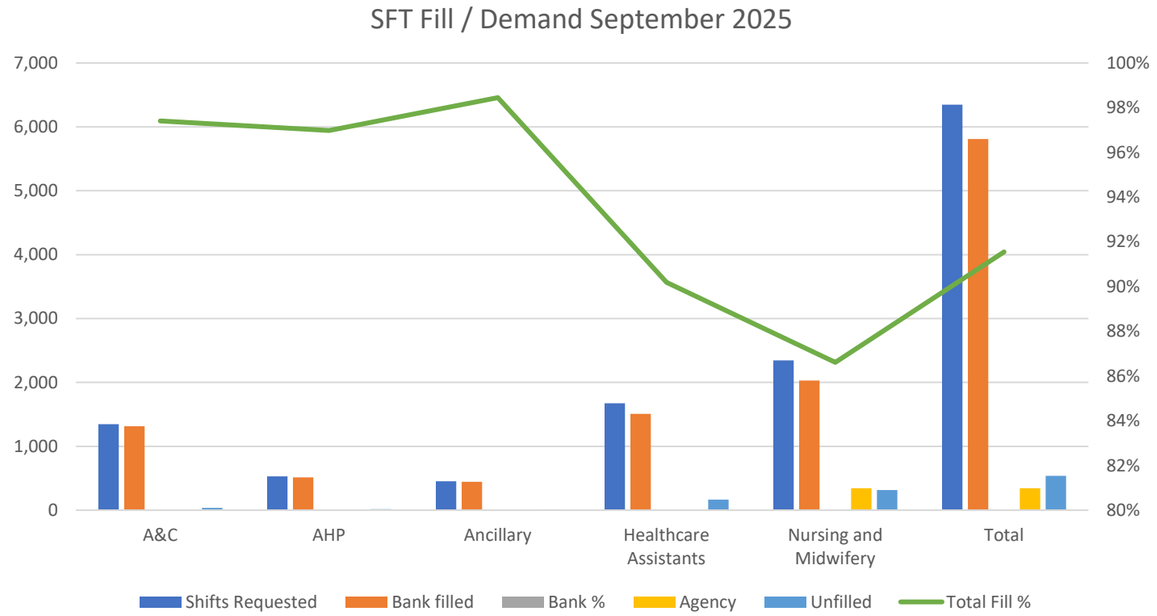


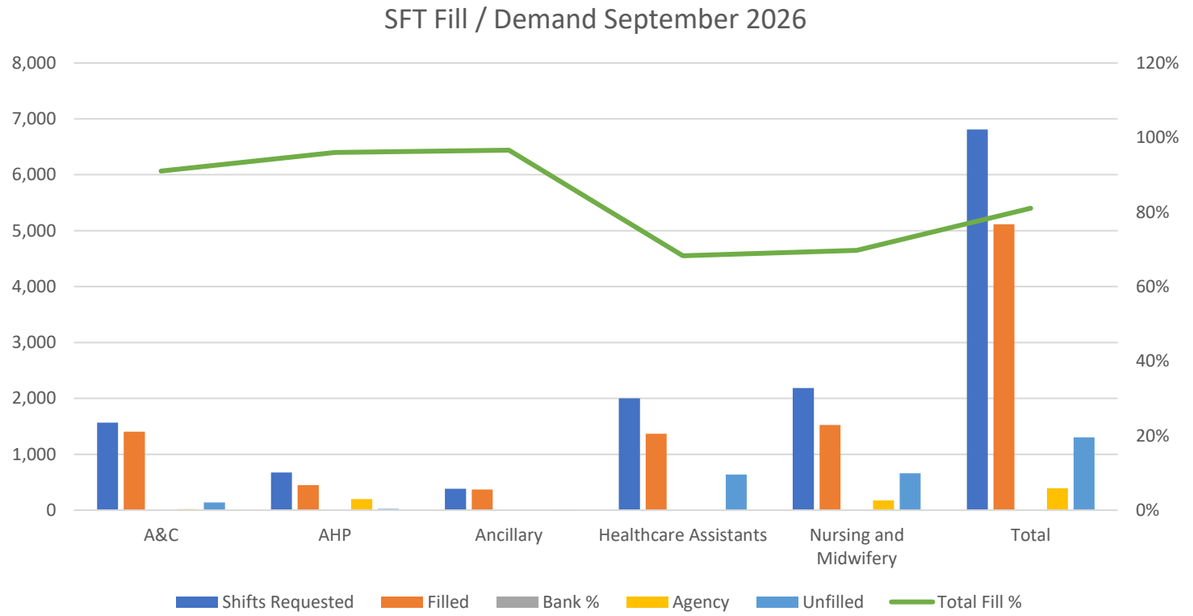


SFT August 2025	Shifts Requested	Bank	Bank %	Agency	Unfilled	Total Fill %
A&C	1,226	1,187	97%	0	39	97%
AHP	519	511	98%	0	8	98%
Ancillary	569	561	99%	0	8	99%
Healthcare Assistants	1,843	1,660	90%	0	183	90%
Nursing and Midwifery	2,328	1,593	68%	499	236	90%
Total	6,485	5,512	85%	499	474	93%

SFT August 2026	Shifts Requested	Bank	Bank %	Agency	Unfilled	Total Fill %
A&C	1,424	1,358	97%	020	46	97%
AHP	585	389	96%	180	16	96%
Ancillary	393	386	98%	0	7	98%
Healthcare Assistants	2,010	1,361	68%	0	649	68%
Nursing and Midwifery	2,156	1,447	65%	140	569	72%
Total	6,568	4,941	75%	340	1,287	80%

SFT Fill / Demand for September 2025 / 2026





SFT September 2025	Shifts Requested	Bank filled	Bank %	Agency	Unfilled	Total Fill %
A&C	1,348	1,313	97%	0	35	97%
AHP	529	513	97%	0	16	97%
Ancillary	452	445	98%	0	7	98%
Healthcare Assistants	1,672	1,508	90%	0	164	90%
Nursing and Midwifery	2,345	2,031	72%	343	314	87%
Total	6,346	5,810	86%	343	536	92%

SFT September 2026	Shifts Requested	Filled	Bank %	Agency	Unfilled	Total Fill %
A&C	1,568	1,405	90%	20	138	91%
AHP	674	450	67%	200	24	96%
Ancillary	383	370	97%	0	13	97%
Healthcare Assistants	2,001	1,366	68%	0	635	68%
Nursing and Midwifery	2,185	1,523	62%	174	662	70%
Total	6,811	5,114	75%	394	1,303	81%

Performance against KPIs

KPI Reference	Performance Indicator	KPI Target	Measured by	KPI performance August	KPI performance September
1	The MI data pack is submitted to the Group for review at least 7 days in advance of Supplier Review Meeting.	100%	Confirmation of date of issue by the Supplier, validated receipt by the Group .	No	N/A
2	The MI data pack received by the Group is accurate, complete and submitted in the correct template alongside the correctly templated data extract upon which the data is based on.	100%	Confirmation of quality of MI report by the Group confirming that MI data pack.	No	N/A
3	Response to ad-hoc data requests to be submitted at least 2 working days. Eg. FOIs, Reporting data.	100%	Confirmation of date of issue by the Supplier, validated receipt by the Group.	Yes	Yes
4	The Supplier will provide an on demand real time dashboard accessible by the Buyer in real time with a maximum refresh rate of 24 hours, which includes but is not limited to: • Bank fill rate analysis and spend • Agency usage and spend • Forward look on fill and spend	100%	Confirmation of quality of MI report by the Group confirming that MI data pack.	No	No
5	The overall % of Assignments filled by the Supplier during a calendar month.	80%	The volume of assignments filled against the overall volume of vacant Assignments received over the course of a calendar month for each staff group.	No 77%	No 75%
6	Contingent labour to be 100% Compliant with national and regional price caps/rate cards.	100%	% of placements within approved compliance.	No	No
7	The supplier should ensure a maximum time to hire within 20 Working days.	100%	Average and % of hires completed within 20 working days from requisition approval to candidate start date.	No	No

KPIs continued

KPI Reference	Performance Indicator	KPI Target	Measured by	KPI performance August	KPI performance September
8	Supplier to provide a booking service with personnel that have a good standard of English language competency, to ensure effective communication with Group staff.	100%	Acknowledgement of provision, to be validated by the Group	Yes	Yes
9	All booking queries within 48 hours of shift starting should be acknowledged within 2 hours.	100%	% of queries acknowledged within SLA.	Yes	Yes
10	All booking queries more than 48 hours before shift starts should be acknowledged within 1 working day.	100%	% of queries acknowledged within SLA.	Yes	Yes
11	Compliance to NHS Employers Safer recruitment standards.	100%	% of workers fully compliant	Yes	Yes
12	Where workers are subject to investigations by professional bodies including but not limited to NMC, GMC or HPAN notices to inform the Groups at the earliest opportunity not exceeding 1 working day.	100%	% of queries acknowledged within SLA.	Yes	Yes
13	In the event the worker holds substantive employment within the BSW Hospitals Group and is subject to any investigation or safeguarding concern the Supplier must inform the buyer within 1 working day and collaborate to support safe working practices.	100%	% of queries acknowledged within SLA.	Yes	Yes

KPIs continued

KPI Reference	Performance Indicator	KPI Target	Measured by	KPI performance August	KPI performance September
14	All invoices submitted in accordance with the Good Invoicing Guide and via the Tradeshift account.	100%	% of queries acknowledged within SLA.	Yes	Yes
15	The Supplier will manage invoicing from Agencies with 99% accuracy	99%	% of invoices correctly formatted and submitted through Tradeshift.	No	Yes
16	Supplier Representatives attendance to Supplier Review Meeting.	100%	Attendance log of Supplier Review Meeting	Yes	Yes
17	Supplier initial response to queries within 24hrs of the response being communicated by the Group.	100%	% of queries acknowledged within SLA.	Yes	Yes
18	The Buyer expects the Supplier to resolve most complaints about workers within 14 days and complex clinical complaints in a reasonable timeframe to be agreed with the Buyer.	100%	% of queries acknowledged within SLA.	Yes	Yes

Actions – Key priorities

Action	Owner	Due date
Monitor fill rates across sites to drive increase in performance	Associate Director of HR Operations & Group Head of Resourcing	Open
Recruit Bank Workers to increase the resource available to meet demand	Bank Partners	Open
Weekly reports commencing 15th October at site level by department for CNOs and HRDs	Temporary Staffing Contract Manager	15.10.26
Finance to validate the financial opportunities to support the benefit realisation	Finance	15.10.26
Bank Partners contract team will meet with key stakeholders of hot spot/high usage areas to review demand	Bank Partners	12.10.26

BSW Group Board

Agenda item	4.4.3
Report title	Freedom to Speak Up Annual Report 2025/26
Date of meeting	5 November 2026
Sponsor	Group Chief People Officer
Prepared by	Group Freedom to Speak Up Guardians / Group People Directorate
Assurance / Approval Process:	Care Organisation Assurance Committees

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

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R2	Taking Our People With Us

KEY MESSAGES

This report brings together the 2025/26 Freedom to Speak Up annual reports for the three Care Organisations, providing a Group view for the period 1 April 2025 to 31 March 2026.

Overall assurance

Process: Reasonable Assurance that processes and routes for speaking up are in place.

Outcomes: Limited Assurance that staff consistently feel safe to speak up without fear of detriment and that concerns lead to timely action and learning.

Key themes: The main themes are psychological safety and responsiveness, workplace behaviour and management capability, and detriment following speaking up. These are broadly consistent with national themes. The key area requiring further assurance is what happens when concerns are raised, rather than whether routes to speak up are available.

RECOMMENDATION

The Group Board is asked to:

- **Note** the overall Limited Assurance assessment; comprising Reasonable Assurance on the availability and operation of FTSU routes, Limited Assurance on psychological safety, detriment and organisational responsiveness.
- **Approve** the three Care Organisation FTSU Annual Reports for 2025/26.
- **Endorse the development of** a Group FTSU improvement framework, including common definitions, standardised detriment review and reporting, local ownership, with Group assurance and triangulation.
- **Support targeted improvement plans** for identified hotspots, with evidence of sustained improvement in leadership and management behaviour.

Appendix

Appendix 1 – FTSU Annual Reports for GWH, RUH and SFT (located in the reading room)

Freedom to Speak Up Annual Assurance Report 2025/26

1. Purpose and assurance scope

This report brings together the 2025/26 Freedom to Speak Up annual reports for GWH, RUH and SFT to provide a comparative Group view. The reporting period is 1 April 2025 to 31 March 2026.

The overall assessment is Limited Assurance. There is Reasonable Assurance that accessible FTSU routes and Guardian arrangements are in place, but Limited Assurance that staff consistently feel safe from adverse consequences and trust that concerns lead to timely, visible action.

The Group's principal speaking-up themes are broadly consistent with national patterns, particularly workforce wellbeing and workplace behaviours. The 328 reported cases equate to approximately 19.3 cases per 1,000 employees, but workforce size alone does not establish an expected reporting level. Reported detriment and some thematic proportions exceed broad national comparators, subject to differences in definitions and recording. National context therefore supports proportionate interpretation but does not remove the need for assurance on timely response, protection from detriment and demonstrable learning.

2. Alert, advise, assure

2.1 Alert

- Psychological safety and confidence in organisational response are common risks. GWH reports an 11.8 percentage-point gap between staff feeling safe to speak up (60.7%) and believing concerns will be addressed (48.9%); SFT reports declining confidence in concerns being addressed; RUH reports worker wellbeing, inappropriate behaviours and bullying/harassment as leading or increasing themes.

- RUH recorded 8 cases where staff stated they faced detriment; SFT recorded 14 cases involving perceived negative treatment; GWH recorded no case formally categorised as detriment, although fear of adverse consequences recurred in casework. The difference may reflect culture, case mix or coding and cannot be resolved from the reports alone.
- Leadership and management behaviour is a material risk. At SFT, 70 concerns, representing 50% of all cases, involved line-manager competence or behaviour. GWH reports inappropriate attitudes and behaviours as its largest primary category, with 18 of 54 cases, and identifies inconsistent leadership behaviour. RUH reports 73 inappropriate behaviour/attitude themes and 50 bullying/harassment themes, noting that cases can contain more than one theme.
- The reports are not directly comparable. GWH records one primary category per case; RUH and SFT allow cases to contain multiple themes. RUH's own annual total is 134, while comparator tables in the GWH and SFT reports state 135. The Board should avoid league-table conclusions until definitions and validation are standardised.

2.2 Advise

- Adopt a single Group minimum dataset covering case volumes, themes, anonymous reporting, detriment, response timeliness, closure, feedback and actions. This is necessary before trend or Care Organisation comparison can provide reliable assurance.
- Prioritise targeted interventions: SFT identifies ED, Theatres and Maternity; GWH identifies 83 departments rated red or amber on speaking-up indicators; RUH proposes closer triangulation with HR, Culture, Workforce and EDI.
- Strengthen the line-manager response through Speak Up, Listen Up and Follow Up expectations, with evidence of completion and behavioural impact rather than training activity alone.

2.3 Assure

- All three reports describe established, accessible Guardian services, senior oversight and active engagement with workforce, safety, EDI or leadership forums.
- GWH reports that its dedicated 30-hour Lead Guardian model improved visibility, accessibility, escalation and thematic reporting. RUH reports continued staff access, escalation and executive oversight. SFT reports extensive promotion, training, cross-team collaboration and an ambassador network.
- The reports show active triangulation and targeted learning: GWH links FTSU with workforce, staff survey and cultural intelligence; RUH engages HR, Workforce, EDI, safety and safeguarding colleagues; SFT operates the "We Are Safe and Healthy" triangulation arrangement.

3. Comparative intelligence

Measure	GWH	RUH	SFT
Total cases	54	134 in RUH report	140
Anonymous cases	2	29	6
Detriment	0 formally categorised; fear recurs	8 stated cases	14 perceived cases
Leading issues	Behaviours 18; patient quality/safety 12; processes 10	Worker wellbeing 90; behaviours 73; bullying/harassment 50	Worker safety/wellbeing 89; behaviours 80; patient safety/quality 58

Measure	GWH	RUH	SFT
Staff survey signal	60.7% safe; 48.9% confident action follows	Slightly more negative “safe to speak up” response noted; exact score not stated	Decline in safety and confidence; remains above average overall
Specific concentration	83 departments red/amber; highest concentration in Corporate Services	No equivalent hotspot count stated	High-pressure areas include ED, Theatres and Maternity

4. Risk review

Risk theme	Evidence across reports	Assurance	Action required
Psychological safety and responsiveness	Fear of consequences, declining confidence that action follows, and limited visibility of learning are reported across the three Care Organisations.	**Limited**	Agree risk ownership, improvement interventionsy.
Workplace behaviour and management capability	Behaviour, bullying, incivility and inconsistent management practice are recurring themes; SFT quantifies 70 management-related concerns.	**Limited**	Require hotspot plans, executive ownership and evidence of sustained change.
Detriment after speaking up	8 stated cases at RUH, 14 perceived cases at SFT, and recurrent fear but no formal detriment cases at GWH.	**Limited**	Standardise definition, review and Board reporting of detriment.

5. Good practice and innovation

- GWH’s dedicated Lead Guardian model and professional-curiosity approach have strengthened visibility, escalation and thematic intelligence.
- SFT’s ambassador network, induction reach, leadership development integration and cross-functional “We Are Safe and Healthy” triangulation provide an established infrastructure for access and learning.
- RUH’s Report and Support platform provides an additional anonymous route, while quarterly engagement with HR, Workforce and EDI supports triangulation and attention to barriers affecting protected groups.

BSW Hospitals Group Board

Agenda item	4.4.5
Report title	Equality, Diversity and Inclusion (EDI) Report: April 2025 – March 2026
Date of meeting	5 November 2026
Sponsor	Jude Gray, Group Chief People Officer
Prepared by	Sharon Woma, Group EDI Lead
Approval Process: (where has this paper been reviewed and approved)	• GWH Inclusion & Health Inequalities Subcommittee first presentation (SFT and RUH via email) – excluding Pay Gaps 29.07.2026 • BSW Hospitals Group People & OD Committee 09.09.2026 • People & Culture Committees - GWH 22.09.2026; RUH 23.09.2026; SFT 23.09.2026 • SFT Joint Consultative Committee 24.09.2026 • GWH Employee Partnership Forum 05.10.2026 • GWH BSW Hospitals Group Private Board Meeting 01.10.2026

☐ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R2 Taking our people with us	Key Risks • Under-representation of ethnic minority, disabled staff and women in senior leadership roles. • Persistent inequalities in career progression, workforce experience and pay outcomes. • Low disability declaration rates affecting data quality and assurance. • Insufficient organisational ownership and accountability for EDI outcomes.

KEY MESSAGES

The 2025/26 BSW Hospitals Group Equality, Diversity and Inclusion (EDI) Annual Report provides a consolidated overview of the Group's progress in advancing workforce equality, diversity and inclusion across Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust.

For the first time, the report brings together all statutory and mandated workforce reporting requirements, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap, Ethnicity Pay Gap and Disability Pay Gap reports, alongside progress against the NHS England EDI Improvement Plan and the Group's EDI objectives. This integrated approach strengthens transparency, reduces duplication and provides a single source of assurance on workforce equality performance across the Group.

While progress has been made in several areas, including increased collaboration across the three organisations, expanded pay gap reporting and improvements in some staff experience measures, inequalities remain in progression and representation in senior roles and workplace experience for some protected characteristic groups.

Pay Gaps: Pay gaps continue to reflect under-representation of some groups in senior and higher-paid roles, primarily driven by staff in medical and dental roles. A deep dive to understand the drivers will lead to a targeted action plan for 2026-27.

WRES Metrics: Notable improvements in harassment/bullying/abuse [HBA] from patients at RUH and discrimination at GWH; and a notable decline in shortlisting to appointment at SFT. Whilst some metrics have improved slightly or remained relatively the same, the report acknowledges that further work is still required.

WDES Metrics: Notable improvements in HBA from colleagues at GWH; however, there was notable decline in disabled staff reporting HBA, staff feeling pressure to work despite not being well enough to perform their duties and feeling valued – all at SFT. The majority metrics have remained relatively the same with some incremental improvements in places. Work will focus on supporting managers including access to resources and awareness raising. The Group will capitalise on external expertise (membership to Business Disability Forum) to help shape the 2026-27 programme of work.

A key priority for 2026/27 will be the development of a BSW Group EDI service, EDI objectives and an EDI Strategic Plan, aligned to the Group Strategy, NHS England requirements and regional priorities; and to work closely with Divisions and Departments to equip and support them to build capability and to play a role in future progress.

Rating: Moderate Assurance – progress is evident (WRES improvements, stable WDES and Gender Pay Gap metrics) and a baseline has been set for Ethnicity and Disability Pay Gaps; and governance arrangements are in place; however, persistent inequalities remain and require sustained organisation-wide focus, multiprofessional approach to taking action and leadership commitment.

RECOMMENDATION

The Group Board is asked to:

- Take assurance from the progress made and note the areas of continued risk.

(This report was approved in the Private Board Meeting 1.10.2026 to enable the Group to publish the report by 31.10.2026).

APPENDICES

1	EDI Annual Report

BSW Hospitals Group Board

Report title	Lord Mann Recommendations Update Paper	Agenda item	4.4.5
Meeting	BSW Hospitals Group Board		
Date of meeting	5 November 2026		
Sponsor	Jude Gray, Group Chief People Officer		
Prepared by	Sharon Woma, Group EDI Lead		
Approval Process:	First presentation		

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

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

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

KEY RISKS / BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title		
R2 Taking our people with us	Balancing the rights of individuals with opposing beliefs Ensuring racialised groups experience equal protection NHSE judicial review to take place, as employers, we assume our own legal risks Staff capacity to engage fully due to work pressures	Risk Score	

KEY MESSAGES

- The antiracism workstream has moved from mobilisation into early stages of delivery, with Group-wide engagement, interim training and a benefits-realisation tracker now established or scheduled.

- Assurance remains partial. Several interventions are still in planning phase including engagement and impact assessment, and NHSE roll out of mandated training, consultation on adding Jewish and Sikh identifiers to NHS protected characteristics and publication of national uniform guidance (badges, symbols etc) is still pending. However, the Let's Talk Inclusion Survey which is still live does include some early indication of staff needs.

- The Board is asked to note the progress highlighted in the update report, and to recognise the capacity and engagement and other risks, and support sustained leadership sponsorship for long-term cultural change.

ALERT

- Awaiting roll out of national training and further guidance from NHSE.
- Capacity pressures across workforce and uneven engagement will impact speed of progress. Engagement is key, particularly before implementing the adoption of the IHRA definition of antisemitism and its examples, to ensure staff can share concerns and decisions do not breach Human Rights. Petitioning against the NHS's adoption did not achieve its target, however, a legal firm is representing claimants against NHSE in a Judicial Review citing a 'lack of public consultation, transparency and safeguarding' and the BAME & Allies Healthcare Professionals Coalition is concerned about parity across different forms of racism and discrimination.
- All three organisations have received FOI requests, signalling the public and media interest in the IHRA antisemitism definition and the Government's antimuslim hostility statement adoption and what actions Trusts have undertaken to date.

ADVISE

- Note see actions. Benefits will be realised over the long-term. Future board assurance reports will include link to action tracker.
- The Board is asked to recognise this is long-term commitment and investment, requiring cultural change and improved capability of staff at all levels of the care organisations to address racism in all its forms.

ASSURE

- Work has commenced including engagement and the provision of interim staff training whilst we await rollout of national mandated modules.
- An integrated approach has been adopted, recognising the common thread across the Lord Mann recommendations, WRES, EDS and NHS England High Impact Actions. Therefore, the NHSE recommendations build on existing work by strengthening and reinforcing the Group's ambition to address disparities experienced by ethnically diverse groups.

RECOMMENDATION

The Group Board is asked to:

- **Receive and note the progress and current level of assurance described in this report.**
- **Endorse sustained Board and senior leadership sponsorship and support and acknowledge this is a long-term commitment to change.**

Lord Mann Recommendations Board Update: November 2026

Work has commenced to implement the NHSE recommendations following the publication of the Lord Mann Report which reviewed how the NHS identifies, reports and responds to antisemitism and other forms of racism. The table below highlights actions to date and imminent future actions.

COMPLETED | IN PROGRESS | PLANNED | NHSE DEPENDENCY

NHSE Commitment	Actions	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Adoption of definitions and statements	Board approval 2 July 2026							
	See planned engagement							
	Embed statements etc into policy and practice							++
Implement Violence Prevention and Reduction Standard	VPR Standard was implemented before the Recommendations and audits take place against the standard by the committees							
Implement NHS Staff Standards	People Operations review							
	Working group to launch 18 November							
NHS Core Skills Framework module on EDI or bite-size module (nationally led)	Interim training – Race Aware workshop 6 Oct.							
	Interim training – pilot Cultivating a respectful culture face-to-fact at all sites in December							
	Staff self-help resources to be developed in New Yr.							++
	OD to review leadership programmes							++
	Roll out NHSE training for staff and Board when available							
Engagement and awareness raising with staff, staff representatives, patients and communities through internal and external communication channels	Let's Talk Inclusion survey is currently live							
	People Operations Briefing session 2 July							
	IHISC presentation 30 September							
	Virtual staff engagement – 17 November							
	Formation of Group Super Staff Network							
	NHSE to consult on Jewish and Sikh protected characteristic datasets							
	NHSE to publish engage on national uniform guidance							
Board and committee engagement – Staff Survey Data on the experience of racism in organisation; and action planning	Board presentation of EDI annual report Oct 26							
	Racism question added to NHS Staff survey							
	Benefits Realisation tracker being built							
Completion of survey by 31.07.26	Group completed NHSE survey re adoption							

++ Likely to be carried out over a number of weeks/months.

Dear Chair, Chief Executive, Chief People Officer and Board Members,

Re: Important Mann Review updates, NHS employer responsibilities and maintaining confidence in anti-racism approaches

We are writing to NHS employers on behalf of the **BAME & Allies Healthcare Professionals Coalition (BAHPC)**, a coalition formed following publication of the **Lord Mann Review**. The Coalition brings together healthcare professional organisations representing approximately 24,000 healthcare workers, alongside allies from minoritised communities and patient groups across the United Kingdom.

We are writing following our recent dialogue with DHSC and NHS England to update NHS organisations and highlight several considerations as Mann Review implementation continues.

DHSC acknowledges concerns, but key questions remain

Following dialogue with DHSC and NHS England on 10 September 2026 regarding stakeholder confidence in the Mann Review, the Coalition has now received a formal written response from DHSC.

DHSC acknowledged that meaningful stakeholder engagement should extend beyond attendance at meetings and provide a genuine opportunity to inform policy development, and confirmed that concerns and evidence raised by Coalition members would be considered as implementation work progresses. The Coalition welcomes this acknowledgement and the continuation of dialogue.

However, important questions remain regarding how stakeholder evidence influenced the Review, how parity between different forms of racism has been considered, and how confidence amongst affected communities will be restored. As the dialogue continues, we look forward to understanding how these concerns will be translated into action and reflected in future decision-making.

Confidence remains the central issue

One of the strongest themes emerging from both our engagement with communities and our recent discussion with DHSC and NHS England is that the principal challenge is not implementation alone. **It is confidence.**

For many stakeholders, the issue is no longer simply the Mann Review itself, but whether all forms of racism are being addressed with consistent evidential standards, equal urgency and visible leadership.

These concerns regarding parity and equity have been amplified by rising reports of anti-Muslim hostility, anti-Black racism and wider racially motivated violence in recent years, alongside continuing evidence from the NHS Workforce Race Equality Standard (WRES)

showing persistent inequalities affecting Black and minority ethnic staff, and Medical Workforce Race Equality Standard (MWRES) data demonstrating disproportionate experiences of discrimination and disadvantage affecting ethnic minority doctors.

At the same time, many stakeholders struggle to identify comparable levels of national leadership visibility, engagement and policy response when those communities are affected.

Communities lose confidence when similar evidence appears to result in different levels of institutional action. The Coalition's rapid growth reflects that loss of confidence.

The Coalition also considers it important to state that, whilst we have engaged constructively with DHSC and NHS England, our participation in stakeholder discussions should not be interpreted as endorsement of the Mann Review, its findings or associated implementation activity, nor as evidence that stakeholder concerns have been resolved. That position has been maintained throughout.

Important clarification regarding definitions

A significant portion of the recent stakeholder discussion focused on the relationship between the Lord Mann Review and the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism. During that discussion, DHSC and NHS England clarified that:

- The earlier request to NHS organisations regarding IHRA adoption pre-dated publication of the Mann Review.
- DHSC believed the IHRA issue and the Mann Review had become conflated in public discussion.
- DHSC and NHS England ***neither endorse, nor mandate*** **any particular definition.**
- NHS employers retain responsibility for decisions relating to adoption and implementation of definitions, if they choose to adopt a definition.
- NHS employers also retain the associated legal responsibility and liability for those decisions.

This clarification is important.

The **IHRA definition is not legally binding** and does not override existing legal duties. Following the landmark David Miller judgment, anti-Zionist beliefs now attract clear protection under equality law. NHS employers should therefore exercise considerable caution before embedding contested non-statutory definitions within workforce, disciplinary or regulatory processes, particularly where staff may hold protected beliefs. Responsibility, liability and accountability for these decisions remain with employers, not DHSC or NHS England.

Why methodology and transparency matter for implementation confidence

One of the Coalition's central concerns is that reviews can be judged solely by their recommendations, rather than by the quality of the process that produced them.

Methodology, evidential standards, transparency and stakeholder engagement are not procedural details. They are safeguards that help ensure recommendations are proportionate, evidence-informed and capable of commanding confidence amongst the communities most affected by them.

Stakeholders remain unclear how different forms of evidence, including longstanding workforce datasets such as WRES, were comparatively evaluated and how that evaluation translated into specific recommendations.

Where reviews do not transparently explain how evidence was assessed and prioritised, observers inevitably attempt to interpret those decisions themselves. The risk is not simply disagreement with recommendations. The risk is that communities begin to reach competing explanations regarding why particular recommendations were prioritised and whether all forms of racism were treated with equivalent weight and scrutiny. Once those perceptions take hold, confidence in both the process and the resulting recommendations becomes increasingly difficult to restore.

This concern is particularly relevant given wider evidence regarding stakeholder confidence. The report **Too Hot To Handle?** found that many racialised NHS staff already lacked confidence that concerns relating to racism would be addressed effectively, making transparency and accountability especially important.

Beyond confidence, another risk that follows is implementation drift. Following publication of the **Cass Review**, a number of affected stakeholder groups argued that implementation and public debate had moved beyond what they understood the Review to recommend. Whatever one's view of those arguments, they illustrate an important principle: where stakeholders do not understand how evidence has been assessed, how recommendations were prioritised, or how implementation decisions are subsequently made, confidence begins to erode. As confidence erodes, interpretations begin to diverge, with some affected stakeholder groups arguing that the Review was being used in ways that extended beyond its findings and, in their view, against the interests of the very communities it was intended to serve.

Similar concerns have been raised in relation to the **Lord Mann Review**. Recent confusion regarding the relationship between the Review and the **IHRA definition** provides one example. This returns to the point that **visible leadership is now essential from DHSC and NHS England**, to ensure that implementation remains faithful to both the spirit and purpose of the Review, and to prevent confidence deteriorating further amongst the communities it seeks to serve.

For NHS employers, the lesson is clear:

Robust anti-racism policies require more than good intentions. Transparent and competent processes are essential to good faith interpretation and implementation.

Questions NHS employers are entitled to ask

As the Cass Review example demonstrated, transparent and competent processes as well as engagement with affected stakeholders are just as important as visible leadership on As implementation work continues, NHS organisations are entitled to seek clarity regarding:

- What evidence supports a particular intervention?
- What Equality Impact Assessment has been undertaken?
- What consultation informed implementation decisions?
- How have staff networks and affected communities influenced proposals?
- How is parity across different forms of racism and discrimination being demonstrated?
- How does any proposed intervention align with Equality Act obligations, employment law and human rights protections?
- What review mechanisms exist should unintended consequences emerge?

The Coalition believes these are questions of good governance and support robust implementation rather than undermine it.

A practical and constructive way forward

One of the clearest messages arising from our dialogue with DHSC and NHS England, is that implementation plans of the Lord Mann Review remain a work in progress. A number of workstreams remain under development. NHS organisations should therefore be cautious about assuming that implementation details are settled or that local discretion has been removed.

The current position does not require NHS employers to adopt any particular definition. It does, however, require employers to continue meeting their legal, equality, workforce and governance responsibilities.

Many NHS organisations are choosing to proceed cautiously by relying upon established legal and evidence-based approaches, including:

- Equality Act and employment law obligations;
- Human rights and freedom of expression protections;
- Workforce Race Equality Standard (WRES) data;
- Local anti-racism and anti-discrimination policies;
- Staff engagement and lived-experience evidence;
- Equality Impact Assessments; and
- Existing bullying, harassment and disciplinary procedures.

At the same time, many stakeholders continue to express concerns that they were included too late in the process to influence key decisions.

Stakeholder engagement is not attendance. Stakeholder engagement is influence.

Communities build confidence when they can see that their concerns, evidence and lived experiences have shaped decisions. The Coalition's concern is not that some communities

were absent from discussions, but that many believe they were present without being influential. This perception has contributed significantly to the loss of confidence surrounding the Mann Review and its implementation.

For NHS employers, this means ensuring that implementation remains evidence-based, legally robust, transparent and capable of demonstrating parity across different forms of racism and discrimination. Employers should be able to explain clearly why interventions have been prioritised, what evidence supports them, and how affected communities have influenced decision-making.

In our view, law, evidence, parity, equity and meaningful stakeholder influence provide the most robust and defensible basis for tackling racism and discrimination.

The Coalition remains committed to constructive engagement and would welcome discussions with Trusts seeking to strengthen local engagement, review implementation considerations and build confidence amongst staff, patients and communities.

Who we are

The **BAME & Allies Healthcare Professionals Coalition** is a broad alliance of healthcare professional organisations, staff representatives and community stakeholders committed to tackling racism, discrimination and inequality in healthcare through evidence-informed, inclusive and trusted approaches.

Established following publication of the Mann Review, the Coalition brings together organisations representing a diverse range of healthcare professionals, nurses, midwives, doctors, allied health professionals, students and community advocates. Collectively, coalition member organisations engage with and represent up to 24,000 healthcare professionals, students and stakeholders across the UK.

The Coalition supports robust action against Islamophobia, anti-Black racism, anti-Arab racism, antisemitism and all forms of discrimination. Its focus is to promote meaningful stakeholder engagement, good governance and lawful, evidence-informed implementation of policies affecting healthcare staff and the communities they serve.

Coalition Members
Asian Professionals National Alliance (APNA)
Association of Pakistani Physicians of Northern Europe (APPNE)
Association of Pakistani Physicians and Surgeons UK and Foundation (APPS UK)
British Arab Nursing and Midwifery Association UK (BANMA)
British Egyptian Medical Association (BEMA)
British Islamic Medical Association (BIMA)
British Pakistani Psychiatrists Association (BPPA)
British Somali Medical Association (BSMA)
Diaspora Uganda Nurses Midwives' Society (DUNMS)
Isabel Zendal Association: Association of Spanish Nurses & Healthcare Workers Living in the UK
Kenyan Nurses and Midwives Association UK (KENMA-UK)
MedAct
Muslim Doctors Association (MDA)
Muslim Doctors Cymru
Nigerian Nurses Charitable Association UK (NNCAUK)
NHS Muslim Women's Network
Nurses for Palestine
PalMed UK
Staff Equality Networks
Uganda Nurses and Midwives Association UK
United Iraqi Medical Association United Kingdom and Ireland (UIMA)

Great Western Hospitals NHS Foundation Trust

Managing Director's Report: August data 2026 GWH

Report field	Detail
Agenda Item	5..1
Date of meeting	BSW Hospitals Group Board – 5 November 2026
MD / Lead	Lisa Thomas, Managing Director GWH
Purpose	FOR ASSURANCE

Executive Summary

The September assurance cycle presents an overall position of partial assurance. Governance and improvement arrangements are established, but pace of delivery remains constrained by urgent and emergency care demand, long elective waits and overdue follow-ups, financial and recurrent efficiency delivery, workforce affordability, winter resilience, EPR readiness and the concentration of significant risks with controls that are not yet fully effective.

The central triangulating theme is organisational capacity. High occupancy and poor patient flow continue to affect patient safety, experience and productivity. The same operating context increases temporary staffing and escalation costs, limits the pace of recurrent savings, restricts clinical and managerial capacity for transformation, and limited capacity competes directly with the resource required for EPR implementation and estate improvement.

There are areas of positive assurance. Elective activity was above plan year to date and the overall RTT waiting list remained below planned size. Cancer performance improved across the principal standards, deconditioning performance improved, agency usage remained controlled below plan, emergency preparedness and health and safety standards were strong, and clinical governance in several services demonstrated measurable improvement.

The top scoring risks on the risk register directly relate to patient outcomes including stroke timely access to care, high hospital occupancy and surgical unit assessment unit capacity, interventional radiology service capacity, maternity day assessment capacity. Other significant risks relate to failure to deliver the financial and performance standard plan, insufficient clinical leadership and estate capacity and PFI hand back.

The GWH leadership teams focus remains on delivery of the recovery plan delivering improvements in both RTT, Cancer, UEC and financial trajectories. Progress is being made on RTT and UEC and there is more developed work with system partners to help mitigate some of the increases in demand and the pressures on flow.

1. Alert | Advise | Assure

ALERT

Issue	Board-level narrative
Urgent and emergency care / flow	Four-hour performance was 63.6% in August. Ambulance handovers averaged 41 minutes, and corridor care remained high. Improvement actions are in place through Right Care, the whole-hospital flow sprint and discharge support, but in line with recovery plans improvement remains a

Issue	Board-level narrative
	central focus. Recovery plans were shared as part of the preparation of the regional board to board meeting in October. The Right Care programme continued to provide a structured framework for improvement, with delivery focused on front-door streaming, GP redirection, enhanced triage, workforce optimisation, frailty pathways, live operational dashboards and strengthened discharge processes. Recovery remains dependent on sustained internal flow improvements and successful delivery of system-wide actions to reduce demand, improve discharge performance and mitigate winter pressures
RTT, long waits and follow-ups	RTT performance was 57.7% against a 62% operating plan. The total waiting list remained controlled, but 1,000 patients were waiting over 52 weeks and 18 over 65 weeks. The outpatient follow-up backlog exceeded 32,000, including more than 10,000 overdue by over one year, creating clinical and EPR migration risk. Capacity to look at this as improvement project is currently not available. CMO and COO are reviewing options quickly to address next steps. The Trust continues to meet with the regional team directly.
Financial recovery, cash and productivity	At Month 5 the Trust reported a £17.7m deficit, £13.2m adverse to plan. Efficiency delivery was £8.53m against a £14.96m plan and the forecast of in year delivery is approximately £30.5m remains below the £47.2m target. Recovery plans were shared as part of the preparation of the regional board to board meeting in October. The biggest risk to delivery is the ongoing urgent care activity above plan placing the organisation under significant financial and operational pressure. There is a cashflow shortfall projected in March 2027 without revenue support or additional corrective action. Focus in aligned to improving the run rate of expenditure to essentially improve cash outflows. The Capital programme remains constrained; Emergency capital requirements create a forecast pressure of approximately £4.7m to £4.9m. Delivery remains dependent on group prioritisation of capital funding and expectation of accessing further national pots of funding.
Stroke pathway	Stroke remains the highest quality risk at score 13 with SSNAP at level E. Whilst progress has been made on pathway improvements without significant investment in ACP model and increased therapy further improvement is likely to stall.
Maternity services	Maternity triage does not fully meet the national specification. The audit reported 73.3% assessed within 15 minutes and 56% receiving obstetric review within the required timeframe. As part of the action plan, the maternity leadership team are developing plans to both improve the physical environment to meet the service specification but also the medical input to the day assessment pathway.
Delivery Capacity	Organisational capacity remains constrained by simultaneous financial recovery, performance recovery, transformation and improvement programmes, winter readiness and EPR implementation. The level of change is significant with resource constraints in finance and business intelligence which continue to be factors in our pace of recovery.
EPR readiness and delivery capacity	The Shared EPR programme moved to Red within the corporate portfolio. Key dependencies include pathology, RIS/PACS, SME capacity, training release for 700 to 900 staff per week, un-outcomed appointments, devices, clinical safety, archive and RPA requirements. The level of resource to plan at care organisation is a key constraint to delivery of a successful EPR. Prioritisation is underway to align resources to mitigate risks.

ADVISE

Issue	Board-level narrative
Workforce morale	Sickness levels increased in August which we cannot infer a more general trend yet, however, informal feedback highlights workforce feeling the pressure from the sustained operational pressures. This is a significant risk in ED staffing; several listening events are happening in October to understand what more can be done to support staff under sustained pressure. There is a gap in the approach to staff engagement which requires further work in coming months to sustain delivery. The Director of Coms and Chief People Officer are aligning an approach.
Neonatal staffing	Neonatal nursing and medical establishments remain below BAPM standards, despite daily oversight and 12-hour, seven-day ANNP cover. There is a business case to improve staffing levels, however this will have a financial implication.
Activity levels	UEC and Planned activity levels are above contracted levels, this is forecast to continue based on the RTT recovery plan. This has been raised through the formal contract meeting with the ICB monthly.
Sterile services	Finance committee approved a procurement process to procure a commercial solution for the reprovision of sterile services department. Sterile services flags through JAG accreditation, FTSUP concerns, ventilation standards and capacity constraints. The case is a longer term solution on the expansion land and will release capacity on the GWH site.

ASSURE

Issue	Board-level narrative
Elective and cancer improvement	Elective activity was 104.5% of plan year to date and the total RTT waiting list remained below planned size. Cancer performance improved across the 28-day, 31-day and 62-day standards, supported by Cancer 360 oversight.
Breakthrough objective – deconditioning	Deconditioning improved to 48% of inpatients sitting out for lunch (the improvement target over the year is to reach 75%). This is a 3% improvement on last month and is trending in a positive direction. The wards which have had the best improvement are modelling good visible ward leadership, daily improvement huddles and regular review of performance data.
Premises assurance report	The committee received a Premises assurance report prior to submission, this showed 4 of the five domains scoring results equivalent to good or above. The Estates Competency domain achieved 73% and represents the principal area for further improvement, particularly regarding estates strategy alignment, sustainability, land and property governance, planning processes and access to specialist professional advice

Key Achievements and Good News

- Elective recovery continues to impact, with RTT performance improving an the overall waiting list remaining below planned levels.
- Cancer performance has improved across the 28-day, 31-day and 62-day standards, supported by enhanced oversight through Cancer 360 and strengthened recovery governance.
- Patient flow improvements are beginning to emerge, with corridor care episodes reducing by approximately 35% and the new Medical Short Stay Unit now operational, supporting both flow and ward decant programmes.

- Hip fracture mortality is now in line with the national average and the service is no longer a national outlier.
- Radiology roster redesign delivered 800 additional scans whilst reducing reliance on bank staffing.
- Health, Safety, Fire, Security and Emergency Preparedness arrangements continue to provide strong assurance, EPRR achieving substantial compliance and Health & Safety KPI targets exceeded.

2. Performance Triangulation

The August position presents a consistent picture of an organisation operating beyond sustainable capacity.

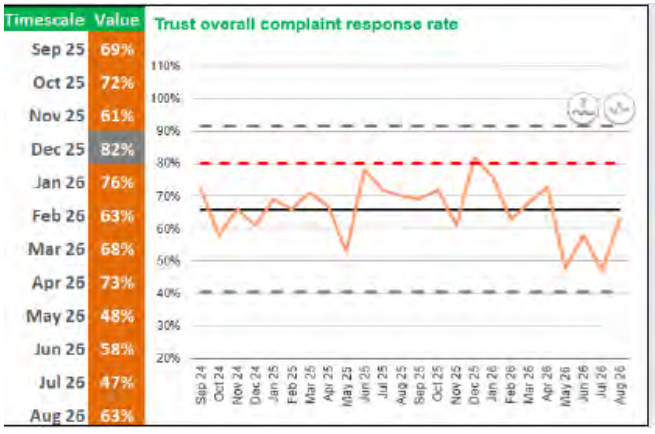
Urgent and emergency care performance remained significantly below plan, with four-hour performance around 64%, high corridor care, prolonged ambulance handovers and discharge delays creating sustained pressure across the hospital. This operational pressure is directly linked to increased workforce utilisation, higher temporary staffing requirements, reduced productivity and a worsening financial position, with the Trust reporting a £17.7m deficit and an efficiency delivery gap against plan.

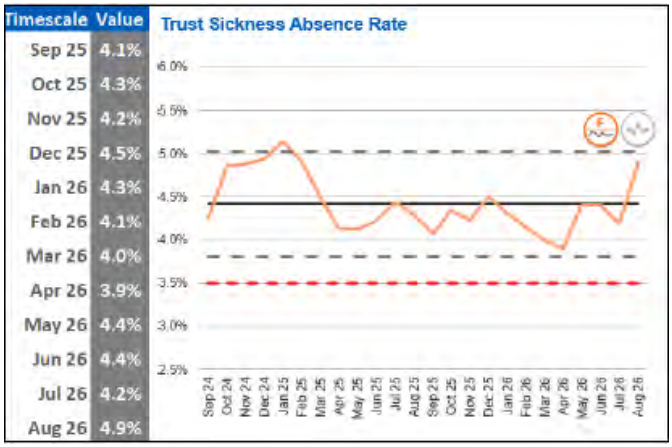
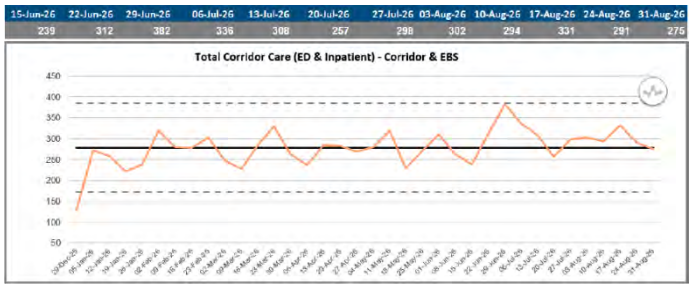
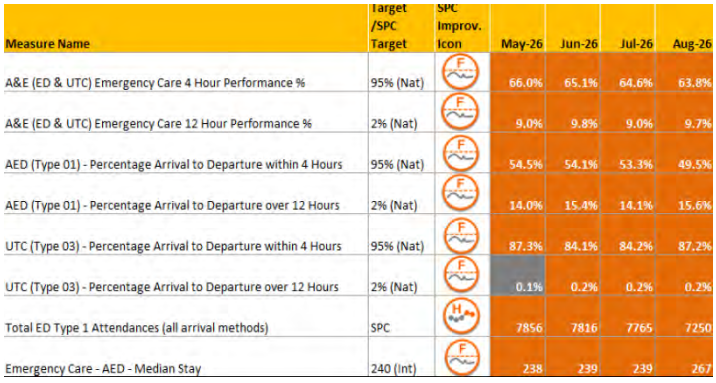
At the same time, long elective waits, a large overdue follow-up backlog, cancer and diagnostic constraints, demonstrate that performance challenges are affecting quality, safety, workforce and finance simultaneously rather than as isolated issues.

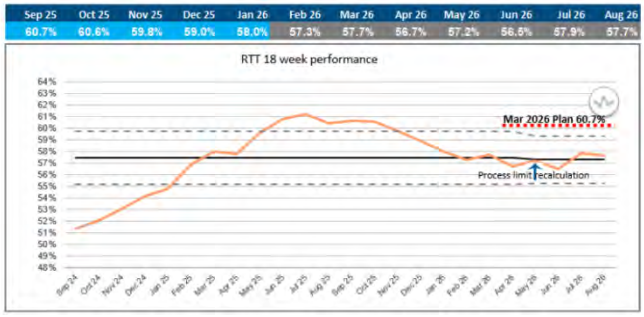
Positive assurance remains evident in elective activity delivery, improving cancer trajectories, deconditioning work, agency control, health and safety performance and emergency preparedness. However, the overarching theme from the assurance cycle is that organisational capacity remains the critical limiting factor, with patient flow, workforce affordability, financial recovery, winter resilience, estate constraints and EPR readiness all competing for the same finite leadership, clinical and operational resource.

The key risk is not the absence of plans but the organisation's ability to deliver multiple recovery priorities concurrently whilst continuing to operate at very high occupancy and demand levels.

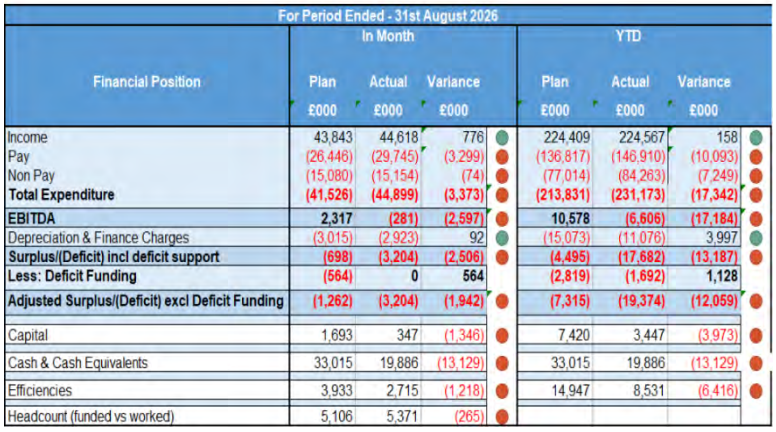
2.1 Performance position

Metric	August reported position	Action/response
Complaints		Complaint response performance improved slightly in August due to ongoing work across divisions and with PALS support to track and monitor updates. This remains below the Trust KPI of 80%. Complaint improvement actions currently include: • Weekly divisional oversight check and challenge meetings • Design of digital complaints proforma to reduce duplication of work • Increase investigation managers including the Advanced Clinical Practitioner workforce.

Metric	August reported position	Action/response
Trust sickness absence rate		August sickness absence increased in month to 4.9% with long term sickness at 2.7% and short term at 2.2%. • The Improving Attendance Working Group continues to deliver targeted interventions to reduce short-term absence, with activity focused on identified hotspot areas across FaSS, SPC and Corporate. • MSK and Healthy Lifestyle interventions continue to be embedded across hotspot areas. The implementation phase has been extended to the end of September to maximise engagement and impact.
Total Corridor care		There has been a small reduction in total number of episodes of corridor care in August (1328) when compared to July (1393) . The following initiatives continue to be embedded to support reduction in corridor care and other key metrics. • UTC diverting patients to GP appointments in the community • Additional shifts in UTC and ED to respond to peaks in demand • New ward daily processes resulting in higher numbers of patients attending the discharge lounge earlier in the day.
UEC performance standards	 4-hour performance (type 1 and 3) decreased to 63.8%. This is below the 26/27 national target. The decrease in overall performance relates to type 3 performance decreasing due to a mismatch between demand and	A full recovery plan has been shared with Board as part of the June and September submissions to NHSE. The recovery plan is profiled as follows: • Improvements in UTC streaming and redirection from July through to January including additional commissioning of primary care emergency slots, optimising pharmacy first and direct bookings via 111 and reviewing wound care commissioning for winter • Improvements in UTC capacity and process from August with additional capacity via an additional GP shift 12-8pm, 7 days a week, and

Metric	August reported position	Action/response
	capacity on certain days of the week with August attendances overall remaining high compared to previous years.. Total % over 12 hours (Type 1) in August was 15.6% increased by 1.5% from the previous month. Any prolonged length of stay in ED leads to overcrowding and subsequent delays in ambulance offload.	implementation of GIRFT national best practice for acuity based triage and navigation • Improvements in main ED capacity and process with the implementation of a revised roster to reduce breaches and an additional consultant from 4pm-10pm at weekends to improve time to assessment • Reduction in diagnostic delays across the front door through increased access to ultrasound and point of care testing from September and testing of a mobile imaging car for virtual ward from August • Reduction in breaches due to bed capacity from the main ED from October through the realisation of benefits from the Right Care flow programme and whole system flow improvements to reduce discharge ready delays on specialty wards • Improvements in children's emergency unit 4 hour performance with return to plan by January following implementation of integrated clinical pathways with the Paediatric Assessment Unit
RTT performance	 RTT performance is provisionally reported at 57.7% for August, broadly maintained compared to July and reflecting the continued impact of targeted recovery actions across a number of specialties. Whilst performance has stabilised, it remains adverse to operating plan of 62%. The Trust's RTT waiting list remains well controlled at 43,128 pathways, performing favourably against the planned position of 44,000 pathways. This represents a further	There were 18 patients waiting over 65 weeks at month-end, an increase of four patients compared to July, highlighting the need for continued focus on the identification and treatment of very long waiters. Overall, the August position demonstrates continued progress against key recovery indicators, with maintenance of headline RTT performance, a further reduction in the overall waiting list, and a significant reduction in the 52-week cohort. Whilst the increase in 65-week waits remains an area of concern, the overall trajectory continues to move in the right

Metric	August reported position	Action/response
	reduction from July and reflects continued management of pathway growth despite ongoing demand pressures. Maintaining control of the PTL remains a critical enabler for creating the operational headroom required to support sustainable RTT recovery. The provisional long-wait position has improved further, with 1,000 patients waiting over 52 weeks, equivalent to approximately 2.3% of the RTT waiting list. This represents a reduction of 107 patients compared to July and demonstrates continued progress in reducing the longest-wait cohort	direction, with continued PTL control providing a strong foundation for further RTT improvement over the remainder of the year. A full recovery plan has been shared with Board as part of the June and September submissions to NHSE.
Cancer performance	 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. 39% of the 63.5 breaches allocated to GWH were on a Urology pathway 31D performance fell short in July due to capacity issues in outpatients. Of the 27 pathways that breaches, 13 were in Skin. Faster Diagnosis in July was impacted by outpatient capacity where these delays accounted for 44% of the breaches. Colorectal was responsible for 40% of the breaches, where the bulk were as a result of outpatient capacity. Gynae pathways accounted for 15% of the breaches where admin delays accounted for the bulk of the breaches, these breaches include pathology reporting delays	A full recovery plan has been shared with Board as part of the June and September submissions to NHSE. Weekly performance review meetings remain in place with specialty level action plans. Weekly PTL meetings with all services and support services to ensure that each patient on the PTL is reviewed and has a next action. • Derm & Plastics (challenges with OUH capacity to meet SLA requirements). • Urology –Pathways being impacted by delays to reporting of radiology due to capacity as a result of vacancies, and delays to PET scans in Oxford for patients on a Prostate pathway • Colorectal – triage delays & 1st OPA capacity post triage and surgical capacity • Increasing referral numbers and the pathway delays discussed in the Faster Diagnosis and 62-day treatment slides also impact the length of time a pathway is open.

Metric	August reported position	Action/response
Infection and prevention \	 Cases of C. difficile, E. coli and Klebsiella reduced in August, although rates remain above the South West average. Review of cases has identified opportunities to strengthen fundamental care and infection prevention practices	A Trust-wide improvement programme is being implemented to support consistent safe practice, reduce avoidable infections, and improve patient outcomes. There has been an increase in Methicillin-Sensitive Staphylococcus aureus (MSSA) cases from 6 in July to 8 in August. GWH remains above the South West average. Skin and soft tissue remain the primary cause of infection, alongside a growing pneumonia case load seen in quarter 2, with contributory factors associated with peripheral access devices. The identified improvement opportunities are relevant across several infection prevention priorities, with a focus on a consistent approach to safe practice during clinical procedures.
Finance	 At the end of Month 5, the Trust has reported a £17.7m deficit, which is £13.2m worse than planned. The key drivers are - Shortfalls in delivery of CIP plans, including specialty level schemes, outpatients, corporate services redesign, group level schemes Hunter healthcare identified. - Ongoing pressures of UEC demand in excess of capacity and planned activity levels. Resulting in higher bank and locum usage than plan. - Sickness levels across key workforce groups higher than plan.	Financial recovery actions are in train including a continuation of workforce controls with focus on rostering controls for nursing, medical staffing control group, targeted reduction of locum consultants. Discretionary spend panel, reviewing all non pay costs to reduce run rate. Focus on delivery of identified CIP schemes to accelerate delivery or unblock any barriers. Hunter Healthcare contract stops at the end of September so handover of scheme identification is underway to ensure delivery of identified opportunities are achieved.

2.2 Cross-domain analysis

Operational demand and impaired flow remain the strongest common drivers across the assurance domains. High occupancy and corridor care affect quality and patient experience, constrain elective capacity and increase the need for escalation staffing. The recovery position is therefore dependent on both internal flow improvement and system action on discharge, supported capacity and demand management.

The planned-care position combines positive volume delivery. The controlled overall waiting-list size and improved cancer standards provide a platform for recovery. The recovery plan remains focused on harm review, specialty trajectories, workforce and diagnostic capacity, and the reliability of data ahead of EPR migration.

Financial and workforce recovery are closely linked. Agency control is positive, but substantive and bank staffing remain above plan predominately related to capacity above funded levels. Focus internally remains on tight rostering, improvements internally to reduce length of stay and therefore the need for as many escalation beds whilst working with system partners to expedite discharges.

Capital, estate and digital dependencies compound delivery risk. EPR, PFI expiry, Building Safety Act compliance, theatre ventilation, maternity triage and Sterile Services all draw on the same limited clinical, managerial, digital and corporate capacity. Prioritisation and sequencing decisions are therefore required at organisational and Group level to maintain focus on delivery.

3. Assurance Committee Summary

Committee / route	Key focus	Assurance received	Escalations/Board visibility
Quality & Safety Committee	August quality position and Integrated Performance Report Nutrition and hydration deep dive Maternity and neonatal oversight and 10 Point Plan baseline Divisional governance, gynecology, learning from deaths and PSIF Safe staffing, transfusion safety, digital clinical safety and CQC preparedness	Reported harms reduced overall, although severity worsened. Deconditioning improved, with 48% of inpatients sitting out for lunch. Hip-fracture mortality was in line with the national average and the service was no longer a national outlier. Cervical screening met most national standards, with strong governance and patient feedback. Mortality indicators remained within expected ranges; safe staffing processes and CQC preparedness governance were established	Patient flow, corridor care and four-hour performance, with impact on timely assessment, privacy, dignity and experience. Five falls caused moderate harm or above; bloodstream infections remained above the South West average. Stroke pathway risk remained high, with SSNAP at level E and inconsistent whole-pathway reliability. Maternity triage estate and timeliness of review; neonatal establishments below BAPM standards. Overdue incidents, Duty of Candour, risk reviews and actions; gynaecology pathway ownership; theatre cancellations. Board visibility of GWH-1267, GWH-570, GWH-1560, GWH-1577 and GWH-1382.

Committee / route	Key focus	Assurance received	Escalations/Board visibility
People & Culture Committee	Workforce WTE and pay against plan, sickness and temporary staffing Freedom to Speak Up, Staff Survey and Psychological Safety Medical learner experience and NETS action planning EDI and transgender inclusion Workforce risks, leadership capacity and Fit and Proper Person Test assurance	GWH sickness compared positively with the Group, despite the recent increase. Responsible Officer and medical governance arrangements provided strong assurance. A dedicated Freedom to Speak Up Lead Guardian improved accessibility, oversight and thematic reporting. Radiology roster redesign reduced bank use and delivered 800 additional scans in July. Plans were in place for the Staff Survey and flu campaign. All four GWH Executive FPPT files reviewed were compliant with the national framework	Sickness rose to 4.86%, above the 3.5% Trust target. GWH-1382 Interventional Radiology and GWH-1493 clinical leadership capacity both scored 12 with minimal assurance and overdue reviews. FTSU showed a material gap between feeling safe to speak up and confidence that concerns would be addressed. NETS themes included bullying, discrimination, sexual safety, wellbeing and specialty-level quality concerns. EDI gaps remained in opportunity, senior representation and pay; temporary staffing fill and nursing expenditure needed scrutiny.
Finance, Performance & Infrastructure Committee	Operational recovery across UEC, RTT, cancer and diagnostics Month 5 financial position, efficiency delivery and productivity Recovery plan credibility, trajectories and system dependencies Digital and EPR readiness, cyber and clinical safety capacity Estates, capital, Premises Assurance, health and safety, Sterile Services and Way Forward risks	Elective activity and the overall waiting-list position provided a basis for recovery, although long waits remained a concern. Cancer performance improved across the principal standards and Cancer 360 strengthened visibility. Month 5 efficiency delivery improved compared with earlier months, but remained below plan. Estates and Facilities reported good assurance, including progress on fire safety, lifecycle delivery and condition survey mobilisation. Premises Assurance showed four of five scored domains equivalent to Good or above; health and safety performance was positive. Cyber assurance was positive with no material incident reported in the period, while residual risk remained managed	UEC remained below trajectory, with corridor care, bed pressure, ambulance handovers and discharge dependencies affecting delivery and cost. RTT long waits, overdue follow-ups, cancer and diagnostic constraints required explicit harm and delivery assurance. Month 5 deficit and efficiency shortfall, weak recurrent delivery and workforce growth above plan required Board visibility. Capital commitments exceeded available funding; PFI, Building Safety Act, theatre ventilation and suboptimal environments remained material risks. • Shared EPR readiness, clinical safety officer capacity, training release, devices, data quality and portfolio capacity required decisions. • Board visibility of the integrated recovery position, recurrent

Committee / route	Key focus	Assurance received	Escalations/Board visibility
			savings, system dependencies and the 12+ risk profile
Senior Leadership Committee	Integrated review of performance, quality, workforce, finance and transformation Winter resilience, patient flow and whole-hospital recovery Long waits, cancer, diagnostics and overdue follow-ups EPR readiness, digital dependencies and organizational capacity Capital, estate, corporate projects, patient experience, EDI and the corporate risk profile	Elective activity was 104.5% of plan year to date and the total RTT waiting list remained below planned size. Cancer measures improved and Cancer 360 strengthened pathway oversight. Agency use remained controlled below plan; deconditioning improvement continued. EPRR reported substantial compliance with 60 of 62 applicable core standards. Health, Safety, Fire and Security exceeded Quarter 1 KPIs; the corporate projects portfolio had established oversight. FTSU, patient experience, GIRFT, EDI and ORBIT governance continued to mature.	UEC performance, ambulance handovers, corridor care and the residual winter bed and system-capacity gap. RTT at 57.7%, long waits and an outpatient follow-up backlog exceeding 32,000, including more than 10,000 overdue by over one year. Month 5 deficit of £17.7m, £13.2m adverse to plan; efficiency delivery £8.53m against £14.96m plan with weak recurrent benefit. . Shared EPR moved to Red because of testing, integration and readiness pressures. Capital pressure, PFI and estate constraints; stroke and clinical leadership risks; psychological safety and organisational response. Escalation of all ten approved 12+ risks, with particular Board focus on stroke, flow, finance, capital and estates

4. Deep Dive / Other Business

4.1 EPR readiness and organisational capacity

EPR readiness is now a principal organisational risk and will be reflected on the risk register from September.

There is significant work being undertaken as part of the organisational readiness preparation. The required decisions extend beyond programme delivery and include training release and backfill, temporary activity reduction, sufficient subject matter experts, devices, data quality, outcomes backlogs, clinical safety, archives, RPA and legacy-system retirement.

The programme competes directly with recovery and transformation activity for clinical, managerial, digital and corporate resource. The deputy COO alongside the deputy CNO and Chief clinical information officer are leading the work (alongside their substantive roles). The revenue financial implications of the EPR in to 2027/28 are being developed (e.g. backfill for training costs) but highlight a material cost pressure into next

years planning which is a challenge in the context of the financial recovery outlook and ongoing regulatory concerns.

5. Maternity and Neonatal Services

Maternity services were considered as part of the Quality and safety committee, the summary was:

Alert

- Neonatal medical staffing remains non-compliant with BAPM Tier 2 standards for night and weekend cover.
- GWH remains non-compliant with national standards for high-risk neonatal follow-up and was identified as an NNAP Alarm outlier. Improvement work is underway to strengthen follow-up pathways and specialist oversight.
- Estate constraints across maternity triage, day assessment, antenatal clinic and theatre services continue to affect patient flow and service resilience during periods of escalation. Operational processes remain in place to support safe care and manage demand pressures.

Advise

- Maternity Care Bundle implementation is progressing under designated leads, with governance oversight in place. Delivery of some elements remains dependent on cross-divisional and external partner support

- Increasing maternity theatre activity continues to place pressure on maternity, perioperative and anaesthetic workforce capacity, with staffing not fully aligned to AfPP recommendations.

- BR+ completion remains below target and maternity acuity compliance has reduced during the reporting period.

- Review of maternity service and staffing models is underway to ensure alignment with current and future activity levels.

- CNST Year 8 preparations are progressing, with safety leads identified and improvement plans in development across all domains.

Assure

- PQOM provides a structured framework for proactive oversight, escalation, and Board assurance across maternity and neonatal services.

- Enhanced neonatal operational oversight, daily staffing and capacity reviews, and ODN escalation processes remain in place to support safe care delivery.

- No patient safety incidents associated with theatre pressures, neonatal capacity challenges, or acuity and flow pressures have been identified during the reporting period.

- Risks continue to be monitored through established governance structures, with mitigations in place and ongoing quality improvement activity supporting safe and sustainable service delivery.

6. Risk Escalation

The corporate risk register applies the 5+5=5 methodology with residual scores calculated as likelihood, impact and controls effectiveness. Risks scoring 12 and above are reported to Group Board. The following table using the actual residual scores.

Risk ID	Title	Score	Board-level concern
GWH-570	**Surgical Assessment Unit patient safety**	5+4+3=12	**Controls** Three daily divisional huddles on weekdays to monitor SAU demand and pressures. Daily 9am safety and quality meeting covering acuity, staffing and immediate concerns. Matron of the Day oversight and escalation. Admission criteria and escalation protocols. Rapid triage arrangements. Real-time dashboards covering occupancy, acuity, flow and assessment delays. Coordination with ED, theatres and inpatient wards. **Actions** Use the completed triage-room audit and submitted SBAR to seek a maximum of 12 trolley spaces in Dorcan. Review the impact of the second registrar and introduce monthly monitoring of first assessment and senior review KPIs.
GWH-1085	**High hospital occupancy and impaired patient flow**	5+4+3=12	**Controls** Additional cohort and escalation capacity. Seasonal-plan interventions. Enhanced safety and welfare checks and immediate escalation of concerns. Nerve Centre information supporting patient placement and quality review. Emergency Zone Operational Group and system-partner coordination. NCTR improvement plan. UEC and Flow Programme. Length-of-stay breakthrough objective. Corridor-care monitoring and the site escalation policy. Medical Short-Stay Unit opened in July 2026. **Actions** Monitor Virtual Ward referrals and appropriateness, including the possible effect of the community contract change. Implement GIRFT recommendations. Review OPEL action cards. System ICB recovery plan actions
GWH-1267	**Stroke pathway quality and timely access to care**.	4+5+4= 13	**Controls in place** Operational and performance management oversight of SSNAP data entry. Revised Stroke Unit SOP, including two ring-fenced beds on Falcon Ward. Cross-divisional SSNAP recovery plan. Active safeguarding of dedicated stroke beds to support timely specialist admission. Monthly performance dashboard issued to domain leads.

Risk ID	Title	Score	Board-level concern
			Monthly escalation and oversight with the Chief Medical Officer. Stroke performance included as a Trust-wide driver metric. Control effectiveness assessed through independently benchmarked quarterly SSNAP reporting. **Actions** Complete a comprehensive review of the therapy service, including staffing patterns and the factors affecting stroke pathway performance. Undertake therapy demand and capacity modelling to align resources with patient need and identify improvement opportunities. Consider ACP staffing model
GWH-1382	**Interventional Radiology workforce resilience**	4+4+4=12	**Controls** Clinical triage to determine whether patients can wait or require transfer. Transfer of urgent cases to tertiary providers. Limited bank and agency cover. Third-party provider SLA. NHS England support for a hub-and-spoke model. Emergency support arrangements with NBT and Gloucestershire. Monitoring of activity, transfers, delays and use of temporary cover. **Actions** Confirm the future regional IR model with GWH and partner providers. Maintain contracted external cover for two days per week during 2026/27 unless recruitment succeeds. Agree formal emergency and out-of-hours SLAs. Continue executive and network discussions with surrounding tertiary hospitals. Progress substantive recruitment.
GWH-1401	**Building Safety Act compliance and liability risks**	5+3+4=12	**Controls** Oversight through senior Trust governance. Monthly risk review. Legal advice from Bevan Brittan on the Trust's position and the Higher-Risk Building boundary. Engagement with the Building Safety Regulator and Building Control. Regulatory submissions covering relevant GWH developments. Serco acting as Principal Designer/Contractor, with competence checks being finalised. Monitoring through TMC and FIDC. **Actions** Test the proposed legal approach with the Building Safety Regulator. Resolve Principal Contractor qualification requirements with the PFI provider and Serco. Determine whether any part of the GWH building can sit outside the Building Safety Act regime. Escalate the need for an alternative competent contractor. Maintain reporting to senior governance forums.

Risk ID	Title	Score	Board-level concern
GWH-1493	**Insufficient clinical leadership capacity and development**	4+4+4=12	**Controls** Appointment of a new deputy Chief Medical Officer. Support from existing associate medical director and executive leadership capacity. Triumvirate Clinical Leadership Programme. Essential Management Skills programme for clinical leads. Monitoring of programme participation, completion and leadership workforce indicators. **Actions** Progress the Deputy CMO clinical transformation role. Redesign medical leadership roles and structure. Review the consultant leadership-development offer with BSW and produce an options appraisal. Complete a needs assessment, gap analysis and review of internal, external and funding options.
GWH-1560	**The footprint of the Maternity Care Centre and Day Assessment Unit is not adequate to fulfil the demand.**	4+4+4=12	**Controls** Completed environmental risk assessment. Emergency buzzer arrangements. Annual PROMPT obstetric emergency training. Maternity Early Warning Score system for recognising and escalating deterioration. Supporting assurance through training records, drills, incident reviews, audits and governance monitoring. **Actions** Implement an SOP for responding to obstetric emergencies in the Maternity Care Centre. Develop construction, service-relocation and operational-impact plans. Prepare the capital case for reconfiguration. Introduce a Flow Midwife. Repurpose office space into a clinic room following removal of carpeting.
GWH-1576	**Failure to deliver planned improvement programme**	5+4+4=13	**Controls in place** Financial governance arrangements with defined savings targets, timelines and accountable owners. Regular financial reporting to track delivery, forecast variances and support decisions. External expertise used where internal capacity is insufficient. Corporate project oversight to identify overlaps, resource constraints and priorities. Monthly executive review meetings linked to breakthrough objectives. Monthly Financial Improvement Programme Board oversight of progress, risks, mitigating actions and forecast delivery. Delivery remains dependent on recurrent savings pipeline and operational pressure constrain clinical and management capacity. **Actions:** recovery action plan

Risk ID	Title	Score	Board-level concern
GWH-1577	**Suboptimal clinical environment affecting care quality and patient experience**	4+4+4=12	**Controls** Trust executive oversight. Infection prevention and control audits and improvement arrangements. Patient feedback and duty-of-candour arrangements. Health and safety assessments and monitoring. Divisional review of environmental risks. Capital bids for high-risk areas, including maternity triage. Way Forward capital master planning. Use of Medical Short-Stay Unit decant capacity to enable refurbishment. **Action** Map, review and connect Trust risks relating to the broader clinical-environment theme.
GWH-1608	**Insufficient capital funding for estate betterment and PFI hand back readiness**	4+4+4=12	**Controls** Trust-approved PFI Expiry Capital and Betterment Plan. Prioritisation informed by condition surveys and overseen through EFM governance. Engagement with system, IPA and DHSC routes to identify funding. Resourced PFI Expiry Programme Plan identifying critical activity and resource requirements. Reporting of progress, capacity constraints and funding assumptions. Application to charitable funds for betterment works. **Actions** Define the balance between internal resource, external specialist support and capital or revenue funding. Escalate material capacity and funding constraints through the corporate risk framework. Identify expiry-critical activities, required skills and internal capacity gaps. Introduce regular capacity and cost reporting. Secure targeted specialist support where internal capacity is insufficient.

6.1 Risk narrative

The ten approved corporate risks are mutually reinforcing. Demand and flow pressures affect safety, access, workforce cost and financial recovery. Workforce fragility limits the pace of clinical improvement and transformation. Capital and estate constraints restrict sustainable solutions, while EPR implementation competes for the same delivery capacity. No risk is supported by fully effective controls.

7. Care Organisation Context

The August position shows a Care Organisation with established governance and active improvement work, but with limited headroom to deliver multiple recovery, safety, digital and estate priorities concurrently. The key focus remains on:

- Sustained improvement in UEC flow, ambulance handovers, corridor care and discharge delay, including system dependencies.

- RTT long-wait and overdue follow-up recovery, with explicit clinical harm assurance and EPR migration controls.
- Recurrent financial improvement and workforce run-rate reduction, linked through one quality-assured trajectory.
- Stroke recovery, Interventional Radiology resilience, Surgical Assessment Unit safety and challenged pathways.
- Maternity triage, neonatal workforce and delivery of the NHS England 10 Point Plan actions.
- Risk-led capital prioritisation covering PFI betterment, Building Safety Act, theatre ventilation, Sterile Services and clinical environments.
- EPR readiness decisions on training, activity impact, SMEs, devices, data, clinical safety and legacy-system retirement.
- Visible feedback and measurable action in response to FTSU, staff experience, NETS and EDI intelligence.

BSW Hospitals Group Executive Committee

Agenda item	3.3
Report title	Managing Directors Report – Salisbury NHS FT
Date of meeting	13th October 2-26
Sponsor	Cara Charles-Barks, CEO
Prepared by	Nick Johnson – Managing Director SFT
Approval Process: (where has this paper been reviewed and approved)	N/A – produced following Care Organisation Management Committee

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
	All BAF risks are affected by the content of this report.

KEY MESSAGES

SFT continues to deliver predominantly safe care and is maintaining progress in cancer recovery, productivity and national oversight performance. However, urgent and emergency care remains materially below plan, stroke performance is significantly challenged, workforce availability has deteriorated and pressure injury performance remains above target without evidence of sustained improvement.

The combination of operational cost pressures and non-delivery of planned coding and clinical transformation benefits means the original break-even financial plan is no longer considered achievable. The Trust's current likely forecast is a **£13.1m deficit**, assuming completion of the

key worker accommodation transaction and (an additional to SFT work) reduction in NCTR following additional ICB-led demand-management work. Failure to secure either assumption would worsen the forecast.

RECOMMENDATION

The Group Executive Committee is asked to:

- Receive and note the performance, quality, workforce and financial position.
- Note that SFT no longer expects to deliver the original break-even plan, with a current likely forecast of a £13.1m deficit, subject to delivery of key assumptions.
- Note the urgent and emergency care recovery arrangements and the continued impact of poor flow on access, quality, workforce and finance.
- Note the deterioration in stroke performance and the actions being taken to restore therapy and acute pathway performance.
- Support continued Group oversight of the key worker accommodation transaction, coding delivery, clinical transformation, EPR affordability, cash support and system action to reduce NCTR.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Quality and Safety Committee Escalation Report	
Finance and Performance Committee Escalation Report	
People and Culture Committee Escalation Report	

1. ALERT ADVISE ASSURE

ALERT

Financial sustainability and recovery

The Trust reported a £3.3m year-to-date deficit at Month 5, in line with the phased plan, including deficit support and transitional funding brought forward into August. This reported position does not, however, reflect the likely full-year outcome. Operational cost pressures, particularly those associated with urgent care, high workforce unavailability, premium staffing and sustained escalation capacity, are being compounded by the non-delivery of planned coding and clinical transformation schemes. As a result, the Trust does not expect to deliver the original break-even plan.

The current likely forecast is a £13.1m deficit. This assumes that:

- the key worker accommodation transaction completes as planned;
- additional ICB demand-management work reduces NCTR and associated bed and workforce costs;
- existing recovery schemes continue to deliver; and
- further deterioration in operational performance is avoided.

The £13.1m position should therefore be regarded as conditional rather than secured. Non-delivery of the key worker accommodation transaction, failure to reduce NCTR or continued slippage in coding and clinical transformation would result in a higher deficit.

The Trust delivered £9.3m of CIP against a £10.3m year-to-date target. Although the £32.5m annual programme is more than fully identified, delivery is weighted towards the second half of the year and remains dependent on a number of schemes that are not yet delivering at the required pace. The CIP Cell, divisional recovery huddles, Delivery Group and internal turnaround team continue to provide scheme-level oversight, develop replacement opportunities and track recurrent run-rate improvement rather than relying solely on reported in-year savings.

Cash sustainability

Cash remains a critical and immediate risk. COMC approved submission of a £14.3m Revenue Support PDC application covering November 2026 to March 2027. Without this support, cash balances would fall below the DHSC minimum requirement of £2.122m, requiring significant restrictions to supplier payment runs and creating risks to medicines, consumables, operational continuity and Better Payment Practice Code performance. Daily cash monitoring, expenditure controls, debt collection and active management of supplier payments remain in place.

The need for Revenue Support PDC reflects working-capital pressures, repayment of income received but not earned in 2025/26 and the underlying deficit position. The cash requirement reinforces the urgency of improving recurrent financial performance and reducing reliance on non-recurrent mitigations.

Urgent and emergency care

Urgent and emergency care remains the principal operational challenge and performance continues to be poor. Four-hour performance improved marginally to 67.3%, but remained significantly below the 78.5% Month 5 plan. Average ambulance handover time deteriorated from 26 to 37.1 minutes, handovers exceeding 45 minutes increased from 117 to 301, and ED 12-hour

breaches increased from 663 to 885. Bed occupancy increased to 96.7%, with corridor and escalation care also increasing.

NCTR reduced marginally from 80 to 76 patients, but remains materially above the target of 45. The continuing delay in discharging patients who no longer require acute care is contributing directly to high occupancy, ED crowding, ambulance handover delays, escalation care, premium staffing expenditure and the Trust's financial forecast.

A comprehensive UEC recovery plan is in place and being managed through the UEC Board. The principal actions are:

- opening the Urgent Treatment Centre;
- expanding medical, surgical and frailty Same Day Emergency Care pathways;
- introducing the national streaming and redirection tool;
- expanding ED Majors capacity;
- relocating Rapid Assessment, Treatment and Triage closer to the ambulance entrance;
- strengthening alternatives to conveyance with SWAST;
- improving real-time demand and waiting-time information;
- implementing the findings of the Wiltshire discharge review; and
- working with the ICB on additional demand-management and community interventions.

COMC received assurance that governance and monitoring arrangements are in place, but recognised that the current actions have not yet delivered a sustained recovery in access performance. The Quality and Safety Committee has also been asked to strengthen the identification and monitoring of harm associated with prolonged waits, corridor care and delayed flow.

Stroke performance

Stroke performance is significantly below the expected standard and requires focused recovery. In August, only 22% of stroke patients received a CT scan within one hour of arrival, down from 71% two months earlier. Average motor therapy provision reduced to 32 minutes per patient per day, against a target of 120 minutes, and SFT has remained at an SSNAP rating of E for four consecutive quarters. Delayed access to the stroke unit, particularly out of hours, is being exacerbated by ED crowding and wider flow pressures.

Therapy workforce availability is a material contributor, with group gym sessions cancelled during periods of staff absence despite redeployment and reductions in outpatient activity. Recruitment to the approved 5.25 WTE stroke therapy investment is underway. A stroke performance dashboard is being introduced alongside enhanced training for stroke bleep holders, thrombolysis and NIHSS assessment, a structured rehabilitation timetable and an Improving Together A3 focused on four-hour stroke pathway performance. CT perfusion scanning has also commenced, strengthening hyper-acute assessment for selected patients.

COMC received assurance that no additional material safety concerns had been identified beyond those already recognised through workforce, therapy and access constraints. Nevertheless, current performance remains unacceptable and requires sustained executive and divisional oversight.

ADVISE

Elective access and diagnostics

RTT performance reduced to 69.6%, below the 71.2% Month 5 trajectory for the first time in more than a year. Patients waiting more than 52 weeks increased from 118 to 126, and those waiting more than 65 weeks increased from four to eight. Time to first outpatient appointment increased from 101 to 107 days, although this remains materially improved against the 139-day baseline.

DM01 performance deteriorated to 81.6% against an 88.9% plan, its lowest level since May 2025. Audiology vacancies, Cardiology and Endoscopy sickness, booking performance and Cardiac CT capacity remain the principal constraints. Recovery actions include additional Cardiac CT capacity, recruitment within Audiology, improved Endoscopy utilisation and intensive support for Central Booking.

Central Booking is within a 12-week intensive-support programme, with continuous recruitment, competency-based training, daily huddles, backlog trajectories and a real-time performance dashboard being developed. Although there are signs of improvement, the service remains a material patient-safety, utilisation and income risk.

Cancer recovery

Cancer performance continued to improve. The 28-day Faster Diagnosis Standard increased to 79.5%, close to the 79.9% plan and continuing to demonstrate special-cause improvement. The 62-day standard increased to 73.5%, but remained below the 78.3% trajectory. The backlog increased from 56 to 74 patients, although the position remains improved compared with the previous 12 months.

Cancer 360 is live in Urology and Lung and is being extended to the remaining tumour sites. Timed pathway work, strengthened patient tracking, additional multidisciplinary team coordination and targeted diagnostic actions continue. Capacity in breast reconstruction, systemic anti-cancer therapy staffing and aseptic services remains a risk to sustained recovery.

EPR readiness and affordability

EPR readiness is progressing through the Organisational Readiness Group and specialty-level heat maps. Significant dependencies remain, including subject-matter expert capacity, the Clinical Safety Officer role, approximately £1.5m of training backfill, devices, data quality and legacy-system decommissioning.

These requirements create additional pressure on an organisation already managing financial recovery, winter delivery and workforce constraints. COMC has therefore escalated the need for explicit Group assurance on the cumulative affordability and operational consequences of EPR delivery at SFT.

Fertility Services

A fertility storage incident has been identified relating to the historical interpretation and application of commissioner funding arrangements for gamete and embryo storage. As a precaution, invoicing, debt recovery and storage-related decisions have been suspended while the Trust undertakes a comprehensive review. A multidisciplinary task-and-finish group has been established to oversee patient identification, governance, communications, Duty of Candour considerations and any wider clinical, legal, financial or reputational implications. Whilst there is currently no evidence of immediate patient harm, the matter remains under active executive oversight and will continue to be monitored through the Trust's quality governance arrangements.

Patient safety and Quality including CQC

Care Hours per Patient Day remain low, compared to Group comparators and bank shift fulfilment was approximately 60% in month. Wards continued to be staffed to amber. This means ward leaders and supernumerary posts are pulled in to the rota numbers to deliver care reducing their ability to train and manage the ward, for example sickness.

The Trust continues to make progress against a broad programme of quality, governance and operational improvement; however, the published CQC ratings and the continued presence of Regulation 12 warning notices remain significant matters of external scrutiny. Whilst the ratings reflect historical inspections and do not fully represent the current position of the organisation, the notices reinforce the need to maintain focus on urgent and emergency care, patient flow, workforce sustainability and quality governance.

ASSURE

Cancer recovery continues to provide evidence that structured pathway management and focused intervention can deliver improvement. The 28-day Faster Diagnosis Standard is showing special-cause improvement, the 62-day position improved in month, and the rollout of Cancer 360 is strengthening patient-level oversight.

Productivity remained broadly stable at -11.4%, representing continued improvement from the -15.0% baseline, although it remains substantially below the target of approximately -5.8%. Elective inpatient, outpatient and unplanned-care activity sustained the position despite annual leave, workforce unavailability and operational pressure.

The Trust's National Oversight Framework ranking improved from 79th to 48th of 134 organisations, with the average metric score improving from 2.38 to 2.29. The Trust remains in segment 3 because deficit support funding results in a financial override. NHS England's Level 2 review provided moderate assurance, recognising credible recovery governance and programme infrastructure.

Mortality remains within the expected range, with a rolling SHMI of 0.9451. Call for Concern and Martha's Rule arrangements are increasingly embedded, and NHS England has reduced direct oversight of the current neonatal audiology service following improved assurance.

1.2 Key Achievements and Good News

- The Trust improved its national oversight ranking from 79th to 48th of 134 organisations.
- The 28-day cancer standard improved to 79.5% and continues to demonstrate special-cause improvement.
- The 62-day cancer standard improved to 73.5%, supported by pathway redesign and Cancer 360.
- SFT maintained 100% one-to-one care in labour and 100% supernumerary labour ward coordinator cover.
- Medical appraisal compliance increased to 92.4%, above target for the third consecutive month.
- Patient-led validation continues to support elective recovery, with an 8% removal rate among responding patients.
- The national Joint Investment Committee supported progression of DASH from outline to full business case.
- CT perfusion scanning has commenced for selected hyper-acute stroke patients, strengthening diagnostic capability.
- Overdue policies reduced from 82 in January to 51 in September.
- Surgery received national recognition for improvements in the skin-cancer pathway

Section 2: Performance Triangulation

2.1 SPC Variation

Sustained improvement

- Cancer 28-day Faster Diagnosis: 79.5%, continuing special-cause improvement and remaining close to the 80% standard.
- Productivity: -11.4%, retaining special-cause improvement against the -15.0% baseline, although materially below target.
- Complaints closed within agreed timescales: continued special-cause improvement.
- Medical appraisal compliance: 92.4%, above the 90% target for three consecutive months.
- Mixed-sex accommodation: remains below the historical mean, with relatively few patients affected.

Adverse variation or performance requiring intervention

- Ambulance handovers: 37.1 minutes, demonstrating special-cause concern.
- Handovers exceeding 45 minutes: increased to 301 and remained above the statistical upper control limit.
- ED 12-hour breaches: increased to 885.
- Stroke CT within one hour: reduced from 71% two months earlier to 22%.
- Stroke motor therapy: 32 minutes per patient per day against a target of 120 minutes.
- Sickness absence: 4.65%, remaining a special-cause concern.
- RTT: reduced to 69.6%, below plan for the first time in over a year.
- Diagnostics: reduced to 81.6%, with deterioration across imaging and capacity constraints in Cardiac CT, Endoscopy and Audiology.
- Staff unavailability: increased to 25.7%, its highest level since December 2025.

Common-cause variation without sustained improvement

- Pressure injuries: reduced in month to 2.5 per 1,000 occupied bed days, but remain within common-cause variation and above the 1.5 target. There is not yet evidence that the prevention system has achieved a sustained improvement.
- ED four-hour performance: improved marginally to 67.3%, but remains within common-cause variation and materially below plan.
- NCTR: reduced marginally to 76, but remains within common-cause variation and materially above the target of 45.
- Temporary escalation and corridor care: increased in August and remains within common-cause variation at an unacceptable level.

The SPC position demonstrates targeted improvement in cancer, productivity and selected governance measures, but no sustained recovery in the areas creating the greatest organisational pressure. UEC, NCTR, workforce availability, diagnostics and stroke remain the principal performance concerns.

The in-month reduction in pressure injuries is welcome but does not yet constitute a statistically reliable improvement. Similarly, the marginal improvement in ED four-hour performance does not alter the underlying UEC position. Recovery plans are in place, but these now need to demonstrate measurable and sustained movement rather than continued common-cause variation.

2.2 Cross-Domain Analysis

1. Domain	Current Position	Actions Underway
Quality & Safety	Pressure injuries remain above target without sustained statistical improvement. Stroke access and therapy performance are materially below standard. Potential harm associated with corridor care and prolonged waits requires further assurance and monitoring.	PURPOSE-T implementation, continence pathway redesign, stroke therapy recruitment, Stroke Improvement A3, revised mortality review prompts and strengthened oversight of harm associated with corridor care and delayed flow.
Access & Flow	ED 4-hour performance remains materially below plan. Ambulance handovers and 12-hour breaches deteriorated during August, with NCTR remaining at 76 and occupancy at 96.7%.	Urgent Treatment Centre mobilisation, SDEC expansion, ED Majors capacity, relocation of RATT, implementation of the national streaming tool, Wiltshire discharge review actions and additional ICB demand-management work.
Elective, Cancer & Diagnostics	Cancer performance continues to improve, however RTT has fallen below trajectory, long waits have increased and diagnostics performance has deteriorated. Central Booking remains a material utilisation and patient-safety risk.	Patient-led validation, Advice & Refer, Cancer 360 implementation, specialty pathway redesign, Central Booking intensive support programme, Cardiac CT expansion and Audiology recruitment.
Workforce & Finance	Staff unavailability is 25.7% and premium staffing expenditure remains above plan. The Trust now forecasts a likely £13.1m deficit rather than break-even, driven by operational pressures and delayed delivery of coding and clinical transformation benefits.	Refreshed sickness A3, Strategic Workforce Forum, divisional recovery huddles, CIP Cell, coding improvement programme, clinical transformation delivery and active management of KWA and NCTR dependencies.
Transformation & Infrastructure	EPR readiness is progressing, but affordability, workforce and capacity dependencies remain significant. Capital headroom remains severely constrained.	Specialty readiness heat maps, Group escalation of EPR resource requirements, DASH Full Business Case development, value engineering and risk-based capital prioritisation.

2.3 Assurance Committee Summary

Committee	Assurance Level	Key Focus Areas	Unresolved / Escalated
Quality & Safety Committee	Limited Assurance	UEC-related harm, stroke performance, pressure injuries, maternity 10-Point Plan, fertility storage incident, paediatric diabetes and audiology oversight.	Stroke access and therapy performance; evidence of harm associated with corridor care; maternity triage and second obstetric theatre capacity; fertility storage incident; paediatric diabetes sustainability concerns.
Finance & Performance Committee	Limited Assurance	Financial recovery, cash sustainability, CIP delivery, urgent care performance, winter planning, Central Booking, EPR readiness, capital programme and DASH.	Likely £13.1m deficit; £14.3m Revenue Support PDC dependency; non-delivery of coding and clinical transformation benefits; NCTR performance; EPR affordability; limited capital headroom.

People & Culture Committee	Limited Assurance	Staff unavailability, sickness absence, workforce affordability, mandatory training, appraisal compliance, EDI and organisational change capacity.	25.7% staff unavailability; premium staffing expenditure; appraisal compliance; workforce plan delivery; HR, OD and change-management capacity.

2.3 Plan position

2026/27 Business Plan Scorecard

Performance against trajectory (in year)

Domain	Metric	26/27 NHSE Instruction	Current Month Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26
UEC	ED Attendance Growth	*Versus 25/26 actual*		3.7%	2.4%	-0.1%	3.2%	7.4%
	NEL Admission Growth	*Versus 25/26 actual*		1.6%	-5.4%	-2.4%	-8.7%	-8.3%
	Eliminating Corridor Care	*0> 45mins by Nov '26*		234	237	309	214	296
	4-hour ED performance (type 1)	*66.9% by Mar '27*	69.8%	57.4%	58.3%	50.3%	50.6%	49.8%
	4-hour ED performance (all types)	*82% by Mar '27*	78.4%	71.2%	73.0%	66.30%	66.6%	67.3%
	12-hour ED performance	*96.1%*	*Trajectory*	89.9%	90.7%	84.5%	87.4%	82.2%
	Ambulance handover	*Reduce toward 15 mins*	19 mins	22 mins	30 mins	37 mins	26 mins	37 mins
Elective & Diagnostic	GP Referral Growth	*Per planning assumption*		-1.4%	-4.8%	-4.4%	-14.00%	-5.00%
	18w RTT Performance		70.9%	71.5%	72.00%	72.47%	71.03%	tbc
	52 Week Waiters	*Reduction towards zero*	0	45	69	84	118	tbc
	52 Week Waiters %	*Improvement on 1%*	-	0.1%	0.1%	0.28%	0.40%	tbc
	Diagnostics 6 week wait	*10% Improvement*	89.3%	84.7%	87%	86.20%	84.70%	81.56%
Cancer	28 day FDS	*80% annual ave*	79.9%	79.4%	79%	78.9%	79.5%	tbc
	31 day	*94%*	93.6%	87.6%	96%	96.20%	93%	tbc
	62 day RTT	*80%*	78.3%	61.8%	75%	71.03%	73.5%	tbc
Workforce	30% Reduction in agency use	*30% improvement from M06*	*Trajectory*	41.26%	23.81%	30.46%	26.09%	19.93%
	10% reduction in bank spend	*10% reduction from M06*	*Trajectory*	-31.40%	-8.02%	-12.52%	-14.29%	-32.54%
	Sickness rate (rolling 12 month average)	*Improvement*	*Trajectory*	4.13%	4.18%	4.24%	4.33%	4.39%
Finance	2% productivity improvement	*(min 2% improvement)*		0.35%	0.19%	0.68%	0.33%	0.57%
	Savings Plan	*32.5m (£90.8m over 3 yrs)*		£1.4m	£1.8m	£1.8m	£2.0m	£2.3m
	Balanced or surplus financial position	*Balance or surplus*		£0.0m	£0.0m	£0.0m	£0.0m	£0.0m
Discharge	Non Criteria to Reside (NC2R)	*Number of NC2R*		81	73	77	80	76
	Pathway 0 - Home	*% within 24 hours*		61.1%	38.7%	30.5%	37.3%	55.6%
	Pathway 1 - Home with support	*% within 48 hours*		11.7%	9.9%	9.1%	10.4%	12.0%
	Pathway 2 - Community setting	*% within 48 hours*		14.0%	6.5%	7.3%	4.2%	13.8%
	Pathway 3 - Residential care	*% within 7 days*		16.7%	27.8%	36.4%	33.3%	21.0%

* draft - unvalidated position

Section 3: Deep Dives

3.1 Financial recovery, coding and clinical transformation

The Trust is on its phased financial position at Month 5, but the original break-even plan is no longer considered achievable. Operational cost pressures, including high NCTR, escalation capacity, workforce absence and premium staffing, have not reduced at the rate assumed in the plan. At the same time, coding improvement and clinical transformation schemes have not delivered the required benefits.

The current likely forecast is a £13.1m deficit, conditional on completion of the key worker accommodation transaction and a reduction in NCTR following additional ICB demand-management work. The forecast will worsen if these dependencies do not materialise.

The Trust has delivered £9.3m of CIP against a £10.3m year-to-date target. The immediate focus is on:

- accelerating recurrent delivery rather than relying on non-recurrent mitigation;
- recovering coding opportunities and associated productivity recognition;
- identifying alternatives to delayed clinical transformation schemes;
- reducing premium staffing and workforce costs;
- protecting elective and outpatient activity;
- completing the KWA transaction; and
- working with the ICB to reduce avoidable demand, NCTR and length of stay.

The key financial message is therefore not simply that the Trust has moved away from break-even. It is that recovery is dependent on resolving operational and transformation barriers, several of which are outside the direct control of the Care Organisation.

3.2 Urgent care, NCTR and winter

UEC performance remains poor. Four-hour performance is 67.3%, ambulance handovers average 37.1 minutes, 301 handovers exceeded 45 minutes and 885 patients spent more than 12 hours in ED. NCTR remains at 76 and occupancy at 96.7%. These measures describe a hospital operating with insufficient headroom and continuing reliance on escalation capacity.

The recovery plan is comprehensive and is now focused on changing the whole pathway rather than ED alone. The UTC, SDEC expansion, streaming and redirection, ED capacity changes, discharge improvement, alternatives to conveyance and ICB demand-management work are intended to reduce conversion, length of stay and NCTR.

The winter plan assumes demand 4.4% above the October-to-March mean, equivalent to approximately 48 additional attendances per week, and identifies an unmitigated requirement of up to 70 additional beds. Each intervention is being developed with clearer ownership, milestones, workforce, cost, quality impact and quantified contribution to the bed gap.

3.3 Stroke recovery

Stroke performance requires a dedicated recovery focus. Only 22% of patients received CT within one hour in August, motor therapy provision averaged 32 minutes against a 120-minute target, and SFT has remained at SSNAP rating E for four consecutive quarters. Flow constraints, delayed access to the stroke unit and therapy workforce gaps are the key causes.

The principal actions are:

- recruitment to the approved 5.25 WTE therapy establishment;
- implementation of the stroke performance dashboard;
- enhanced training for stroke bleep holders, NIHSS assessment and thrombolysis;
- structured rehabilitation and Therapy Link roles;
- the new treadmill facility;
- an Improving Together A3 focused on four-hour stroke access; and
- use of CT perfusion for selected hyper-acute presentations.

Progress will be monitored through divisional performance arrangements and COMC, with particular attention to whether additional workforce investment translates into measurable improvement in therapy intensity and SSNAP performance.

3.4 Workforce sustainability

Workforce unavailability remains a binding constraint on performance recovery and financial delivery. The Trust is above its workforce and pay plan, with staffing patterns differing materially from the original assumptions. Fewer administrative and clerical staff are contributing to constraints

in Central Booking and other operational support functions, while higher clinical and medical staffing reflects current demand, escalation and service requirements.

The workforce position is being managed through divisional recovery arrangements, attendance management, rostering, the Strategic Workforce Forum and enhanced temporary-staffing controls. However, operational recovery and workforce reduction must be managed together. A workforce reduction based on lower bed use cannot be achieved sustainably unless NCTR, length of stay and escalation capacity first reduce.

3.5 Maternity, neonatal and children's services

Immediate maternity safety controls remain effective, including full compliance with one-to-one care in labour and supernumerary coordinator cover. However, maternity triage, workforce and estates gaps mean SFT remains the Group's most challenged Care Organisation against the national 10-Point Plan. A deliverable response, including the approximately £6m investment requirement, is being prepared for Trust Board and NHS England review.

The second obstetric theatre risk remains formally escalated. Interim controls reduce immediate exposure but do not resolve the underlying infrastructure constraint.

Paediatric diabetes has emerged as a further service-sustainability concern. Diabetic ketoacidosis admissions are approximately double comparator averages, and improvements are required in workforce capacity, psychological support, point-of-care testing and school support. A time-bound recovery plan has been commissioned.

Section 4: Risk Escalation

Risk ID and Title	5+5+5 Score	Controls Assessment	Reason for Escalation and Action Underway
SFT-7573: Sustained use of escalation areas	13	Limited effectiveness	Escalation areas and corridor care continue to affect patient safety, experience and operational effectiveness. UEC recovery and winter interventions are underway, but occupancy and NCTR remain high.
SFT-8759: Unavailability of cash balances	13, under review	Limited effectiveness	A £14.3m Revenue Support PDC application is required to maintain minimum cash balances and normal supplier payments. Daily cash monitoring, payment controls and debt recovery remain in place.
SFT-8791: Financial position 2026/27	13	Limited effectiveness	Break-even is no longer expected. The likely forecast is a £13.1m deficit, conditional on delivery of the Key Worker Accommodation transaction and a reduction in NCTR. Planned coding and clinical transformation benefits remain undelivered.
SFT-8800: Failure to reduce NCTR to plan	13	Limited effectiveness	NCTR remains at 76 patients against a target of 45, contributing to high occupancy, escalation care, UEC underperformance and additional workforce costs. System discharge and ICB demand-management actions continue.
SFT-8789: Failure to meet emergency access standards	12	Limited effectiveness	ED four-hour performance, ambulance handovers and 12-hour breaches remain materially off plan. A comprehensive recovery plan is in place, including the UTC, expanded SDEC, additional ED capacity, streaming and redirection, and discharge improvement.

SFT-6229: DSU estate infrastructure failure	12	Limited effectiveness	End-of-life infrastructure remains a risk to safety, service continuity and patient experience. DASH remains the principal long-term mitigation, supported by local operational controls.
SFT-7734: Limited capital funding for safety, buildings and equipment	12	Partially effective	Limited capital headroom restricts the Trust's ability to address urgent estates, equipment and digital risks. Risk-based prioritisation continues through Trust and Group capital governance.
SFT-7917: Fire risk in Main Theatres corridors	12	Limited effectiveness	Daily and weekly checks mitigate the immediate risk, but the absence of suitable alternative storage prevents full resolution. A sustainable estates solution remains necessary.
SFT-8102: Central Booking workforce and process instability	12	Limited effectiveness	Workforce shortages, immature processes and operational backlogs create risks to patient safety, access, utilisation and income. A 12-week intensive-support programme, recruitment, training and dashboard development are underway.
SFT-8926: DASH capital shortfall	12	Partially effective	A funding gap of approximately £6m remains. Value engineering, cost control, national funding discussions and future Group capital prioritisation continue.
SFT-6412: Harm to women and babies through lack of a dedicated second obstetric theatre	12	Limited effectiveness	The single-theatre constraint presents a continuing risk to timely emergency intervention, patient safety and dignity. Interim controls remain in place while the options appraisal and business case progress.
SFT-8780: HR, organisational development and change-management capacity	12	Limited effectiveness	People and change capacity is constrained by simultaneous transformation, consultation, EPR readiness and operational recovery requirements. Recruitment, prioritisation and Group oversight continue.
SFT-9003: Clinical information held outside the formal patient record	11	Controls initially absent	Although below the formal escalation threshold, COMC requested continued visibility because of the weakness in controls and dependency on EPR. Trust-wide communications have reinforced the formal patient record as the single source of truth while the scope and required controls are established.

The Care Organisation's principal risks are mutually reinforcing. Poor urgent care flow, high NCTR and workforce unavailability increase escalation capacity, patient-safety exposure and premium staffing costs. These operational pressures are a material contributor to the failure to deliver the break-even financial plan. In parallel, coding and clinical transformation schemes have not delivered their planned benefits, leaving the Trust more exposed to operational cost pressures.

The likely £13.1m deficit assumes successful completion of the key worker accommodation transaction and material improvement in NCTR following additional ICB work on demand management and discharge. These are significant dependencies rather than secured mitigations. If either fails to deliver, the financial risk will increase. The Trust is therefore managing financial recovery as an integrated operational, workforce and transformation challenge rather than a narrow cost-control exercise.

The same interdependency is visible in stroke performance. ED crowding and constrained flow delay access to specialist stroke care, while therapy workforce shortages restrict rehabilitation intensity. Pressure injury performance, although improved in month, remains subject to common-cause variation and does not yet demonstrate that current controls have changed the underlying system.

The principal strategic risk is that the combined demands of UEC recovery, financial turnaround, winter, EPR, workforce reduction and clinical transformation exceed available delivery capacity. Group and system support are therefore required on the KWA transaction, ICB demand management and NCTR, coding, clinical transformation, EPR resources and capital prioritisation.

Section 5: Care Organisation Context

SFT continues to demonstrate resilient clinical leadership and a strong improvement culture. Progress in cancer performance, national oversight ranking, medical appraisal compliance and selected service developments demonstrates that the organisation can deliver improvement when priorities are focused and the necessary capacity and dependencies are in place.

The overall position is nevertheless more challenging than the Month 5 reported financial position alone suggests. The Trust no longer expects to deliver break-even, with a likely £13.1m deficit after assuming delivery of KWA and system action to reduce NCTR. Poor whole-hospital flow, workforce unavailability and delays in coding and clinical transformation are now central to both the operational and financial position.

The immediate organisational focus is therefore on delivering the established UEC recovery plan, improving stroke care, reducing NCTR and workforce absence, securing cash support, progressing coding and clinical transformation, and protecting EPR readiness. This requires disciplined prioritisation and timely resolution of Group and system dependencies, rather than further proliferation of activity.

COMC approved the Strategy Deployment and Partnerships Committee Terms of Reference for progression through Group governance, approved submission of the Revenue Support PDC application and approved the revised Conflicts of Interest Policy. The Committee also noted continued progress in reducing overdue policies, while recognising that wider procedural-document compliance requires sustained oversight.

Appendix A-C – Sub-Committee Summary

Finance & Performance Committee

Key Decisions / Actions Agreed

- Approved continuation of the Financial Recovery Programme and CIP governance arrangements.
- Endorsed submission of the Revenue Support PDC application (£14.3m).
- Supported progression of the DASH Full Business Case.
- Supported continuation of the Central Booking Recovery Programme.
- Endorsed additional Cardiac CT capacity and diagnostic recovery actions.
- Supported progression of Cancer CNS business cases.
- Requested continued oversight of EPR affordability and readiness.
- Escalated:
    - Financial Position 2026/27.
    - Cash Sustainability.
    - Central Booking Workforce and Process Instability.
    - Failure to Reduce NCTR to Plan.
    - DASH Capital Shortfall.
    - DSU Infrastructure Failure.
    - Limited Capital Funding.

Quality & Safety Committee

Key Decisions / Actions Agreed

- Approved the Fertility Storage Incident response framework and Task & Finish Group arrangements.
- Supported implementation of the Maternity & Neonatal 10-Point Plan programme.
- Supported progression of the second obstetric theatre options appraisal and business case.
- Endorsed continued delivery of the pressure injury improvement programme.
- Supported the Paediatric Diabetes Recovery Plan.
- Approved strengthened mortality review and corridor-care harm monitoring arrangements.
- Supported submission of the Fuller Inquiry Mortuary Assurance Statement.
- Noted reduction in NHS England oversight of Audiology following improved assurance.
- Escalated:
    - Harm to Women and Babies through Lack of Dedicated Second Obstetric Theatre.
    - Maternity Triage / 10-Point Plan compliance risks.
    - Fertility Storage Incident.
    - Paediatric Diabetes sustainability concerns.
    - Potential harm associated with corridor care and delayed flow.

People & Culture Committee

Key Decisions / Actions Agreed

- Approved the refreshed Sickness Improvement A3.
- Supported establishment of the Strategic Workforce Forum.

- Endorsed continued workforce establishment and affordability controls.
- Supported divisional attendance-management escalation processes.
- Approved actions arising from the EDI Annual Report.
- Supported continued Medical Appraisal and Revalidation arrangements.
- Escalated:
    - Staff Unavailability.
    - HR, OD and Change Management Capacity.
    - Workforce affordability and delivery of workforce reductions.
    - Organisational capacity to deliver concurrent transformation programmes.

Care Organisation Management Committee (COMC)

Key Decisions / Actions Agreed

- Approved submission of the £14.3m Revenue Support PDC application.
- Approved revised Conflicts of Interest Policy.
- Approved Strategy Deployment & Partnerships Committee Terms of Reference for progression through Group governance.
- Supported progression of the DASH programme into Full Business Case development.
- Endorsed the Trust response to the Maternity & Neonatal 10-Point Plan.
- Requested enhanced monitoring of harm associated with corridor care and delayed access.
- Commissioned further review of fertility storage arrangements.
- Requested strengthened oversight of Stroke performance and recovery actions.
- Noted continued reduction in overdue policies and procedural documents.
- Escalated:
    - Failure to Meet Emergency Access Standards.
    - Financial Position 2026/27.
    - Cash Sustainability.
    - Failure to Reduce NCTR to Plan.
    - Central Booking Workforce and Process Instability.
    - Transformation Programmes Not Delivered to Time.
    - Second Obstetric Theatre Risk.
    - DASH Capital Shortfall.
    - Limited Capital Funding.
    - HR, OD and Change Capacity.
    - Sustained Use of Escalation Areas.
    - Clinical Information Held Outside the Formal Patient Record (for visibility and monitoring).

Key Strategic Themes Emerging from COMC

- Break-even is no longer considered achievable; current working forecast is a £13.1m deficit, subject to delivery of KWA and NCTR assumptions.
- UEC performance remains the principal operational challenge.
- Stroke performance has emerged as a significant clinical-performance concern.
- Workforce availability continues to be the principal constraint on operational recovery.
- EPR readiness is progressing, but affordability and organisational capacity remain significant risks.
- Successful delivery of recovery plans is increasingly dependent on Group and system actions rather than Trust actions alone.

BSW Hospitals Group Board

Agenda item	
Report title	RUH Managing Director's Report
Date of meeting	5 November 2026
Sponsor	John Palmer, Managing Director, RUH
Prepared by	John Palmer, Managing Director, RUH Becky Maxwell, Chief Medical Officer, RUH Simon Sethi, Chief Operating Officer, RUH Jon Lund, Site Director of Finance, RUH Sarah Chalkley, Deputy Chief Nursing Officer, RUH Jo Baker, Associate Director for Vulnerable People, RUH Fiona Bird, Deputy Director of Strategy, RUH Abby Strange, Interim Corporate Governance Manager
Approval Process: (where has this paper been reviewed and approved)	Reviewed and approved by John Palmer, Managing Director

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

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
N/A	

KEY MESSAGES

The October governance cycle provides Limited Assurance: progress is evident in planned care, nursing recruitment and governance, but significant financial, operational and patient-safety risks remain. Board attention is required in four areas:

- **Financial recovery:** the year-to-date deficit is £17.2m, £12.1m worse than planned. Group financial recovery support and evidence of lasting savings are required, while

maintaining safe care. Group support is also required to unlock commissioner funding for elective and urgent care activity above IAP levels.

- **Urgent and Emergency Care (UEC) and winter:** the Every Minute Matters programme is supporting local improvement, but a confirmed 95-bed winter capacity gap remains. Recovery requires coordinated action with health and care partners on demand, discharge and community capacity; RUH cannot resolve this alone.
- **Waiting times and service sustainability:** timely decisions are required on planned-care recovery and pathology staffing proposals, subject to funding and delivery plans. Priorities also include the maternity staffing proposal ahead of the November Maternity Incentive Scheme (MIS) deadline and joint action to secure sustainable mental-health and specialist palliative-care services.
- **Shared Electronic Patient Record (EPR):** strategic direction is required on planned activity changes, minimum requirements for safe implementation, equipment readiness and support after launch. Improved programme coordination does not yet demonstrate operational readiness.

The next test is measurable financial improvement, more timely care, reduced patient harm and sustainable staffing—not stronger processes alone.

RECOMMENDATION

The Group Board is asked to:

- **Note** the overall Limited Assurance assessment and the significant risks requiring continued oversight by the Group and its health and care partners.
- **Enable timely consideration** of the third phase of the planned-care recovery programme across eleven specialties.
- **Support progression** of the cellular pathology staffing and service-stabilisation plan, subject to confirmed funding, a clear plan for moving beyond transitional arrangements and review of opportunities across the Group.
- **Confirm** the financial recovery support and oversight arrangements available to RUH from the Group.
- **Provide Group support** to unlock commissioner funding for elective and urgent care activity above IAP levels.
- **Provide strategic direction** on planned activity changes during implementation of the shared EPR, minimum clinical-safety requirements, equipment readiness and support after launch.
- **Support escalation to the relevant health and care partners** on UEC demand, discharge, community capacity, mental-health pathways and specialist palliative care.

APPENDICES

Appendix 1:	RUH Quality and Safety Committee Upward Report
Appendix 2:	RUH Finance and Performance Committee Upward Report
Appendix 3:	RUH People and Culture Committee Upward Report
Appendix 4:	RUH Response to NHS England (NHSE) South West mid-year review
Appendix 5:	Commercial Programme Cluster Updates
Appendix 6:	Proposed Risk Mitigations and Board-Aligned Delivery Timetable

Royal United Hospitals Bath NHS Foundation Trust

Managing Director's Report:

Report Title:	Managing Director's Report: RUH Care Organisation Assurance, Risk and Delivery Position
Date of meeting:	5 November 2026
MD / Lead:	John Palmer, Managing Director
Purpose:	☒ FOR ASSURANCE ☐ FOR DECISION ☒ FOR STRATEGIC STEER

Section 1: Executive Summary

1.1 Alert | Advise | Assure

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

Urgent and Emergency Care (UEC) remains the principal immediate patient-safety and operational exposure. Building on the position previously reported to Group Executive Committee (GEC), September data shows admitted performance and ambulance handovers deteriorated, while increased reported corridor care reflects both operational pressure and enhanced identification and reporting. Sustainable improvement depends on RUH delivery of Every Minute Matters and system delivery of demand management, No Criteria to Reside (NCTR), community capacity and clear clinical thresholds. The detailed September position is set out in the UEC deep dive.

Financial recovery has moved into Group turnaround. The latest reported actual position is a £17.2m year-to-date deficit at September 2026 (M6), £12.1m adverse to plan. At August 2026 (M5), the £48m year-end deficit forecast outturn was the worst-case scenario, £38m adverse to plan; the unrated base scenario was a £34m deficit. Risks 3165 and 3289 remain scored 14 and 12 respectively. Recovery actions and dependencies are set out in Section 3.

Shared EPR readiness requires a balanced but candid assessment. Governance and programme maturity have improved, and the October 2027 go-live date remains unchanged. However, assurance remains limited because critical dependencies relating to clinic scheduling, migration-critical data quality, specialist capacity and business continuity remain unresolved. Risk 3400 remains scored 12, and programme delivery continues to compete for the clinical and organisational capacity needed for operational and financial recovery.

Clinical and workforce fragility is concentrated in cancer, cellular pathology, maternity/neonatal services, palliative care and mental-health/eating-disorder pathways. Several controls rely on temporary staffing, outsourcing or staff working beyond planned capacity. These measures contain immediate failure but do not provide a sustainable way forward. Timely Group decisions are required on pathology and specialty recovery investment, while commissioner and system intervention is required for mental-health pathways and specialist medical palliative care.

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

The second-half recovery strategy must protect elective capacity while resetting UEC. Care Organisation Management Committee (COMC) supported Tranche 3 recovery across eleven specialties because it is expected to restore the 18-week trajectory and generate a positive contribution, but mobilisation risk remains in Ear Nose and Throat (ENT), Pain and Gynaecology and approval must now pass through Group turnaround governance. Cancer and diagnostic recovery have identifiable recovery actions but remain exposed to referral growth, pathway-specific deterioration and workforce dependencies. Focused action and limited investment may improve performance, but delivery cannot yet be considered assured. UEC is not considered locally recoverable without system delivery. Group support is required to unlock commissioner funding for elective and urgent care activity above IAP levels.

Winter resilience is not fully assured. The previously reported 72-bed planning gap has been superseded by a revised modelled deficit of **135 beds**. Confirmed openings provide 40 beds, leaving a **95-bed confirmed gap**, potentially reducing to 50 only if the 25 virtual beds and 20 beds at St Martin's are delivered. The Integrated Care Board (ICB) has convening and commissioning responsibilities; RUH must evidence that existing capacity is being used before seeking additional capacity.

Workforce controls are not yet expressed as a single RUH trajectory linking Whole Time Equivalent (WTE), pay, bank and agency use, sickness, substantive recruitment and safe staffing. RUH sickness remains above plan, and action is being focused on areas above 5%, with a further deep dive required if the trajectory does not improve. Emergency Department (ED) nursing vacancies reduced from 22 WTE in April to 10 WTE in September, turnover remained low and the Enhanced Care Team reduced reliance on temporary mental-health staffing. However, day fill rates remained below 90%, sickness remained above funded headroom and temporary staffing use increased, so resilience remains constrained.

Food safety, fire safety and estate infrastructure remain areas of continued focus. COMC noted that the Food Alert Audit identified significant concerns across six wards. Finance and Performance Committee (FPC) received partial assurance; hot food service in ED remained withdrawn pending completion of controls and evidence of staff competency, with the audit trail remaining open. Fire compartmentation, retrospective fire strategies, electrical capacity and backlog maintenance remain material estate risks; existing controls provide oversight but

do not fully mitigate the underlying infrastructure challenges, which require sustained capital investment and executive oversight to support future service delivery and development.

The new assurance structure is beginning to improve triangulation, but committee reporting has not yet reached the desired level of maturity. Quality and Safety recorded mixed assurance, People and Culture partial assurance, and Finance and Performance did not record a single overall rating. For this report, the cumulative position across the three committees has been assessed as Limited Assurance because material risks and dependencies remain unresolved. COMC discussion highlighted the importance of triangulation across quality, workforce, finance and performance, and continued development of the assurance process.

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

The 2025/26 National Cost Collection was submitted to timetable without resubmission or data-quality failure. Published 2024/25 benchmarking showed a reference cost index of 95. This is lagged evidence, but it supports confidence in the costing base and provides a sound platform for specialty-level turnaround analysis.

Core financial controls remain in place but have not translated into improved financial performance. The Grip and Control report provided moderate assurance over established processes; however, the Month 5 scenarios presented to COMC in October—a £48m worst-case forecast deficit and a £34m unrated base-scenario deficit—and the move into Group turnaround demonstrate that control-process assurance should not be interpreted as assurance over delivery of the financial plan.

Maternity reporting for August identified 14 compliant and 11 partially compliant 10-Point Plan deliverables, with no non-compliant deliverables reported. One-to-one care in childbirth has been maintained despite workforce pressure. Workforce sustainability and delivery of improvement actions are the principal areas requiring continued oversight. The immediate priority is to progress the Birthrate Plus staffing proposal ahead of the November maternity incentive-scheme deadline.

Implementation of the 5+5+5 methodology is progressing. The Risk Management Group reviewed 18 risks scoring 12 or above, approved a quarterly risk-profile review cycle and piloted the new approach using the Chief Nursing Officer (CNO) portfolio. Assurance remains partial because several transferred risks await owner validation and several entries require stronger wording, controls and scoring before progression.

1.2 Key Achievements and Good News

- Night-time air ambulance landings were supported in principle, subject to completion of the required safety, workforce, planning and engagement arrangements.
- Shared EPR governance and clinical digital leadership arrangements have strengthened.
- A formal governance process for exceptional treatment requests is being established, supporting greater consistency and transparency in future decision-making.

Figure 1: Integrated Performance Report (IPR) Executive Summary September Data

Long waits reduced, but cancer, urgent care and financial pressures threaten recovery.

MOMENTUM

69.6% RTT

Long waits reduced, but RTT is 1.5% below trajectory

- 52-week waiters fell to 131 (0.33%), with zero over 65 weeks
- Diagnostics improved to 85.97%, with 167 fewer six-week breaches
- Frailty SDEC opened on 16 September
- Annual turnover improved to 7.41%, below the 11% target

CRITICAL PRESSURES

£17.1m deficit

£12.1m adverse to plan. Cash £2.81m, with depletion forecast by November

- Demand - GP referrals +19% YTD vs plan. Cancer demand +33% in September. ED attendances +3.9% above plan.
- Provisional cancer: 28-day 70.4%, 31-day 87.0%, 62-day 54.3%
- 683 corridor patients. Ambulance handover averaged 63.4 minutes
- Rolling sickness 5.67%. Temporary staffing 41.1 WTE above plan

NEXT 90 DAYS

Q3 recovery focus

Group Turnaround and Every Minute Matters support recovery and safer care

- Recover cancer, RTT and diagnostics in challenged specialties
- Improve internal flow and system NCTR discharge pathways; address W45 roll out
- Close the £5.4m savings gap and secure NHSE revenue support
- Progress pressure injury and IPC actions, with targeted Healthier Workforce support

Section 2: Performance Triangulation

2.1 Statistical Process Control (SPC) Variation

COMC discussion highlighted material variation across UEC, cancer and diagnostics, and elective pathways requiring executive attention. September deterioration in admitted performance and ambulance handovers limits assurance over timely access to care, despite relative resilience in some UEC measures. Cancer and diagnostic performance remain vulnerable, while elective performance remains comparatively resilient, with the principal risks concentrated in a smaller number of specialties.

Within UEC, weekly ED attendance data have shown upward special-cause variation since September 2026, with several points above the upper control limit and daily attendances averaging a peak of 348 in the week ending 4 October 2026. This evidences increased demand, although it does not establish the cause of the deterioration in access measures. The wider UEC demand context and recovery actions are set out in Section 3.

Figure 2: SPC Daily Average ED Attendances, by Week.

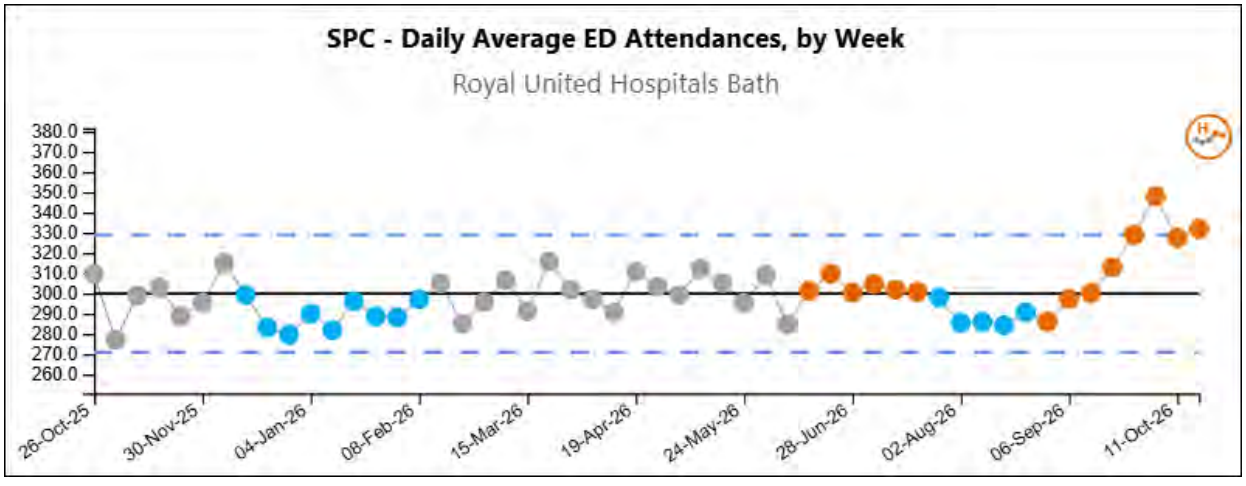


Figure 3: Quality Alerting Watch Metrics September Data

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% complaints responded to within agreed timescales with the complainant		90.0%		Sep-26	80.6%	X			Common Cause Variation
People we care for	Concerns are acknowledged within 2 working days		90.0%		Sep-26	61.0%	X			Special Cause Concerning - Below Lower Control Limit
People we care for	Medication Incidents per 1000 bed days		7.0		Sep-26	8.0	X			Common Cause Variation
People we care for	MRSA Bacteraemias Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Aug-26	6				Special Cause Concerning - Above Upper Control Limit
People we care for	Number of complaints received		30		Sep-26	45	X			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Sep-26	7	X			Special Cause Concerning - Run Above Mean
People we care for	Number of Hospital Acquired Pressure Ulcers Category 3		4		Sep-26	6	X			Common Cause Variation
People we care for	Number of reopened complaints each month		3		Sep-26	7	X			Common Cause Variation
People we care for	Readmissions - Total		10.5%		Aug-26	10.6%	X			Special Cause Concerning - Above Upper Control Limit
People in our Community	% Difference in DNA rates between IMD 1-2 and IMD 9-10		0.0%		Sep-26	6.5%	X			Special Cause Concerning - Two Out of Three High
People in our Community	% Difference in RTT performance between IMD 1-2 and IMD 9-10		0.0%		Sep-26	-2.5%	X			Common Cause Variation

2.2 Cross-Domain Analysis

Quality & Safety

Quality, safety and operational pressures remain closely linked. The UEC position limits assurance over timely assessment and safe care, with workforce and safe-staffing pressures constraining resilience. Building on the position previously reported to GEC, recent quality indicators show increased pressure-ulcer harm and complaints, with a continued risk of breaching infection prevention thresholds. Concerns also remain in medicines governance, maternity, radiation protection and mental-health pathways. Combined with EPR readiness demands, these pressures continue to reduce organisational headroom and require sustained executive oversight.

Response: A Trust-wide pressure-ulcer improvement plan is being developed, supported by individual case review, examination of staffing during affected periods and analysis of recurring harm patterns. Further actions include auditing inconsistent use of the Acute Kidney Injury (AKI) bundle, improving early complaints contact through training and divisional escalation, and progressing medicines-safety work on insulin and reconciliation.

Workforce & Finance

Workforce affordability and delivery depend on the relationship between pay, sickness and temporary staffing. Sickness remains above plan and temporary staffing use has increased, despite improved ED nursing recruitment. Temporary cover supports service delivery but adds premium-pay pressure; tighter pay control must therefore be considered alongside safe staffing and productivity.

Response: Substantive recruitment trajectories are being used to stabilise nursing establishments and reduce reliance on temporary cover. The Healthy Workforce programme has reinstated targeted management of long-term absence and sickness hotspots, with action plans required for areas above 5% sickness. Daily staffing reviews and redeployment continue to manage immediate gaps.

Access & Operational Delivery

Operational performance remains closely linked to patient flow, workforce capacity and financial recovery. UEC recovery requires coordinated RUH and system delivery and must protect elective capacity; local action alone does not provide assurance of sustainable improvement. Elective delivery remains comparatively resilient; however, all three cancer standards remain below target due to sustained referral growth and pathway-specific workforce constraints. Recovery actions are in place, but the latest evidence does not yet support stronger assurance. Winter delivery and EPR readiness continue to draw on the same workforce and operational capacity, requiring continued executive oversight.

Response: Immediate recovery depends on securing approval and mobilisation of the Tranche 3 initiatives, including additional skin-pathway capacity, and confirming funding for additional Community Diagnostic Centre (CDC) activity. Further work is being undertaken to address MRI capacity within the challenged cancer pathway, alongside consideration of remaining recovery funding. Longer-term planning will need to align capacity with referral demand to reduce repeated deterioration in cancer performance.

Figure 4: Cross Domain Assurance: Key delivery dependencies requiring executive oversight

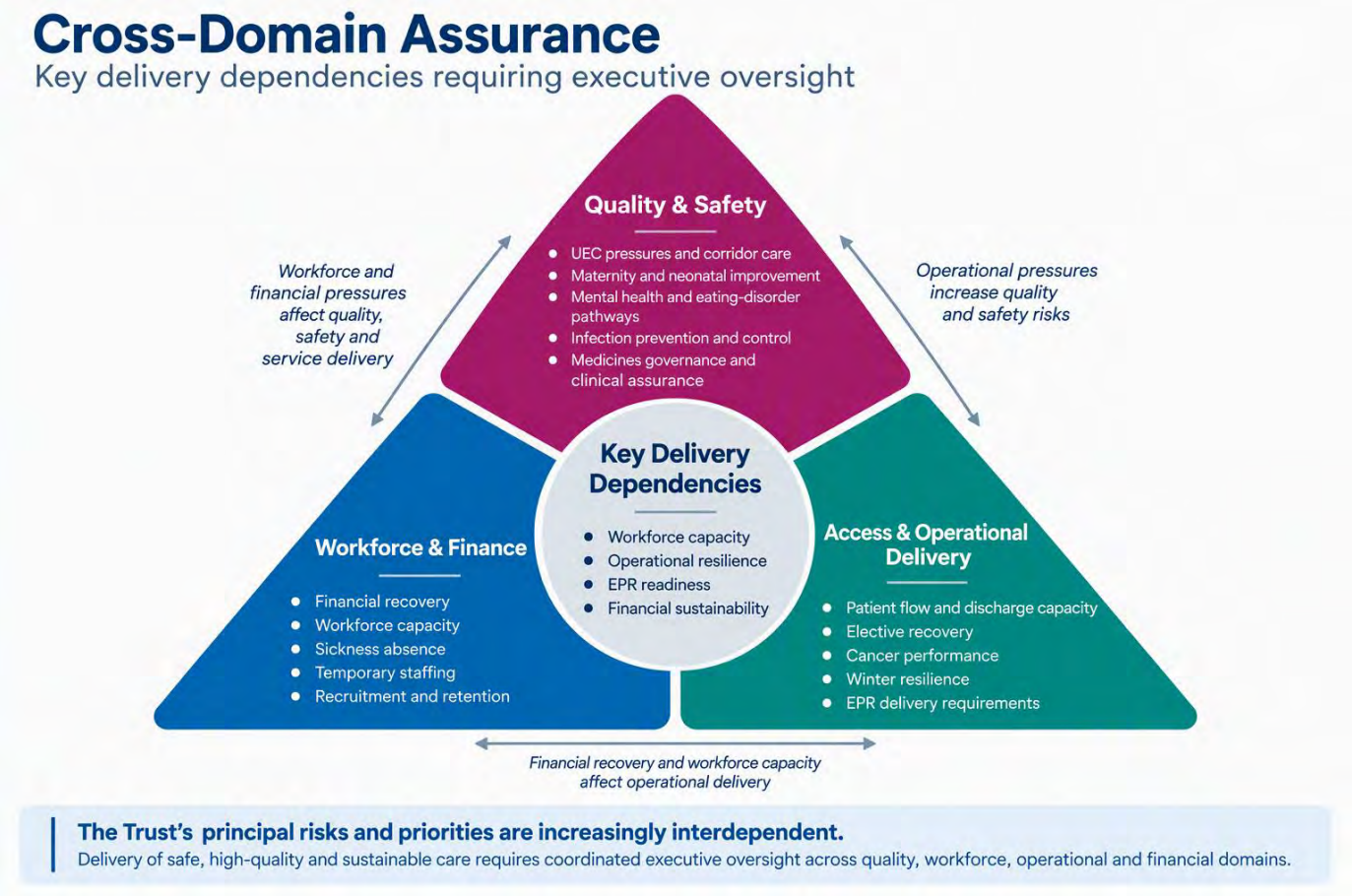


Figure 5: Business Plan Performance Detail September Data

	CURRENT POSITION	QUARTER 2 & 3 FOCUS
PERFORMANCE	Continue to operate in a highly pressurised environment with both GP referrals (+17.5%) and emergency demand (+5.8%) exceeding plan. 4-hour performance static in month at 56.72%. Patients spending >45mins in the corridor increased in month, and under further pressure in Oct with launch of W45. RTT performance fell 0.5% to 69.6%, below the 71.1% trajectory; patients waiting over 52 weeks reduced from 154 to 131. Cancer 28 day, 31 days and 62 day remain below target; validation ongoing, 62 day pressures of most concern.	Launch of Every Minute Matters, whole system programme to improve UEC access, including ED and UTC optimisation, internal flow and improved partnership working to reduce urgent demand and NC2R discharge delays. Sustaining improvement in elective operational standards (RTT, Cancer, Diagnostics) and addressing delivery risks within challenged specialties. October Call to Action linked to Group Turnaround focussing on UEC and RTT performance as part of RUH contribution to Group position.
FINANCE	Year to date £17.1m deficit, £12.1m adverse to plan, driven by £0.3m industrial action, £2.8m structural issues, £2.5m SO, UEC demand escalation £1.5m and savings shortfall of £5.4m. 101% of Savings plans identified, of which 68% (£28.5m) are assessed as Green in delivery or fully developed. £11.4m of savings have been delivered, inclusive of £2.4m of transitional income re-phased. Cash closed September at £2.81m, with forecast depletion by end of November.	Group Turnaround programme being stood up during October; this includes a refreshed approach to RUH FIPB/Firms. Resourcing to step in to support the Turnaround programme, in absence of Hunter, under review. Priority remains the shift of opportunities and plans in progress into green schemes and achievement of 25% CIP target for Q2 / 30% for Q3 Application being submitted to NHSE for revenue support.
QUALITY	Front-door urgent and emergency care, pressure injury prevention, and reducing E. coli and C. difficile infections remain key quality and patient safety priorities, with improvement workstreams continuing to mature under robust governance and oversight. Workforce resilience remains a focus, in both nursing and the maternity and neonatal workforce.	CNO-led improvement activity to strengthen quality and safety across urgent and emergency care, including Executive leadership of the internal flow Every Minute Matters workstream, pressure injury prevention and infection prevention and control. The Quality Governance Framework is being refreshed, embedding the Quality & Safety Committee and strengthening responsive oversight, assurance, and reporting arrangements.
WORKFORCE	Retention is improving, with 12-month turnover at 7.41% against the 11% target; however, workforce capacity remains misaligned with service requirements and affordability continues to be a principal risk. Staffing is 67.4 WTE above plan, including temporary staffing 41.1 WTE above plan, while vacancies persist in nursing, clinical support and Estates & Facilities. Long-term absence accounts for 58.1% of time lost, and the rolling sickness absence rate is 5.67%.	The Healthier Workforce Programme is focusing support on stress-related absence and high-absence teams, with long-term absence reviews linked to individual support plans and recovery monitored through divisional reviews. Key projects include the development of a new Group Absence Policy and a Violence and Aggression workstream to strengthen attendance management and staff wellbeing. Targeted action plans are being developed for all areas with sickness absence above 5%, while recruitment is being prioritised in services with the highest vacancy rates.

Figure 6: Business Plan Performance Metrics September Data

September 2026 — ***Performance against trajectory (in year)***

Domain	Metric	26/27 NHSE Instruction	Current Month Trajectory	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
UEC	ED Attendance Growth YTD	*Versus 25/26 actual*	-0.5%	3.6%	3.0%	4.2%	3.9%	3.5%	3.9%
	NEL Admission Growth YTD	*Versus 25/26 actual*	-4.6%	12.4%	5.5%	5.6%	5.6%	5.9%	5.8%
	Eliminating Corridor Care	*0> 45mins by Nov '26*	0	556 (15%)	683 (15%)	587 (6.5%)	602 (6.5%)	530 (5.9%)	683 (7.2%)
	4-hour ED performance (type 1)	*66.9% by Mar '27*	60.6%	61.2%	56.6%	57.8%	56.2%	56.1%	56.7%
	4-hour ED performance (all types)	*82% by Mar '27*	70.6%	71.1%	67.0%	68.9%	68.4%	67.9%	68.1%
	12-hour ED performance	*96.1%*	92.4%	92.0%	90.1%	88.7%	86.5%	88.6%	86.6%
	Ambulance handover	*Reduce toward 15 mins*	28	33.1 mins	68.7 mins	53.2 mins	76.4 mins	51.8 mins	63.4 mins
Elective & Diagnostic	GP Referral Growth YTD*	*Per planning assumption*	0.0%	10.9%	13.0%	13.2%	17.1%	18.3%	17.5%
	RTT Open Pathways	*Per planning assumption*	34,704	39,237	40,061	39,606	41,031	43,165	42,852
	18w RTT Performance	*74.7% for RUH*	71.1%	70.3%	71.1%	70.4%	70.6%	70.1%	69.6%
	52 Week Waiters	*Reduction towards zero*	278	183	155	133	156	154	142
	52 Week Waiters %	*Improvement on 1%*	0.8%	0.5%	0.4%	0.4%	0.4%	0.4%	0.3%
	Diagnostics 6 week wait	*13.1% for RUH*	13.4%	14.7%	13.1%	11.8%	13.4%	14.5%	14.0%
Cancer	28 day FDS *	*80% annual ave*	76.7%	79.8%	79.4%	78.8%	76.3%	73.3%	72.6%
	31 day*	*94%*	92.0%	92.5%	95.0%	94.4%	95.4%	95.2%	92.8%
	62 day RTT*	*80%*	71.4%	68.5%	70.0%	71.0%	68.9%	68.0%	69.3%
Workforce	30% Reduction in agency use	*30% improvement from M06*	tba	13.3 WTE	21.2 WTE	11.6 WTE	14 WTE	11.3 WTE	15 WTE
	10% reduction in bank spend	*10% reduction from M06*	tba	293.7 WTE	289.2 WTE	302.9 WTE	296.2 WTE	289.5 WTE	277 WTE
	Sickness rate (rolling 12 month average)*	*Improvement*	tba	5.5%	5.5%	5.6%	5.6%	5.6%	5.6%
Finance	2% productivity improvement	*(min 2% improvement)*	2.0%	6.5%	3.5%	1.9%	4.9%	4.9%	-4.7%
	Savings Plan	*37.6m (£56.6m over 3 yrs)*	15,039	1,400	2,170	3,089	4,861	7,458	5,990
	Balanced or surplus financial position	*Balance or surplus*	(5,087)	(2,886)	(5,935)	(7,583)	(10,585)	(13,844)	(17,134)
Discharge	Non Criteria to Reside (NC2R)	*Number of NC2R*	78	88	100	103	116	111	109
	NCTR % Occupancy	*% of Adult Occupied Beds*	9%	18.9%	21.4%	21.8%	24.5%	23.3%	23.1%
	Pathway 0 - Home	*% within 24 hours*	97%	95.0%	94.4%	94.8%	93.1%	94.4%	93.8%
	Pathway 1 - Home with support	*% within 48 hours*	100%	43.5%	44.1%	36.7%	38.9%	46.0%	35.0%
	Pathway 2 - Community setting	*% within 48 hours*	100%	31.6%	26.8%	22.8%	19.2%	35.0%	31.7%
	Pathway 3 - Residential care	*% within 7 days*	100%	42.9%	40.6%	38.2%	39.0%	37.9%	24.4%

2.3 Assurance Committee Summary

The table summarises each committee's recorded assurance position and principal escalations; these remain distinct from the MD's cumulative assessment.

Committee	Assurance Level	Key Focus Areas	Assurance Summary / Escalation
Quality & Safety	Mixed assurance	Mental health and eating disorder pathways; medicines governance; infection prevention and control; maternity improvement; radiation protection; safe and effective clinical governance.	The Committee reported mixed assurance. It received positive assurance on safeguarding and vulnerable people, maternity and neonatal reporting, medicines improvement and regulatory assurance. Significant attention remains necessary on mental-health and eating-disorder pathways, pressure injury harm, infection prevention and control, medicines governance, radiation-protection capacity, maternity delivery dependencies and the reliability of quality data.
Finance & Performance	No single overall rating recorded	UEC performance and flow; financial recovery; elective and cancer recovery; EPR readiness; winter resilience; estates and infrastructure risks.	The Committee identified significant concerns relating to UEC, financial recovery, EPR readiness and estates risks. It received moderate assurance from the Grip and Control report, assurance on the National Cost Collection, and partial assurance from the Food Alert Audit. Financial control-process assurance does not provide assurance over delivery of the financial plan. Continued escalation is required where mitigations depend on Group decisions, commissioner action or wider system delivery.
People & Culture	Partial assurance	Workforce affordability; sickness absence; medical workforce sustainability; safe working; job planning; fragile workforce models and service resilience.	The Committee reported partial assurance. Positive assurance was received on medical appraisal and revalidation, medical job-planning compliance, Staff Survey and flu-campaign readiness, and early implementation of the temporary-staffing model. Continued attention is required on sickness absence, workforce affordability, resident-doctor safe working, temporary-staffing fill, equality outcomes and fragile workforce models in oncology and haematology, cellular pathology and neonatal services.

Section 3: Deep Dive / Other Business

Financial Turnaround

September 2026 (M6) actuals show a £17.2m year-to-date deficit, £12.1m adverse to plan. At August 2026 (M5), the £48m year-end deficit forecast outturn was the worst-case scenario; the unrated base scenario was a £34m deficit. The earlier recovery modelling below shows a £34.9m unmitigated run-rate position, a £23.3m Finance Assurance Model position and a £20.4m submission after £2.9m of further mitigations. These represent recovery assumptions and a submitted position. The approximately £33m, £23m and £20m internal scenarios are directional planning cases; the £4.2m–£48.1m sensitivity range illustrates uncertainty, including material downside exposure. Recovery continues to depend on cost control, elective contribution, reduced temporary staffing, productivity, workforce efficiency and further savings, alongside commissioner resolution and other key dependencies outside RUH's control.

Figure 7: Finance Overview

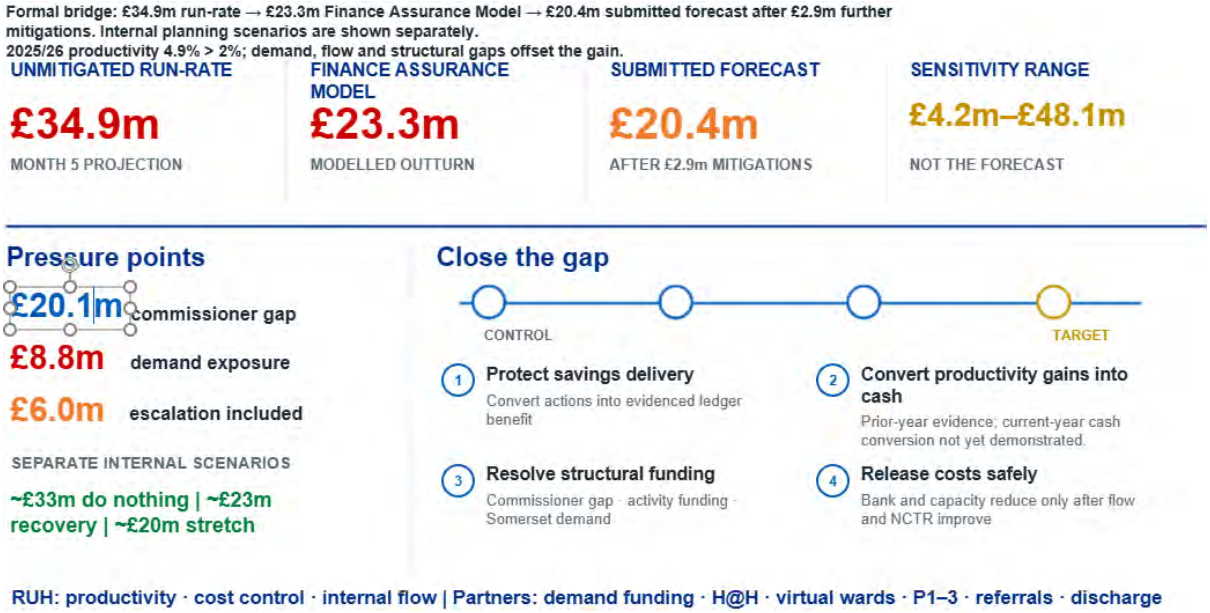


Figure 8: Earlier Month 5 reporting cycle – formal finance bridge to the £20.4m submission

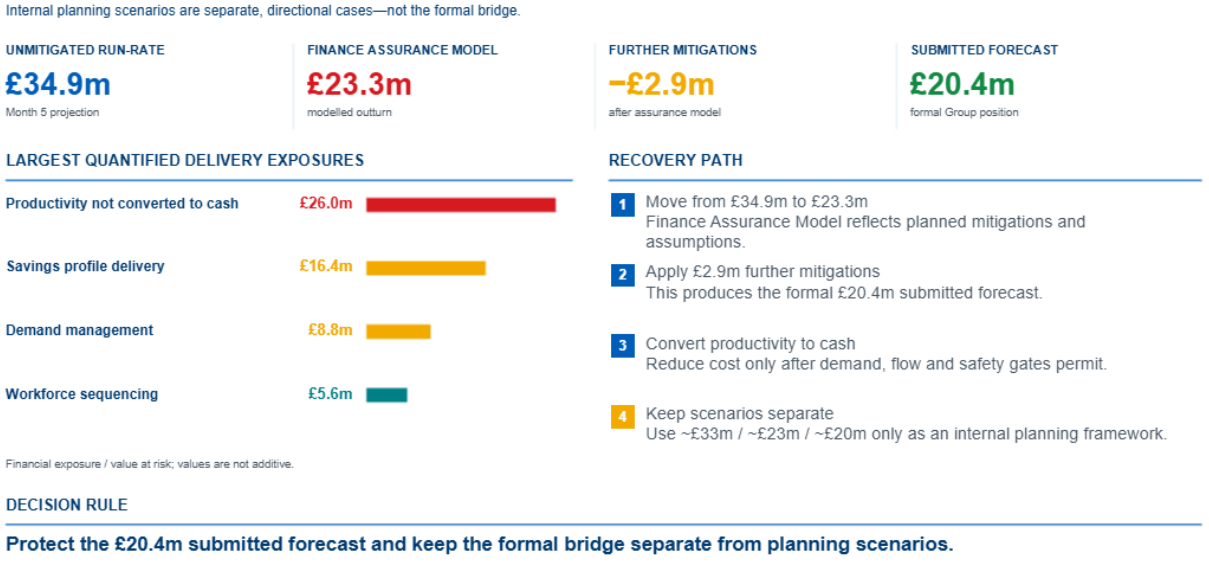


Figure 9: Three critical risks requiring active executive control

Year 1 planning risk matrix | 3 critical • 6 high • 2 moderate

SAVINGS PROFILE	DEMAND MANAGEMENT	PATIENT SAFETY	WORKFORCE SEQUENCING
13	13	12	11
£16.4m exposure	£8.8m exposure	flow dependency	£5.6m exposure

CRITICAL AND NEAR-CRITICAL RISKS

01	Savings plan profiling	13	Commercial opportunities; weekly evidence and ownership.
03	Demand management — financial	13	Community contract performance and/or commissioner funding.
04	Demand management — patient safety	12	Community demand management and UTC reconfiguration.
10	Unsafe or premature workforce reduction	11	Medicine/ED staffing gate; bank reduction only after safe bed closure.

EXECUTIVE CONTROL GATES

Evidence	No savings claimed without ledger conversion.
Funding	Separate RUH actions from commissioner dependencies.
Flow	Close capacity only after sustained NCTR reduction.
Safety	No workforce reduction ahead of safe bed closure.
Capacity	Protect transformation bandwidth through ERP/EPR change.

REMAINING WATCH LIST

Affordability of elective plan • elective performance • shared EPR impact • CDEL sufficiency • staff sickness • change capacity

Turnaround Action

Figure 10: Immediate financial controls (5 of 13 completed, 7 in progress and 1 not yet started)

Ref	Control	Non-negotiable requirement	Accountable owner	Deadline	Evidence of compliance	Done	Current Status
A1.1	Discretionary non-pay freeze	Stop all non-essential non-pay spend, including non-mandatory training and conferences, travel, hospitality, events, furniture, non-replacement IT, printing and subscriptions. Exceptions only where spend is essential for safety, statutory or contractual duties, or releases cash.	All Executives; Site FDs	Immediate	Weekly discretionary spend report in Financial Assurance Model (FAM)	Complete	Weekly spend tracker in place; Divisional control processes re-tested or assurance of delivery
A1.2	Approve commitment, not spend	Re-test all business cases not yet contracted and all Month 5 accruals. No new commitment, including new capacity contracts, without an agreed funding source and Group Executive Committee approval.	Group TD; MDs	16 Oct 2026	Re-tested business case register	In progress	New business cases sent to Group Exec for approval and escalation report via MD
A1.3	Management consultancy	Baseline all consultancy spend and reduce it by at least 80% from current levels, with controls to hold it at that level.	Group CFO; Group TD	Baseline 9 Oct, cut by 31 Oct 2026	Consultancy baseline and exit tracker	Complete	No Consultancy outside of Group Development and Financial Recovery
A2.1	Zero tolerance of SFI breaches	100% compliance with Standing Financial Instructions. No payments will be made without a purchase order ("No PO, No Pay"). Single Tender Waivers by exception only. Non-compliant purchasing is monitored from October and followed up.	Group CFO; all budget holders	Immediate	SFI breach and retrospective-PO report	In progress	Control processes all in place. Monitoring systems being tested
A2.2	Tougher non-pay control panels	Procurement given authority to challenge non-stock requisitions. Weekly requisition review; default to catalogue and stock ordering. Review whether fewer authorisers improves control.	Group TD; Head of Procurement; Site FDs	From w/c 5 Oct 2026	Panel log; non-catalogue spend trend	In progress	Weekly spend tracker in place; Divisional contro processes re-tested or assurance of delivery
A2.3	Budget and forecast discipline	Every cost centre manages within budget and seeks approval before any forecast overspend. Forecasts reflect evidenced, likely outcomes; no unevidenced benefit enters the forecast.	MDs; Site FDs	Monthly, from M6 (9 Oct)	Signed FAM and forecast outturn	In progress	Details of oforecast asumptions by cost centre being shared follwng M6. Key assumptions for income/activity and Winter Plan already shared
A2.4	Cash control	Return monthly cash outflows to no more than inflows. Maintain a rolling 13-week cash forecast, reviewed weekly.	Group CFO; Group TD	Fortnightly	13-week cashflow; aged debt review	Complete	In place
A3.1	External recruitment freeze	Vacancies default to internal, cross-Group advertising only. External adverts and appointments stop; exceptions approved at Group level via Recruitment Control Panel against funded establishment. In-flight recruitment reassessed.	Group CPO; MDs; Group TD	Immediate; formal process by 12 Oct	Weekly vacancy and advert report by CO	Not yet started	
A3.2	Agency and high-cost interims	Stop non-clinical agency. Reduce high-cost agency, interims and locums by 80% from current levels through a managed-exit tracker. Daily CMO/CNO authorisation with reason coding.	Group CPO; CMOs; CNOs	Tracker by 9 Oct, exits through Q3	Managed-exit tracker; WTE vs 29 WTE plan	Complete	CMO high cost agency review undertaken. No route to reudction before 31 March, risk of increase in Cellular Pathology
A3.3	Bank and rosters	Target a 25% reduction in bank spend. CNOs certify (down to Matron level) that rosters are safe and aligned to budget, with action plans where they are not. Weekly roster-to-budget variance review.	CNOs; Divisional Nursing leads	Certification by 30 Oct 2026	Roster certification; bank WTE vs 647 WTE plan	In progress	Controls in place; No plan identified to reduce by 25%
A3.4	Overtime	Overtime stops unless approved by the Care Organisation MD for exceptional circumstances; use Bank instead.	MDs	Immediate	Monthly overtime report	Complete	Overtime already eliminated in RUH, except for Security team
A3.5	Waiting list initiatives and pay premia	Additional medical payments only for formally agreed WLI activity or safety-critical absence cover, once core capacity is shown to be optimised. Review all pay premia against standard terms.	CMOs; Group CPO	Premia report by 16 Oct 2026	Payroll premia report; WLI log by specialty	In progress	90 day test of job planing and rostering underway
A3.6	Sickness absence	Any area above 5% sickness has a signed action plan and timeline to return below 4%, starting with the highest areas.	Site HRDs	30 Oct 2026	Signed action plans	In progress	Healthier Workforce Programme in place

Leadership expectations

- Visible Care Organisation leadership at Engine Room, COMC and All Staff Brief
- Call to Action comms were launched on Monday 12th October 2026.
- Email briefing to senior leaders on Winter Plan financial expectations

Intelligent risk management

- Risk Triangulation and Financial Recovery were a key focus of RUH COMC on Wednesday 7 October
- Strengthened agenda and membership between Finance and Workforce Assurance Committees
- Key working task and finish group approved for triangulation of workforce and pay metrics between Quality & Safety;
- Finance; and Workforce Integrated Performance Reports

UEC

- **Current Position:** UEC remains RUH's most significant patient safety and operational risk (risk 2683: 12). Demand and flow pressures remain sustained. Some UEC indicators improved slightly in September, but admitted performance deteriorated, average ambulance handover increased to around 63 minutes and reported corridor care increased to 683 patients. The increase in reported corridor care reflects both ongoing operational pressure and enhanced identification and reporting of patients cared for in escalation areas. Performance has not deteriorated to the extent that might be expected given demand, but it remains below the required standard and under sustained regional scrutiny.

Figure 11: ED Attendances Daily Average 2024/25 to 2026/27

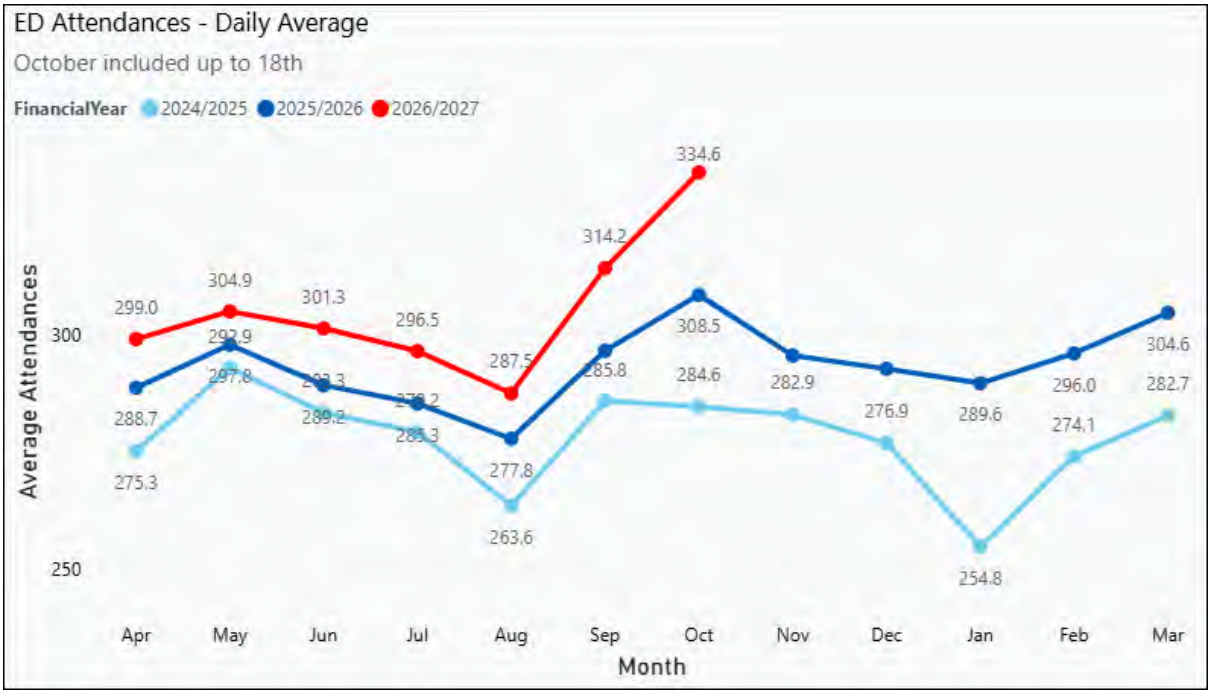


Figure 12: South Western Ambulance Service NHS Foundation Trust (SWAST) Conveyances to RUH Daily Average 2024/25 to 2026/27. Ambulance conveyance data are available to September 2026 only. Subsequent data were unavailable at the reporting cut-off because of a reporting-system issue.

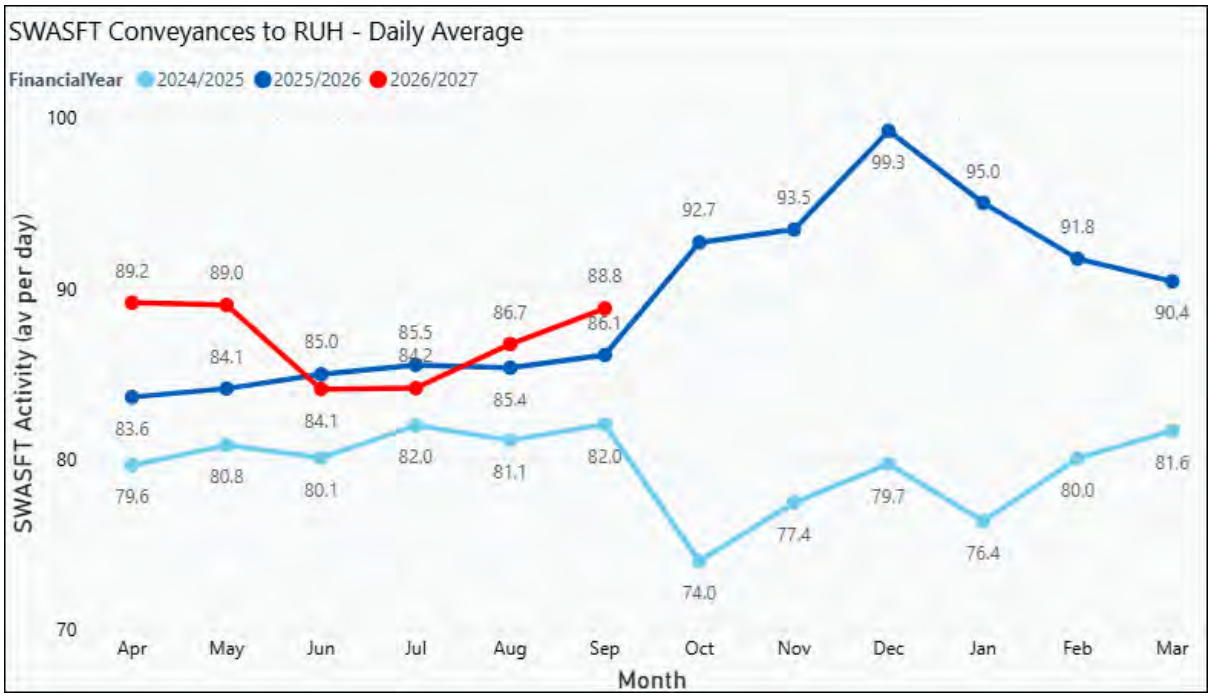


Figure 13: Monthly ED Attendances (total per month) versus Plan. Attendances are above plan in every month apart from May.

Month	Planned	Actual	Difference	% Above Plan
Apr-26	8,630	8,971	341	4.0%
May-26	9,488	9,453	-35	-0.4%
Jun-26	8,882	9,040	158	1.8%
Jul-26	9,045	9,191	146	1.6%
Aug-26	8,539	8,912	373	4.4%
Sep-26	8,960	9,425	465	5.2%
Oct-26	9,222			
Nov-26	8,870			
Dec-26	8,966			
Jan-27	8,255			
Feb-27	8,031			
Mar-27	9,663			

- **Strategic priority 1 – UEC reset:** Every Minute Matters. The reset has been launched at COMC, with executive representatives agreed for all areas. It makes avoidable waiting a shared patient-safety priority. The executive-led weekly Every Minute Matters Group holds workstream leads to quantified weekly deliverables, uses a single dashboard and delay log, and escalates barriers rapidly. These meetings include ICB, SWAST and HCRG Care Group partners.

- **Five areas of focus we will drive every day:**
    - **Reduce avoidable conveyance:** use alternative community capacity and return daily ED demand to plan.
    - **Ambulance handover:** no handovers over 45 minutes.
    - **Front-door assessment:** strengthen triage, Rapid Assessment and Treatment (RAT), Same Day Emergency Care (SDEC) and EEMAC; target Majors 55%, Paediatrics 95%, EEMAC at least 25 patients daily and treatment within 60 minutes for 60%.
    - **Internal flow without corridor care:** fewer than 20 decision-to-admit patients at 17:00; Frailty SDEC 6–8 daily; 30% of discharges by midday and 80% by 17:00; zero corridor care.
    - **Discharge and NCTR:** reduce community NCTR to 55 patients and total NCTR below 9%, with clear ownership across RUH and system partners.
- **Strategic big ticket 2 – a quantified winter plan.** The plan must set out the bed gap and the contribution, timing, workforce and cost of each mitigation. Internal actions include respiratory and escalation capacity, Urgent Treatment Centre (UTC) mobilisation, discharge-lounge use, earlier discharge and a Home for Christmas aim of 30 empty beds by Christmas Eve. External actions must quantify demand reduction, commissioned pathway 1/community capacity, virtual wards, seven-day discharge support and delivery of the community NCTR target set out above. Delivery gaps will be escalated through the weekly group, Winter Cabinet, COMC and the ICB. A deadline for the end of October was set for all plans to be confirmed.

EPR

- **Current position:** Digital services remain stable, but operational readiness remains limited. Risk 3400 is scored 12; the cutover activity and income risk is set out in Section 4.2.
- **Key readiness risks:** Clinic scheduling, data quality, clinical configuration, Subject Matter Expert capacity, ageing devices and clinical business continuity remain incomplete. Cutover controls are still being developed; activity assumptions and recovery planning are addressed in Section 4.2.
- **Mitigation and next steps:** Assurance will strengthen when business-continuity arrangements have been tested and divisions have confirmed delivery against the readiness requirements below.
- **Group steer required:** Agreement is needed on activity assumptions, clinical-safety thresholds and the minimum safe-readiness requirement, prioritisation and confirmation of device and other asset readiness, and the scale of post-go-live operational and clinical support.

Mental Health and Eating Disorder Pathways

Executive Summary

Mental health and eating disorder pathways remain under significant pressure. The evidence, improvement actions and residual system dependencies are set out below.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is a key system partner.

Key Metrics / Evidence

Between 2019 and 2025:

- Eating disorder admissions doubled from 15 to 30.
- Bed days increased from 183.9 to 972.8 and average length of stay from 12.26 to 32.4 days.
- Dietetic contacts increased from 57 to 379, and from 3.8 to 12.6 contacts per admission.

Recorded mental health-related Emergency Department waits over 12 hours rose from 49 to 81 between April and May 2026, and waits over 24 hours from 9 to 26. In May, 196 people were recorded as presenting with mental health needs. A review of 11 prolonged-wait episodes identified documentation, classification, overnight liaison and reporting issues; the figures therefore indicate significant pressure but require validation before providing full performance assurance.

Evidence sources: RUH eating disorder activity and dietetic review (2019 and 2025); Vulnerable People Committee reporting for April and May 2026; and Mental Health Operational Group review of prolonged waits, July 2026.

Service-Level Insight Not Visible in the IPR

Acute services are increasingly caring for people who cannot access specialist inpatient provision, fall outside current pathway criteria or are awaiting assessment or placement elsewhere. This contributes to prolonged Emergency Department waits, acute admissions requiring specialist care that is not otherwise available, pressure on flow and capacity, and increased Section 136 activity. Staff listening events also identified operational impact, gaps in acute-specific training and confidence, and limited access to system support.

Actions Underway, Progress and Remaining Risks/Dependencies

- The Mental Health Operational Group and Eating Disorder Working Group oversee the programme. Current priorities are:
- Ratify and implement the Eating Disorder Pathway, including enhanced care and alignment with the clinical holding policy.
- Use patient journey reviews and staff feedback to improve the pathway and develop acute-focused training.
- Strengthen governance of clinical holding and restrictive interventions, including recording, reporting and assurance.
- Appoint a named consultant lead and improve routine validation and reporting of waits, Section 136 activity and pathway data.
- Continue escalation to the Quality and Safety Committee, AWP and the ICB to inform commissioning and future provision.

Governance and escalation have strengthened, but the full impact on activity, length of stay, enhanced observation and staff capacity is not yet quantified, and data limitations constrain assurance. Residual risks include delayed assessment and specialist care, prolonged acute stays and pressure on flow and staff. Sustainable improvement requires coordinated action with AWP and the ICB beyond the Trust's direct control to agree demand, specialist and mental health bed capacity, commissioning, workforce, cross-organisational responsibilities and a sustainable pathway model.

Supporting evidence: Vulnerable People Committee (April, June and September 2026); Mental Health Operational Group (July 2026); and Least Restrictive Intervention Oversight Group (July 2026).

Relevant Board Assurance Framework (BAF) Principal Risks

No directly applicable BAF principal risk has been confirmed. Relevant operational risks monitored through the Mental Health Operational Group include:

- Risks 2432 and 3168 – mental health bed availability, Section 136 activity, patient flow and prolonged waits.
- Risk 3361 – eating disorder service pressures.

Section 4: Risk Escalation

Figure 15: RUH Corporate Risk Dashboard



A consolidated view of the major risks surfaced through implementation of the Group 5+5+5 methodology and COMC, showing where Board attention should focus to reduce residual exposure.

4.1 Escalation Gateway

Category	Risk ID & Title	5+5+5 Score	Reason for Escalation
☐ Strategic (G-Line)	No new strategic risks escalated in this reporting cycle.		
☐ Compliance	No new compliance risks escalated in this reporting cycle.		
☐ Operational (T-Line)	[3400] Reduction in Activity required during Shared EPR cutover.	[12]	Care Organisation will not meet activity and income plan as activity needs to be reduced during Shared EPR Cutover

The escalation gateway should be read alongside the appended committee upward reports. Risk 3400 is the new operational risk formally escalated during this cycle. The upward reports also identify continuing risks at or above the escalation threshold across quality and safety, finance and performance, people and culture, and estates.

4.2 Risk Narrative

Risk R-3400 Shared EPR cutover – risk score 12 (Likely/Major): A new operational risk has been added to the register because Shared EPR cutover is expected to require a reduction in activity for six weeks, enabling frontline teams to become familiar with the new system and supporting safe implementation. This creates a material risk that the Care Organisation will not deliver its 2027/28 activity and income plan and that elective waiting times will deteriorate. Business planning for 2027/28 has commenced and the reduction is included within planning assumptions, with an expectation that activity will be recovered before and after go-live. However, these controls are planned rather than fully implemented; assurance is therefore limited until the reduction has been modelled, assumptions have been validated by divisions, and credible divisional recovery plans are in place.

Section 5: Care Organisation Context

Approvals and Significant decisions

Decision	COMC Position	Value / Scale	Conditions / Next Step
Tranche 3 elective recovery	Supported for onward consideration	11 specialties; minimum £730k contribution	Group approval and mobilisation oversight required
Trowbridge CDC Phase 1	Ratified	£1.7m capital investment	Service development and April 2027 mobilisation

ENT workforce and waiting list recovery	Supported	£97k recurrent plus non-recurrent support	Delivery through Tranche 3 recovery programme
Cellular pathology workforce plan	Supported for onward consideration	£399k transitional and £444k recurrent investment	Funding, exit strategy and Group-wide opportunity review
Clinical coding backlog	Supported	£136k non-recurrent investment	Delivery and benefit realisation to be monitored
Night-time air ambulance landings	Supported in principle	Enables future night-time air ambulance operations	Subject to certificate of lawfulness, stakeholder engagement, completion of safety controls and inclusion of the landing-site position on the risk register
Pharmacy pre-pack	Approved	Invest-to-save initiative	Recruitment, licensing, mobilisation and implementation of the savings-sharing methodology
Artificial Intelligence Diagnostic Fund lung-cancer pathway	Not supported at this stage	Proposed participation in regional diagnostic initiative	Further clinical review and clarification of benefits, implications and patient-outcome evidence required before reconsideration
Maternity and Neonatal 10-Point Plan	Received and noted	14 compliant; 11 partially compliant	Further discussion required on delivery trajectory and dependencies

Group Programme Responsibility: Commercial Programme

The Commercial Programme is moving from initial scoping into delivery. It aims to use the Group's scale, assets and expertise to diversify income, improve financial resilience and enable visible reinvestment in NHS services. Commercial activity will be treated as core business, governed to the same standards as NHS activity and developed only where NHS care, equity and public confidence are protected.

A draft Commercial Strategic Plan now provides the strategic frame. Its five Board questions address:

Figure 16: Commercial Strategic Plan – Five Board Questions

	Question	Why it must be settled
Q1	What level of ambition is the Group setting?	Determines whether the strategic plan is designed for £40m or for £250m. The resourcing, capability and structural implications are materially different.
Q2	What is the Group's commercial risk appetite?	Delivery, reputational, tax and counterparty risk are all in play. Without a stated position, every business case re-litigates the same questions.
Q3	Who decides what, and at what value?	A commercial scheme of delegation is needed before individual cases arrive.
Q4	Where does the commercial boundary sit?	Procurement consolidation (£8–14m) and shared corporate services (£4–8m) are currently governed elsewhere. The Group has no single statement of its total commercial position.
Q5	How widely should the strategic plan be shaped?	Strategic plan is not solely a Board responsibility. Section 11 proposes internal engagement through Improving Together and an external Commercial Advisory Panel — the latter requires a Board view.

Subject to agreement with the Chair and Group Chief Executive, a future Board development session will test these questions and shape the final plan.

Communications, engagement and external support

A communications and engagement plan is being developed, pending sign-off of the Strategic Plan. It includes early engagement with Executives, Care Organisation leaders, staff and trade unions, governors, patients, partners, universities, NHS England and commissioners.

An external Commercial Advisory Group is also being scoped to support the long-term ambition through independent challenge, market intelligence and partnership development. Likely participants include local authorities, universities, commercial partners and peers with relevant delivery experience. Terms of reference will address conflicts, confidentiality and procurement boundaries.

Resourcing and benefits

Resourcing requirements are being developed to support further improvement in 2026/27 and beyond. Immediate priorities are dedicated programme capacity for Private Care and pharmacy capacity to unlock commercial research and clinical trials. Wider requirements include benefits and analytics, project management, finance, legal, procurement, Human Resources, communications and specialist commercial advice. Proposals will be brought through the appropriate governance route, supported by validated baselines and reconciliation to avoid double counting.

Delivery

Appendix 5 summarises progress in each of the four programme clusters.

Summary and next steps

The next assurance cycle will assess delivery and outcomes against the Group decisions, system action and RUH commitments identified in this report. The support required from the Board is set out in the recommendations; Appendix 6 sets out proposed actions and Board-aligned milestones for agreement.

Appendix 6: Proposed Risk Mitigations and Board-Aligned Delivery Timetable

These actions and milestones are proposed for agreement at the Group Board meeting on 5 November 2026; they are not commitments already secured. Unless otherwise stated, two- and four-week milestones run from that meeting. Reporting will follow the next scheduled Board assurance cycle and its paper-submission deadline. Immediate safety concerns and winter delivery gaps require escalation without waiting for the next Board meeting.

Risk	Specific proposed action	Board-aligned milestone
Financial recovery	Confirm Group turnaround support; complete a Finance-validated recovery bridge with scheme values, owners, monthly benefits and delivery confidence, distinguishing the £34m unrated base scenario from the £48m worst case.	**5 November:** agree support and accountability. **Within four weeks:** validate the bridge through turnaround governance. **Next Board cycle:** report actual delivery, shortfalls and residual exposure.
Commissioner funding above IAP	Quantify elective and urgent care activity above IAP and the funding sought; appoint a Group negotiating lead and seek a written commissioner position. Identify unconfirmed income separately.	**5 November:** endorse Group-led escalation. **Within four weeks:** submit the validated funding ask and agree a negotiation timetable. **Next Board cycle:** report funding secured or unresolved exposure, without assuming agreement.
UEC and winter capacity	Confirm each mitigation's staffed beds, cost and opening date against the 95-bed confirmed gap, distinguishing committed from conditional capacity.	**5 November:** report delivery against the existing end-October deadline and escalate outstanding commitments. **Weekly thereafter:** monitor openings and the remaining gap through Winter Cabinet and system partners; do not wait for the next Board.
UEC flow and delayed discharge	Agree weekly trajectories towards community NCTR of 55, total NCTR below 9%, and discharge timing targets of 30% by midday and 80% by 17:00.	**Within two weeks of Board:** confirm trajectories and partner responsibilities. **Weekly:** review delivery through Every Minute Matters. **Next Board cycle:** report progress against trajectories and unresolved barriers.
Elective, cancer and diagnostics	Progress Tranche 3 and additional CDC activity funding decisions; confirm	**5 November:** confirm the approval route and urgency. **Within two weeks:** obtain a

	specialty mobilisation plans, including skin, MRI, ENT, Pain and Gynaecology.	decision or escalate the delay through Group governance. **Within two weeks of approval:** finalise mobilisation milestones. **Next Board cycle:** report delivery and the impact of any delay.
EPR readiness and cutover	Agree an integrated readiness plan and minimum safety requirements; validate the six-week activity and income impact and credible recovery capacity.	**Within four weeks:** agree owners, milestones and assurance requirements through EPR governance. **January 2027 assurance cycle:** complete initial divisional modelling and recovery proposals. Schedule testing and readiness gates backwards from October 2027 go-live.
Workforce affordability and safe staffing	Produce one trajectory linking WTE, pay, sickness, recruitment, bank and agency use, and safe staffing, supported by sickness-hotspot action plans.	**Within four weeks:** validate the integrated trajectory through the relevant committees. **Next Board cycle:** present the baseline, first delivery evidence and exceptions.
Pathology and maternity sustainability	Progress funding decisions and develop recruitment milestones and a transition from temporary arrangements.	**5 November:** confirm decision routes. **Maternity:** secure consideration before the actual November MIS deadline, using an expedited route if necessary. **Pathology:** seek a decision within four weeks; finalise the transition plan within four weeks of approval.
Mental-health, eating-disorder and palliative-care pathways	Agree partner responsibilities, validate demand and prolonged-stay data, and identify specialist-capacity and commissioning gaps.	**Within four weeks:** complete the initial joint assessment and escalation plan. **Next Board cycle:** report agreed actions and unresolved commissioning gaps. Agree longer-term capacity and delivery milestones with partners.
Quality and patient safety	Finalise improvement plans with owners, audit measures and outcome milestones for pressure ulcers, infection prevention and medicines safety.	**Within four weeks:** approve plans through Quality and Safety. **Next Board cycle:** report implementation and early trends; assess sustained effectiveness over subsequent committee cycles. Escalate immediate safety concerns without delay.

Food safety and estate infrastructure	Evidence food-safety corrective actions and interim controls; prioritise fire, electrical and backlog-maintenance work with funding requirements.	**5 November:** report outstanding food-safety controls and immediate estate exposure. **Within four weeks:** validate corrective-action and capital-priority plans. **Next Board cycle:** report evidenced closures and remaining unfunded risks; capital delivery follows approved funding and project schedules.

Common reporting requirement: Each action should have an accountable lead confirmed when the timetable is agreed. The next Board paper should distinguish completed actions, evidenced risk reduction, overdue milestones and unresolved Group or system dependencies.

BSW Hospitals Group Board

Agenda item	6.1
Report title	Group Risk Register Report
Date of meeting	5 November 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Mark Ellis, Chief Risk Officer
Approval Process: (where has this paper been reviewed and approved)	Group Executive Committee (October 2026) Risk and Assurance Committee (October 2026)

☒ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
All	

KEY MESSAGES

This paper presents the October Group Risk Register, which holds the 46 risks across the three Care Organisations and corporate services that score 12 or above. It sets out the highest scoring risks, the main themes, what has joined and left the register and the quality of this month's submissions. The Committee is asked to note the position and discuss the points in section 6.

RECOMMENDATION

The Group Board is asked to:

1. Take limited assurance from the October Group Risk Register, noting its highest scoring risks.
2. Consider whether the mitigations and recovery trajectories for financial sustainability and liquidity, estates and capital compliance, operational flow and access, and workforce and delivery capacity provide sufficient assurance.

APPENDICES

BSW Group Risk Register, August 2026

Purpose

To present the August 2026 Group Risk Register and draw the Board's attention to the principal risks requiring oversight and assurance.

1. The register this month

The register holds 46 entries, up from 44 in September: 13 from RUH, 13 from SFT, 10 from GWH and 10 from corporate services. Four risks are new, two have left, two scores have increased and three have reduced. The remaining 35 are unchanged.

2. Highest scoring risks

Three risks score 14, the highest on the register, and nine score 13. Half of these twelve are financial.

Ref	Source	Risk	Score	Change
GRP-FIN-01	Corporate	Delivery of the Group financial plan	14	None
GRP-CST-01	Corporate	CST programme: finance tracker and savings forecasting	14	None
RUH-3165	RUH	Delivery of annual financial plan	14	None
GRP-DIG-01	Corporate	Insufficient digital, data and technology resource to meet Group demand	13	None
GRP-CST-02	Corporate	CST programme: digital enablement investment	13	None
GWH-1267	GWH	Stroke service performance and timely access to care	13	None
SFT-7573	SFT	Sustained use of escalation areas	13	New
SFT-8759	SFT	Cash balances to support timely payments to staff and suppliers	13	None
SFT-8791	SFT	Financial position 2026/27	13	None
SFT-8800	SFT	Reduction of No Criteria to Reside to 9% as per plan	13	Up from 12
RUH-3273	RUH	Electrical infrastructure limiting site development	13	None

Ref	Source	Risk	Score	Change
RUH-3289	RUH	Working capital cash shortfall	13	Up from 12

3. Themes

Finance (9 entries). Finance is the most concentrated theme, with six of the twelve highest scoring risks. Delivery of the financial plan appears at Group level and in each of RUH and SFT. Cash and liquidity appear three times: at Group level (GRP-FIN-02), at SFT (SFT-8759) and at RUH (RUH-3289). SFT also records two capital shortfalls (SFT-7734 and SFT-8926).

Quality and safety (10 entries). Five of these relate to patient flow and escalation capacity: GWH surgical assessment and hospital occupancy, SFT escalation areas and No Criteria to Reside, and RUH emergency department overcrowding.

Estates and infrastructure (9 entries). These include fire safety at RUH and SFT, backlog maintenance, electrical capacity and Building Safety Act compliance. The Group's strategic priorities do not include estates, so these risks are linked to the Board Assurance Framework through what they threaten, mostly avoidable harm.

Workforce (6) and digital (5). Four of the five digital entries come from corporate services. No cyber security risk appears anywhere on the register, so the Group priority for cyber security has no linked risk.

4. New risks and risks removed

Four risks have joined the register:

Ref	Source	Risk	Score
CG-02	Corporate	Corporate governance capacity and resilience during transition	12
SFT-7573	SFT	Sustained use of escalation areas, escalated on the SFT register from 10	13
RUH-3235	RUH	Outdated policies and limited governance resource	12
RUH-3400	RUH	Reduction in activity required during Shared EPR cutover	12

Two risks have left the register. SFT-7946 (transformation programmes not delivered to time) reduced from 13 to 11 and is now managed on the SFT Corporate Risk Register. RUH-3314

(discontinuation of the RUH Hospital at Home service), which scored 13 in September, and has been closed following the approval of a business case to continue the service.

5. Board assurance statement

Overall assurance is limited. Positive assurance is provided by the clearer threshold, explicit movement reporting and improved fields for causes, controls, evidence, gaps and actions. This is offset by uneven evidence of control effectiveness, and continued reliance on oversight meetings, plans or future monitoring as evidence.

6. The Board is asked to

1. Take limited assurance from the October Group Risk Register, noting its highest scoring risks.
2. Consider whether the mitigations and recovery trajectories for financial sustainability and liquidity, estates and capital compliance, operational flow and access, and workforce and delivery capacity provide sufficient assurance.

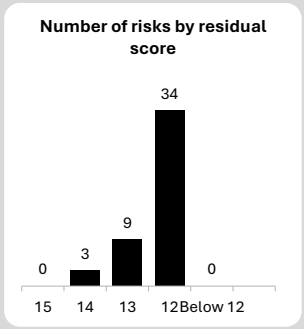
BSW Hospitals Group October 2026 Group risk register dashboard

October 2026 · Generated automatically from the Risk Register sheet · Escalation threshold: residual score 12 and above (L+I+C, 5+5+5 model)

Risks on register	New this period	Score increased	Score reduced	Highest score
46	4	2	3	14

Risk concentration by category and organisation

Category	GWH	RUH	SFT	Corporate	Programme	Group	Total
Quality and Safety	3	3	4	0	0	0	10
Workforce	2	1	1	2	0	0	6
Finance	0	2	4	3	0	0	9
Performance and Access	0	1	2	0	0	0	3
Estates and Infrastructure	3	4	2	0	0	0	9
Digital and Cyber	0	1	0	4	0	0	5
Regulatory & Compliance	0	1	0	1	0	0	2
Strategic	2	0	0	0	0	0	2
Total	10	13	13	10	0	0	46





Exception report

Highest scoring risks (scoring 14 and above)

Ref	Org	Risk title	L	I	C	Score	Status this period	Risk owner
GRP-FIN-01	Corporate	Delivery of the Group financial plan	5	5	4	14	No change	Group Chief Financial Officer
GRP-CST-01	Corporate	CST programme: finance tracker and savings forecasting	5	5	4	14	No change	
RUH-3165	RUH	Delivery of Annual Financial Plan	4	5	5	14	No change	Lund, Mr Jon

Risks with an increased score this period

Ref	Org	Risk title	L	I	C	Score	Status this period	Risk owner

Risks de-escalated from the register this period

Ref	Org	Risk title	Prev	New	Now managed on
SFT-7946	SFT	Transformation programmes and projects are not delivered to time	13	11	SFT CO register
RUH-3314	RUH	Discontinuation of RUH Hospital at Home Service	13		Risk closed following business case approval

Blank rows mean fewer risks currently meet the criterion. De-escalated risks are entered on the Dashboard inputs sheet (yellow block) from the Corporate Risk Registers; all other figures recalculate automatically from the Risk Register sheet.

BSW Hospitals Group - Group Risk Register, October 2026

Residual Score = Likelihood (L) × Impact (I) × Control Score (C). Likelihood measures the chance of the consequence happening, not the cause. Risks scoring 10 and above are included on the Corporate Risk Register.

Control Score: 1 = Fully Effective 2 = Largely Effective 3 = Partially Effective 4 = Limited Effectiveness 5 = Absent. White cells are completed by the risk owner; shaded score cells with formulas calculate automatically.

Consolidation, October 2026: built from the GWH return (v0.3), the SFT return (v0.6, 8 October), the RUH return (resubmitted 9 October with controls completed) and the Corporate Governance register (September). Nine corporate services entries are carried forward from the September GRR, with no October update received. Previous Residual Score is the September Group position. Changes affecting individual rows are recorded in the Consolidation Note column.

IDENTIFICATION						THE RISK				SCORING AND CONTROLS						TRAJECTORY								CONSOLIDATION
Risk Ref	Care Org	Date Opened	Risk Title	Risk Type	Linked BAF Priority	Risk Statement (one sentence)	Causes (facts, one per line, numbered)	Consequences (one per line, numbered)	Live Condition? (event already occurring)	L (1-5)	I (1-5)	Controls in Place (numbered, mapped to causes)	Evidence of Control Effectiveness	C (1-5)	Residual Score (L×I×C)	Previous Residual Score	Direction of Travel	Status this Period	Control Gaps	Actions (numbered, with dates)	Action Owner	Action Due Date	Action RAG	Target Score	Target Date	Risk Owner	Reporting Committee	Date Last Reviewed	Next Review Due	Consolidation Note
GRP-FIN-01	Corporate Service		Delivery of the Group financial plan	Finance	R5 Increasing Financial Sustainability	There is a risk that the Group and its three Care Organisations do not deliver the 2026/27 and three year financial plans, leading to escalation within the NHS Oversight Framework and loss of financial autonomy.	1. The underlying deficit is in excess of available deficit support funding. 2. Cash releasing efficiency (CIP) programmes are under delivering, with productivity running at c.2.5% against a 4% target. 3. £[figure not stated in source]m of savings remain unidentified and a £[figure not stated in source]m gross delivery risk is carried in the 2026/27 plan. 4. Continuing demand, inflation and workforce cost pressures.	1. Worsening Group and system financial position. 2. Escalation within the NHS Oversight Framework to segment 2 or 4. 3. Loss of autonomy through the system triple lock. 4. Constrained capacity to invest in safe, high quality care.	Yes	5	5	1. Monthly financial performance and forecast reporting to each Care Organisation Finance and Performance Committee, consolidated to the Group Finance Committee and the BSW Strategic Commissioning Board via the Group finance tracker. 2. Cash releasing savings (CIP) programmes monitored fortnightly through Care Organisation Engine Rooms and Financial Recovery Groups, risk assessed against trajectory. 3. Enhanced expenditure and vacancy controls operating across all three Care Organisations: executive level vacancy control, agency caps, discretionary spend sign off. 4. Turnaround Programme and external financial advisory support established to the Medium Term		4	14	14	Static	No change							Group Chief Financial Officer		5/28/2026	6/28/2026	Carried forward from the September GRR; no October update received.
GRP-CST-01	Corporate Service		CST programme: finance tracker and savings forecasting	Finance	R7 Improving Value and Productivity	There is a risk that Corporate Services Transformation savings cannot be tracked or forecast reliably, leading to the savings target not being delivered and benefits realisation not being demonstrable.	1. The finance tracker and forecasting tool are still to be built and require significant effort. 2. £[figure not stated in source]m of CST savings has been incorporated into operational plans. 3. Finance support to the programme is constrained to one day per week.	1. Savings delivery cannot be tracked or evidenced. 2. Benefits realisation cannot be demonstrated. 3. The corporate services savings target is not delivered.	Yes	5	5	1. Finance support to the programme, currently one day per week.		4	14	14	Static	No change	No finance tracker or forecasting tool to yet in place, so there is no mitigation against causes 1 and 2. SRO ownership of CST savings delivery is to be established rather than in place.	1. SROs to take ownership for CST savings delivery. [Date not stated in source]						CST Steering Group			Carried forward from the September GRR.
GRP-DIG-01	Corporate Service		Insufficient digital, data and technology resource to meet increasing Group demand	Digital and Cyber	R3 Delivering Digital Maturity	There is a risk that Group Digital Services cannot maintain resilient digital services, modernise ageing technology and deliver strategic transformation, leading to system failures, delayed programmes and increased cyber and information governance risk.	1. Digital, data and technology demand across the three Care Organisations is increasing. 2. Resource capacity, specialist expertise and investment in digital enablers are insufficient to meet that demand. 3. Ageing technology carries accumulated technical debt. 4. Integration activity across the three Care Organisations adds further demand.	1. Reduced service resilience and increased risk of cyber attack and system failures. 2. Delays to critical digital and transformation programmes, and slower EPR optimisation. 3. Increased cyber and information governance risks. 4. Reduced ability to respond to emerging organisational priorities and to business intelligence and analytics requests. 5. Greater reliance on temporary resources, staff burnout and turnover. 6. Failure to realise planned benefits and efficiencies, adversely affecting patient care, staff experience and organisational performance.	Yes	4	5	1. Group Digital Services has established a revised governance model to facilitate improved digital prioritisation against increasing demand, so that constrained resources are allocated appropriately. 2. The new Group Digital Service governance model provides consolidated digital programme oversight and scrutiny of cyber security, information governance and risk management controls.		4	13	13	Static	No change	Two items recorded as controls in the source register are actions rather than controls, and have been moved to the Actions column: the review of the Group Digital Services establishment under Corporate Service Transformation, and the development of operational service level agreements. Until those are complete there is no control against causes 2 and 4.	1. Review of the Group Digital Services establishment as part of Corporate Service Transformation, to operate as a single service across the Group and streamline capabilities and workforce costs in line with the CST target. [Date not stated in source] 2. Development of operational service level agreements to monitor service performance provided across the Group. [Date not stated in source]					Jonathan Hinchliffe		8/10/2026	9/10/2026	Carried forward from the September GRR.
GRP-CST-02	Corporate Service		CST programme: digital enablement investment	Digital and Cyber	R3 Delivering Digital Maturity	There is a risk that the digital investment required to enable new corporate services models is not affordable, leading to the future service states and their associated savings not being achieved.	1. New models for corporate services require investment in digital enablers to achieve future service states. 2. That investment is not currently affordable.	1. Future corporate service states are not achieved. 2. Associated savings are not delivered.	Yes	5	5	1. Digital enabler task and finish group established. 2. Request at Design Authority 17 December to capture a baseline of the digital ask for services.		3	13	13	Static	No change		1. Digital Enablement paper to Group Board, September 2026. 2. PA Consulting to review designs. [Date not stated in source]						CST Steering Group			Carried forward from the September GRR.
GRP-FIN-02	Corporate Service		Cash availability and liquidity	Finance	R5 Increasing Financial Sustainability	There is a risk that the Group has insufficient cash to meet its operational and contractual obligations as they fall due, leading to an inability to meet payment terms and to conditions being attached to emergency cash support.	1. Sustained underlying deficits are eroding cash balances. 2. The Group is dependent on deficit support and NHSE revenue support funding whose availability is increasingly uncertain. 3. There is reliance on non recurrent liquidity measures: capital deferral, extended creditor days and ICB phasing of contractual payments.	1. Inability to meet payment terms to suppliers and partners. 2. Reputational damage. 3. Conditions attached to emergency cash support. 4. Further constraint on the capital programme.	Yes	4	5	1. Daily cashflow forecasting and agreed payment prioritisation principles operated by each Care Organisation finance team. 2. Rolling 13-week and annual cashflow forecasts reported monthly to Finance and Performance Committees with escalation to Boards and the Group. 3. ICB support for liquidity through agreed phasing of contractual payments, notably SFT. 4. Capital programme constrained and capital spend defined to protect cash reserves, for example RUH c.£12m deferral and creditor day management to March 2026. 5. Engagement in the NHSE revenue and cash support process where required.		3	12	12	Static	No change							Group Chief Financial Officer		5/28/2026	6/28/2026	Carried forward from the September GRR; no October update received.
GRP-DIG-02	Corporate Service		LAN refresh and network infrastructure resilience	Digital and Cyber	R3 Delivering Digital Maturity	There is a risk of intermittent or prolonged network outages across the Group, leading to loss of access to critical clinical and operational systems and potential impact on patient safety.	1. Network infrastructure across each Care Organisation is ageing and reaches end of life. 2. The digital refresh programme is subject to delay and insufficient investment.	1. Loss of access to critical clinical and operational systems. 2. Increased reliance on paper based processes. 3. Disruption to patient pathways and elective activity. 4. Reduced staff productivity. 5. Potential impacts on patient safety, service continuity, cyber resilience and organisational performance.	Yes	4	5	1. Group Digital Services has established a revised governance model to facilitate improved digital prioritisation against increasing demand, so that constrained resources are allocated appropriately.		3	12	12	Static	No change	The risk based technology refresh programme is in development and is not yet an operating control. There is currently no control against causes 1 and 2 and no mitigation against the end of the infrastructure itself.	1. Development of a risk based technology refresh programme with defined milestones and delivery oversight, to ensure timely investment in high risk network infrastructure and to target constrained investment in critical clinical and operational areas. [Date not stated in source]					Jonathan Hinchliffe		8/10/2026	9/10/2026	Carried forward from the September GRR.
GRP-DIG-03	Corporate Service		Insufficient clinical informatics capacity and capability across the Group	Digital and Cyber	R3 Delivering Digital Maturity	There is a risk that insufficient clinical informatics capacity and capability across the Group compromises the safe design, implementation and optimisation of digital systems, leading to increased clinical safety risk and unrealised benefits from digital investment.	1. Clinical informatics capacity and capability across the Group is insufficient, including the CCIO, CNIO, Clinical Safety Officer and wider clinical informatics resource. 2. Clinical engagement in and oversight of digital delivery is limited by that capacity. 3. Clinical informatics representation at governance forums, programme boards and design authorities is subject to the availability of representatives.	1. Increased clinical safety risks and delay in managing them. 2. Delayed benefits realisation. 3. Reduced digital confidence among staff. 4. Slower transformation delivery, including the Single EPR. 5. Failure to optimise and maximise the value of digital investment.	Yes	3	5	1. Clinical informatics representation is included within Group Digital governance structures, programme boards and design authorities, subject to the availability and capacity of representatives to attend. 2. Clinical informatics resource identified to support EPR optimisation, digital transformation programmes and operational digital services, subject to the availability and capacity of representatives to attend. 3. Clinical Safety Officer oversight implemented in accordance with DCB0129 and DCB0160 standards.		4	12	12	Static	No change	Controls 1 and 2 are both qualified in the source as subject to the availability and capacity of representatives to attend, which is the cause of the risk. A control whose operation depends on the resource that is in short supply provides limited assurance.	1. Review of the Group Digital Services establishment as part of Corporate Service Transformation, including redesign of current clinical informatics change capability. [Date not stated in source]					Jonathan Hinchliffe		8/10/2026	9/10/2026	Carried forward from the September GRR.
GRP-PED-01	Corporate Service		Workforce plan delivery	Workforce	R2 Taking Our People With Us	There is a risk that the Group does not deliver its workforce plan, leading to continuing loss of control over workforce cost and non delivery of workforce related savings.	1. At month 3 the Group is 183 WTE above plan. 2. There is an adverse pay variance of approximately £5.7m. 3. Temporary staffing remains above trajectory, with bank utilisation above plan.	1. Continuing loss of control over workforce cost. 2. Non delivery of workforce related savings.	Yes	5	4	1. CIP programme. 2. Establishment reviews. 3. Refreshed Group level vacancy control process. 4. Corporate Services Transformation Programme. 5. Substantive recruitment and retention plans. 6. Targeted interventions in hard to recruit clinical specialties.		3	12	12	Static	No change								Group Executive Committee			Carried forward from the September GRR.
GRP-PED-02	Corporate Service		Temporary staffing	Workforce	R2 Taking Our People With Us	There is a risk that outsourcing the temporary staffing model reduces shift fill rates across the AIC staff group, leading to gaps in services, increased workload for permanent staff and an impact on patient care quality and safety.	1. The temporary staffing model has been outsourced. 2. Fill rates may reduce across the AIC staff group, creating gaps within services. 3. Increased public concern has been raised via MP, Governors and Council.	1. Reduced shift fill and gaps within services. 2. Increased workload for permanent staff. 3. Impact on patient care quality and safety.	Yes	5	4	1. Daily meetings. 2. Escalation tracker. 3. Daily monitoring of shift fill.		3	12	12	Static	No change	This risk is also recorded on the Corporate Services risk register and the HR risk register. Single ownership and a master record are to be confirmed.							Group Executive Committee			Carried forward from the September GRR.
GRP-CG-02	Corporate Service	9/24/2026	Corporate governance capacity and resilience during transition	Regulatory & Compliance	R1 Becoming an Effective Group	There is a risk that the Corporate Governance service lacks sufficient capacity, capability and resilience during implementation of the Group operating model, leading to missed statutory deadlines, weaker Board and committee support and reduced assurance quality.	1. The service is moving from three legacy arrangements to a Group/local model whilst continuing statutory and Board-critical activity. 2. Recruitment, slotting-in and redeployment activity is underway, and some posts are not yet substantively filled. 3. Governance and risk investment at Care Organisation level has been identified as below benchmark in existing risk evidence. 4. Expanded Group scope includes three Boards, committees in common, three Councils of Governors, group management, BAF/GRR support and regulatory assurance. 5. Current delivery depends on a small number of experienced individuals and interim support.	1. Statutory, regulatory or constitutional deadlines are missed. 2. Board and committee papers, minutes, action tracking and assurance reports are late or below the required standard. 3. Risks and governance exceptions are not escalated promptly. 4. Key staff experience excessive workload, absence or turnover, worsening the capacity gap. 5. The Group incurs additional interim cost and loses regulator and stakeholder confidence.	Yes	4	4	1. Corporate Governance service redesign and agreed target structure (causes 1-4). 2. Prioritisation of statutory and Board-critical work, supported by Board and committee cycles of business (causes 1, 2, 3). 3. Temporary and cross-site support can be deployed where gaps are identified (causes 2 and 5). 4. Director of Corporate Governance / Group Company Secretary role appointed to lead implementation and professional standards (causes 1-5). 5. Standard templates, common terms of reference and governance document compendium reduce avoidable variation (causes 1 and 4).	The target structure, role descriptions and governance document set are defined, and consultation has concluded. A number of posts not yet in place, recruitment dependencies, resource requirements and transition risks remain live arrangements. There is no current capacity model or service-level performance dashboard demonstrating that demand can be met consistently. Controls are therefore of limited effectiveness.	4	12			New to register	1. Vacancies and transitional staffing arrangements remain unresolved. 2. No agreed minimum safe staffing or resilience standard for statutory and governance roles. 3. Limited succession and cross-cover for specialist responsibilities. 4. Service KPIs and exception thresholds are not yet routinely reported.	1. Complete recruitment, matching and redeployment decisions for the agreed structure by 31 October 2026. 2. Agree a prioritisation and business continuity protocol for capacity shortfalls by 30 November 2026. 3. Implement service KPIs covering paper timeliness, minutes, actions, statutory returns, policy reviews and vacancy levels by 31 December 2026. 4. Establish documented cross-cover and succession arrangements for all critical governance processes by 31 January 2027.	Director of Corporate Governance / Group Company Secretary	1/31/2027	Amber	8	1/31/2027	Director of Corporate Governance / Group Company Secretary	Audit Committees in Common	9/24/2026	10/24/2026	New to the Group register this period, so no previous Group score and no direction of travel. Risk Type spelling aligned to the template list; the return recorded 'Regulatory and Compliance'.
GWH-570	GWH	8/18/2020	Surgical Assessment Unit capacity and patient flow pressure	Quality and Safety	R8 Reducing Avoidable Harm	There is a risk to patient safety at times of pressure due to the increasing demand of patients who attend the Surgical Assessment Unit. The risk is which could take place is a delay in triage and first assessment by a doctor, and the delivery of care in an inappropriate space which could compromise patients experience.	1.Delays in patient triage. 2.Delays in clinical assessment and treatment. 3.Increased risk of patient deterioration. 4.Reduced patient experience and dignity. 5.Increased clinical risk arising from care delivered in unsuitable environments. 6.Failure to achieve urgent and emergency care performance standards.	1.Delays in patient triage. 2.Delays in clinical assessment and treatment. 3.Increased risk of patient deterioration. 4.Reduced patient experience and dignity. 5.Increased clinical risk arising from care delivered in unsuitable environments. 6.Failure to achieve urgent and emergency care performance standards.	Yes	5	4	1.Daily Business Case has been written to outline the proposal regarding a Same Day Emergency Care (SDEC) service. This case was presented at OKBT on 4/9/26 and the team are responding to feedback provided at OKBT 2.Bedding Triage rooms impact patient flow and assessment. Seeing the impact of the increase in 2nd on Registrar is limited due to this. An Audit of the Triage rooms being bedded has taken place Jan 25-Apr 25. SBAR has been submitted to DD to support our request for Dorcan to provide at Maximum 12 Trolley spaces. 2. DAU has no control over type of patients admitted to department. In times of escalation, 3. criteria not always followed resulting in Medical and Orthopaedic patients in the department. This causes flow standstill,, 4. Rapid triaging not always possible most of the time due to triage rooms being bedded 5. Escalation protocols set clear criteria for escalating surgical patients. [Causes 1, 2, 4] 2. Daily Divisional Safety and Quality Meeting takes place at 9:00 am to discuss immediate safety concerns and review acuity and staffing allocation across the division. [Causes 1, 2, 3, 4] 3. Matron of the Day has oversight of the staffing position and acts as an escalation point for safety concerns. [Causes 3, 4] 4. Escalation protocols set clear criteria for escalating surgical patients. [Causes 1, 2, 4]	1. Effectiveness evidenced through real-time dashboard monitoring of occupancy, acuity, flow and time to first assessment. 2. Additional assurance provided by tracking triage room availability, escalation compliance, non-surgical admissions and Matron of Day escalation records. 3. Dashboard data is reviewed routinely to identify and address delays in patient assessment.	3	12	12	Static	No change	1.A Business Case has been written to outline the proposal regarding a Same Day Emergency Care (SDEC) service. This case was presented at OKBT on 4/9/26 and the team are responding to feedback provided at OKBT 2.Bedding Triage rooms impact patient flow and assessment. Seeing the impact of the increase in 2nd on Registrar is limited due to this. An Audit of the Triage rooms being bedded has taken place Jan 25-Apr 25. SBAR has been submitted to DD to support our request for Dorcan to provide at Maximum 12 Trolley spaces.	Head of Service – General Surgery, , Urology and SAU - GWH	3/31/2027	Amber	7	9/30/2026	Luisa Goddard - Chief Nursing Officer	Surgery and Planned Care Divisional Board Meeting	6/11/2026	7/11/2026	Previous score set to the September Group position (12), the return showed 9. BAF reference carried from the September GRR mapping; the return recorded "BAF 4 - SR?". To be confirmed by the Care Organisation.

IDENTIFICATION						THE RISK			SCORING AND CONTROLS							TRAJECTORY							CONSOLIDATION
Risk Ref	Care Org	Date Opened	Risk Title	Risk Type	Linked BAF Priority	Risk Statement (one sentence)	Causes (facts, one per line, numbered)	Consequences (one per line, numbered)	Live Condition? (cause already occurring)	L (1-5)	I (1-5)	Controls in Place (numbered, mapped to causes)	Evidence of Control Effectiveness	C (1-5)	Residual Score (L×I=C)	Previous Residual Score	Direction of Travel	Status this Period	Control Gaps	Actions (numbered, with dates)	Action Owner	Action Due Date	Action RAG	Target Score	Target Date	Risk Owner	Reporting Committee	Date Last Reviewed	Next Review Due	Consolidation Note
GWH-1085	GWH	11/27/2023	High hospital occupancy and impaired patient flow	Quality and Safety	R8 Reducing Avoidable Harm	There is a risk that the high hospital occupancy leads to poor patient flow through the hospital affecting the delivery of safe care	1.Sustained high bed occupancy across the Trust. 2.Delays in patient discharge processes. 3.Increasing demand for urgent and emergency care. 4.Limited downstream bed availability. 5.System-wide pressures affecting flow across health and social care services.	1.Delays in admission from emergency pathways. 2.Delays in treatment and assessment. 3.Increased use of escalation areas. 4.Increased risk of corridor care. 5.Reduced patient experience and safety. 6.Failure to achieve operational performance standards. 7. Impact on staff morale	Yes	5	4	1. Additional cohort areas have been introduced. [Causes 1, 3] 2. Seasonal plan actions are in place. [Causes 1, 3] 3. Safety and welfare checks have been increased. [Causes 1, 3] 4. Safety concerns are escalated immediately. [Causes 1, 3] 5. NerveCentre provides live patient-placement information to support quality reviews. [Causes 1, 2, 3]	1. Control effectiveness is evidenced through routine monitoring of bed occupancy, NCTR performance and length of stay against the agreed breakthrough objective trajectory. 2. Additional assurance is provided through Nerve Centre data on patient placement and time to placement, OPEL escalation levels, elective cancellations attributable to bed pressures, and monitoring of corridor care utilisation. 3. These measures are reported and reviewed regularly to identify deteriorating flow, assess the impact of improvement actions, and support timely escalation and interventions.	3	12	12	Static	No change	1.Sustained high occupancy continues to reduce flexibility across inpatient bed capacity, meaning the organisation remains reliant on escalation areas and additional cohort capacity, which is not fully embedded, recurrent flow capacity. 2. Discharge and transfer delays are not fully within GWH control, with dependency on community, social care and system partner capacity limiting the effectiveness of internal flow controls. 3. The impact of the Medical Short-Stay Unit and other flow improvement	1.Monitor referral to and appropriateness of referrals to the Virtual Ward. Use of virtual ward is encouraged to reduce hospital occupancy – there is a risk with the change of community contract that VW occupancy will be lost. Ensure this is monitored and escalated to partners as required. Data on referrals to be requested. 2.Onboarding and implementation of GIRFT Recommendations 3.Review of OPEL action cards	Chief Operating Officer - GWH	3/31/2027	Amber	8	3/31/2027	Benny Goodman - Chief Operating Officer	Performance, Population and Place Committee	8/26/2026	9/26/2026	BAF reference carried from the September GRR mapping; the return recorded "BAF 3 - SRR". To be confirmed by the Care Organisation. Risk Type taken from the return (Quality and Safety); the September GRR carried Performance and Access.
GWH-1267	GWH	11/6/2024	Stroke service performance and timely access to care	Quality and Safety	R8 Reducing Avoidable Harm	There is a risk that stroke patients will not receive quality care and timely interventions required to aid their recovery which can be evidenced SSNAP performance.	1.Stroke service performance is below expected SSNAP standards. 2.Workforce capacity constraints within therapy services. 3.Demand exceeds available staffing and therapy resource. 4.Delays in delivering specialist stroke interventions. 5.Challenges in maintaining sustainable therapy provision across the pathway. 6.Additional staffing requests have not been approved.	1.Delayed patient assessment and rehabilitation. 2.Reduced recovery outcomes for stroke patients. 3.Failure to achieve SSNAP performance standards. 4.Extended patient length of stay. 5.Increased risk of avoidable patient harm and deterioration. 6.Reputational and regulatory consequences.	Yes	5	4	1. A Performance and Operations Manager oversees data input. [Cause 4] 2. The Stroke Unit SOP has been amended to ensure that patients are not long-term. [Cause 3] 3. There is oversight of the cross-divisional SSNAP performance recovery plan. [Causes 1, 2, 3, 4] 4. Efforts continue to safeguard dedicated stroke beds, support timely admissions and reduce delays to specialist care. [Causes 2, 3] 5. Ring-fenced beds in the Acute Stroke Unit are protected through the new stroke SOP. [Causes 2, 3] 6. A monthly dashboard is sent to domain leads for real-time data review. [Causes 2, 4] 7. Monthly meetings are held with the Chief Medical	1. SSNAP provides independent, nationally benchmarked quarterly reporting of stroke performance across key domains, enabling objective assessment of service quality and outcomes. 2. Current domain scores are reviewed against national standards and trends over time to provide assurance that controls are operating effectively and supporting continuous improvement.	4	13	13	Static	No change	1. Potential that the data is not being input in a timely manner, 2. 4 hour performance impacted by overcrowding in ED and times where inpatient flow is compromised, 3. Operational pressures and high bed capacity impacts on ability to keep these beds ringfenced, 4. SSNAP domains are changing nationally which will affect our approach to recovery,	1.Conduct a comprehensive review of the therapy service including staffing patterns and key performance factors, to assess its current capacity against demand. 2.Conduct a thorough review of therapy demand and capacity mapping to ensure resources are aligned with patient needs and to identify potential areas for improvement.	Divisional Director - DOM	3/31/2027	Amber	8	9/30/2026	Luisa Goddard - Chief Nursing Officer	Unscheduled Care Divisional Board Meeting	8/4/2026	9/4/2026	Previous score set to the September Group position (13); the return showed 12. BAF reference carried from the September GRR mapping; the return recorded "BAF 4 - SRR". To be confirmed by the Care Organisation.
GWH-1382	GWH	4/14/2025	Interventional radiology workforce shortage	Workforce	R6 Reducing Waits	There is a risk to service provision & patient safety due to Interventional Radiologist shortage.	1.Ongoing shortage of Interventional Radiologists. 2.Difficulty recruiting to specialist Interventional Radiology posts. 3.Reliance on a limited number of clinicians to maintain service provision. 4.Lack of a fully agreed regional Interventional Radiology delivery model. 5.Out-of-hours service arrangements remain under review.	1.Delays in Interventional Radiology procedures. 2.Delays in diagnosis and treatment. 3.Reduced service resilience. 4.Increased dependence on external providers and regional support arrangements. 5.Increased patient safety risk. 6.Failure to meet service demand.	Yes	4	4	1. Cases are triaged and decisions are made regarding waiting or transfer. [Causes 1, 2, 4] 2. Patients can be transferred for interventional radiology procedures. [Causes 1, 2] 3. Urgent cases are referred to a tertiary centre. [Causes 1, 2] 4. One Interventional Radiologist is available through the bank for 0.4 WTE per week, when available. [Causes 1, 2, 3]	1. Control effectiveness is evidenced through monitoring of interventional radiology activity, including the number of cases undertaken on site, transferred to partner organisations and delayed. 2. Additional assurance is provided through utilisation of bank and agency cover, activation of NBT and GRH support arrangements, and delivery against the agreed SLA.	4	12	12	Static	No change	1. The Proposed Hospice out-of-hours service provides specialist telephone advice but cannot provide face-to-face assessment or intervention within GWH. It also relies on the ward or medical team recognising the need for specialist advice and contacting the service., 2. Friday planning and handover supports patients already known to the PAEC/LC team but cannot account for new deterioration out of working hours. 3. SLA is in place with a third-party provider for interventional radiologists. [Causes 1, 2, 3]	1.Confirm future model for regional [GWH/GRH/NBT/OUH] IR service 2.Contracted external provider with 2 days per week interventional radiologist cover throughout 26/27 unless successful recruitment 3.Ongoing meetings with Gloucester Royal Infirmary Executives and Radiology regarding emergency cover and future model 4.Recruitment ongoing for IR 5.Support from WoDN in pave way to setting up SLA with tertiary site, most likely NBT	General Manager - Imaging Services	3/31/2027	Amber	7	9/30/2026	Kathryn Bateman - Chief Medical Officer	Trust Management Committee	9/30/2026	10/30/2026	BAF reference carried from the September GRR mapping; the return recorded "BAF 2 - SRR". To be confirmed by the Care Organisation.
GWH-1401	GWH	5/22/2025	Building Safety Act compliance and liability risks	Estates and Infrastructure	R5 Increasing Financial Sustainability	There is a risk that building upgrade and estate improvement programmes are delayed, become unaffordable, or fail to achieve planned outcomes due to Building Safety Act compliance requirements, resulting in deterioration of the estate, service disruption, regulatory non-compliance, and failure to deliver strategic objectives.	1.The Building Safety Act 2022 introduces significant new statutory obligations. 2.National guidance and interpretation continue to evolve. 3.Specialist expertise and resources are required to support compliance. 4.Existing and planned building projects may be affected by new requirements. 5.Organisational understanding of roles, responsibilities and accountabilities continues to develop. 6.There is limited local control over aspects of implementing the legislation at scale.	1.Failure to comply with statutory requirements. 2.Delays to capital and estate improvement projects. 3.Increased financial liabilities and project costs. 4.Regulatory enforcement action. 5.Reputational damage to the Trust. 6.Increased risk associated with building safety management.	Yes	5	3	1. Oversight issues and concerns are maintained, including reporting to TMC and FIDC. [Causes 1, 3, 4] 2. The risk is reviewed monthly. [Causes 1, 2, 3, 4] 3. Legal advice has been procured from Bevan Britten to clarify the Trust's position and approach to defining the Higher-Risk Building boundary. [Causes 1, 2, 4] 4. The advised position is being tested with the Building Safety Regulator to provide clarity and, if appropriate, to implement, enable significant areas of the site to be reclassified as no longer high risk.	1. Control effectiveness is evidenced through ongoing regulatory and governance oversight, including procurement legal advice from Bevan Britten, submissions to the Building Safety Regulator and routine review through established governance forums. 2. Assurance is provided through monitoring completion of required competence assessments, regular monthly risk reviews, and reporting to TMC/FIDC.	4	12	12	Static	No change	1. Control effectiveness is evidenced through ongoing regulatory and governance oversight, including procurement legal advice from Bevan Britten, submissions to the Building Safety Regulator and routine review through established governance forums. 2. Assurance is provided through monitoring completion of required competence assessments, regular monthly risk reviews, and reporting to TMC/FIDC.	1.Continue to regularly update SLT FPIC and H&SG via E&F Board reporting. 2.Escalate to TMC Board the need to find an alternative (quicker) competent contractor 3.Explore whether any part of the GWH building can fall outside of BSA 4.Work with the Building Safety Regulator to test and evaluate a proposed legal approach aimed at simplifying Building Safety Act requirements and enabling progression of Building Safety Act projects through the PFI. 5.Work with the PFI provider and Serco to resolve Principal Contractor qualification requirements and facilitate progression of Building Safety Act projects through the PFI.	Site Director of Estates and Facilities - GWH	3/31/2027	Amber	8	3/31/2027	Rupert Turk – Site Director of Estates & Facilities	EFM / THC Joint Management Board	10/1/2026	11/1/2026	Previous score set to the September Group position (12); the return showed 12. BAF reference carried from the September GRR mapping; the return recorded "BAF 4 - SRR". To be confirmed by the Care Organisation.
GWH-1560	GWH	2/3/2026	The footprint of the Maternity Care Centre and Day Assessment Unit is not adequate to fulfil the demand.	Estates and Infrastructure	R6 Reducing Waits	There is a risk that the current location and layout of the Maternity Care Centre and Day Assessment Unit (DAU), which were rapidly repurposed to meet a CQC requirement and are not designed to support maternity care, is inadequate to meet current and projected demand, with the Maternity Care Centre and DAU not configured to support safe and efficient assessment, triage, monitoring, and emergency response.	1.Rapid relocation of maternity triage to meet a CQC "Must Do" requirement, resulting in services being moved into an area not designed for maternity front-door activity. 2.Inappropriate physical environment and layout, with the Maternity Care Centre and DAU not configured to support safe and efficient assessment, triage, monitoring, and emergency response. 3.Increased demand for services, with rising numbers of women attending the unit. 4.Increasing complexity and acuity of patients, requiring more robust assessment, monitoring, and clinical intervention. 5.DAU attendances exceeding available capacity, creating pressure on space, staffing, and patient flow.	1.Delayed assessment, triage, and treatment of women presenting to maternity services. 2.Delayed recognition and escalation of deteriorating maternal or fetal conditions. 3.Increased risk of adverse maternal and neonatal outcomes, including avoidable harm. 4.Delayed emergency response to life-threatening situations due to restricted space and poor accessibility. 5.Reduced ability for staff to maintain safe observation and monitoring of patients awaiting review. 6.Overcrowding and compromised patient privacy, dignity, and experience. 7.Insufficient patient flow capacity in home setting	Yes	4	4	1. An environmental risk assessment for the department has been completed. [Causes 1, 2, 3, 5, 6, 7, 8, 9, 10] 2. An emergency buzzer is in place. [Causes 6, 7] 3. Midwives attend annual PROMPT training on obstetric emergencies. [Causes 4, 7, 8, 9] 4. Midwives use a structured Maternity Early Warning Score system to identify and escalate maternal deterioration, supported by standardised early-warning tools and maternity-specific escalation frameworks. [Causes 3, 4, 5, 6, 8, 9, 10]	1. The department maintains a completed and signed Environmental Risk Assessment, with identified risks and associated improvement actions monitored and escalated through relevant governance structures. 2. Evidence of implementation and progress against actions is regularly reviewed. 3. Emergency buzzers are in place to enable staff to rapidly summon assistance during maternal and neonatal emergencies. 4. Evidence of control effectiveness includes records of routine emergency drills demonstrating	4	12	12	Static	No change	1.On going risks identifies with no further opportunities to improve the area. 2.Emergency buzzer does not currently work in triage. 3.Although midwives attend annual PROMPT obstetric emergency training, there remains a gap in control as competency can decline between yearly sessions; not all staff maintain up to date training due to staffing pressures; full multidisciplinary participat 4.There is inconsistency in handwriting and escalation of MEWS	1.Develop detailed plans for construction, service relocation, operational impact. 2.Development of capital plan to carry out reconfiguration plans case for presentation at Capital Prioritisation Group in November 2026 3.Implement a Flow Midwife to facilitate the safe movement of patients through the whole of maternity services. 4.Remove carpet from office space to enable repurpose into clinic room 5.Review in detail associated incidents to establish adverse outcomes directly linked to triage.	Head of Midwifery and Neonatal Services	3/31/2027	Amber	7	11/30/2026	Luisa Goddard - Chief Nursing Officer	Maternity Division Governance Group	10/3/2026	11/3/2026	Previous score set to the September Group position (12); the return showed 11. BAF reference carried from the September GRR mapping; the return recorded "BAF 4 - SRR". To be confirmed by the Care Organisation.
GWH-1576	GWH	4/10/2026	Failure to deliver planned improvement programme	Strategic	R5 Increasing Financial Sustainability	There is a risk that insufficient organisational capacity and capability prevents delivery of the Trust's strategic, operational and transformation objectives, resulting in failure to achieve planned improvements, performance standards, and financial targets.	1.Demand for organisational change exceeds available resource. 2.Competing priorities place pressure on existing teams. 3.Workforce and specialist capability constraints limit delivery capacity. 4.Increasing complexity of programmes and regulatory requirements. 5.Dependencies across multiple Trust-wide programmes and workstreams.	1.Delayed or failed strategic objectives. 2.Delays to transformation programmes. 3.Increased organisational pressure. 4.Failure to realise planned benefits and efficiencies. 5.Increased operational pressure on existing teams. 6.Reputational and regulatory consequences.	Yes	5	4	1. Financial governance oversight is in place, with clearly defined savings targets, timelines and accountable owners. [Causes 1, 2, 3, 4, 5] 2. Financial performance information and reporting mechanisms track progress, forecast variances and support decision-making. [Causes 1, 2, 3, 4] 3. External expertise is engaged where internal capacity is insufficient, for example Hunter Healthcare. [Causes 1, 2, 3] 4. Corporate project oversight identifies overlap and dependencies across programmes,prioritisation of effort and resources. [Causes 1, 2, 3, 4]	1. As at Month 4, £6.0m of savings has been delivered against a year-to-date plan of £11.2m. 2. Whilst delivery remains below plan, £47.0m of savings schemes have now been identified against the £47.2m target, representing c.99.5% identification and continued progress in scheme development and ownership. 3. Focus has shifted from scheme identification to ensuring delivery of sustainable expenditure reductions, with a current forecast of £30.7m savings by year end. 4. Overall risk remains high but is considered sufficient to maintain the risk score at the financial	3	12	13	Improving	Score reduced	1. As at Month 4, £6.0m of savings has been delivered against a year-to-date plan of £11.2m. 2. Whilst delivery remains below plan, £47.0m of savings schemes have now been identified against the £47.2m target, representing c.99.5% identification and continued progress in scheme development and ownership. 3. Focus has shifted from scheme identification to ensuring delivery of sustainable expenditure reductions, with a current forecast of £30.7m savings by year end. 4. Overall risk remains high but is considered sufficient to maintain the risk score at the financial	1.Map, review and link risks across Trust which fall under the broader theme of financial sustainability. 2.Engagement with GWH recovery director 3.Submission and delivery of Recovery Plan	Site Director of Finance - GWH	3/31/2027	Amber	7	9/30/2026	Johanna Bogle – Site Finance Director	Finance and Performance Committee	10/4/2026	11/4/2026	Status set to Score reduced; the return recorded No change. BAF reference carried from the September GRR mapping; the return recorded "BAF 4 - SRR". To be confirmed by the Care Organisation. Risk Type taken from the return (Strategic); the September GRR carried Finance.
GWH-1577	GWH	4/10/2026	Suboptimal clinical environment affecting care quality and patient experience	Strategic	R8 Reducing Avoidable Harm	There is a risk that a suboptimal clinical environment compromises patient safety, patient experience, staff wellbeing, and service efficiency, resulting in avoidable harm, reduced quality of care, and inability to meet service requirements.	1.Clinical environments across the Trust have varying levels of suitability for modern service delivery. 2.Estate limitations affect the ability to optimise patient flow and care delivery. 3.Multiple environmental risks exist across different services and locations. 4.Historical estate constraints continue to impact operational effectiveness. 5.Clinical functional fit does not consistently support future service ambitions.	1.Reduced patient experience and increased likelihood of corridor care. 2.Reduced staff experience and wellbeing. 3.Operational inefficiencies and service disruption. 4.Increased clinical risk and safety concerns. 5.Difficulty delivering strategic and operational objectives. 6.Increased estate-related costs and pressures.	Yes	4	4	1. GWH Trust Executive oversight is in place. [Causes 1, 2, 3, 4] 2. Infection prevention and control measures, including audit, minimise risk. [Causes 1, 2, 3] 3. Duty of candour arrangements and patient-safety mechanisms are in place. [Causes 1, 2, 3] 4. Health and safety risk assessments are completed, with routine monitoring. [Causes 1, 2, 3, 4] 5. Environmental risks are regularly reviewed through governance committees. [Causes	1. Annual report for IP&C received in Quality Committee 29th July demonstrating compliance with improvement plan for next twelve months recognising impact corridor care has on IPC risks. 2. Complaints has decreased in month, however the main reported concern relates to waiting times rather than environmental or inpatient experience. 3. Health and Safety oversight remains in place with annual report received at SLT 18th June which shows no significant risks.	4	12	12	Static	No change	1.Current controls provide oversight, escalation and monitoring, but do not fully mitigate the underlying estate condition, physical layout and functional limitations affecting clinical areas. 2. Limited capital availability means identified environmental risks may not be addressed at the pace required to improve patient experience and clinical effectiveness. 3. Estate strategy and masterplanning are in progress, but approved funding, prioritisation and delivery timescales are not yet confirmed for	1.COO Office to further review risk to identify actions and effective controls 2.Map, review and link risks across Trust which fall under the broader theme of clinical environment	Chief Operating Officer - GWH	3/31/2027	Amber	7	1/29/2027	Benny Goodman - Chief Operating Officer	Quality and Safety Committee	10/5/2026	11/5/2026	BAF reference carried from the September GRR mapping; the return recorded "BAF 4 - SRR". To be confirmed by the Care Organisation. Risk Type taken from the return (Strategic); the September GRR carried Estates and Infrastructure.
GWH-1638	GWH	5/12/2026	Insufficient capital funding for estate betterment and PFI handback readiness	Estates and Infrastructure	R7 Improving Value and Productivity	There is a risk that insufficient capital funding is available to support betterment or enhancement works alongside THC-funded lifecycle activities during the final years of the PFI, limiting the Trust's ability to address legacy issues, improve asset condition beyond contractual minimums, and optimise the estate ahead of handback and future service delivery.	1.PFI contract expiry will create significant estate planning requirements. 2.Funding arrangements for betterment works remain uncertain. 3.Existing lifecycle investment may not fully address future estate improvement needs. 4.Capital funding pressures exist across the NHS system. 5.Future ownership and responsibilities may increase organisational costs. 6.External funding support has not yet been secured.	1.Inability to complete required estate improvements. 2.Deterioration in estate condition and infrastructure resilience. 3.Increased financial pressures on the Trust. 4.Delays to strategic estate development plans. 5.Reduced ability to support future service transformation. 6.Increased operational and compliance risks.	Yes	4	4	1. A Trust-approved PFI Expiry Capital and Betterment Plan is developed and maintained, aligned with lifecycle delivery and informed by condition-survey outputs. [Causes 1, 3, 4] 2. Priorities are agreed through the EFM Board, with active engagement with the system, IPA and NHSE to identify and secure central capital funding. [Causes 1, 2] 3. A Trust-approved and resourced PFI Expiry Programme Plan identifies expiry-critical activities, sets out required clinical and corporate capacity, prioritises expiry delivery over business as usual where necessary, and uses tenanted external	1. Effectiveness demonstrated through approved Capital and Betterment Plan, funding secured against identified need, and regular oversight through EFM Board and FIDC. 2. Condition survey findings inform investment priorities and support delivery of the capital programme.	4	12	12	Static	No change	1.Application to Charitable Funds: Request may not be approved. 2.PFI Expiry Programme Plan: Corporate capacity conflicts (e.g. procurement, IT) are not fully within programme control. 3.PFI Expiry Programme Plan: Funding assumptions remain uncertain and are subject to wider Trust and system financial constraints.	1.Define what elements will be supported through internal resource, external specialist support, and anticipated capital or revenue funding, and review these assumptions regularly. 2.Escalate unresolved capacity or funding constraints via the corporate risk framework. Where constraints materially threaten PFI expiry delivery, ensure issues are escalated as corporate risks with clear options and recommendations. 3.Identify expiry-critical activities, required	Estates Planning Manager, GWH	3/31/2027	Amber	8	9/24/2027	Johanna Bogle – Site Finance Director	EFM Key Issues	10/6/2026	11/6/2026	Previous score set to the September Group position (12); the return showed 11. BAF reference carried from the September GRR mapping; the return recorded "BAF 4 - SRR". To be confirmed by the Care Organisation. Risk Type taken from the return (Estates and Infrastructure); the September GRR carried Finance.
SFT-7573	SFT	1/16/2023	Risk of sustained use of escalation areas impacts on patient safety, experience and operational effectiveness.	Quality and Safety	R8 Reducing Avoidable Harm	The risk of sustained use of escalation bed capacity (e.g. D3U, boarded beds) has an impact on patient safety, experience due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services. Current practice is not adhering to GIRFT corridor guidance issued March 2026 as well as UEC standards.	1. Escalation bed capacity (e.g. D3U, boarded beds) is in constant use. 2. There are not enough substantive staff for the increased bed capacity. 3. Patients are not always placed initially in the most appropriate ward. 4. Current practice is not adhering to GIRFT corridor guidance issued March 2026, nor to UEC standards.	1. Impact on patient safety. 2. Impact on patient experience. 3. Impact on operational effectiveness, e.g. ward rounds, clinical support service.	Yes	5	4	SFT Full Capacity Plan in place and released regularly Process for the management of ambulance delays in ED >45mins) Corridor SOP in place D3U and escalation areas SOP site report, clinical safety huddle daily in AMU daily patient safety meeting nurse staffing meetings x2 daily urgent care board improvement works to reduce LOS and bed occupancy Continual review of the SFT Bed Capacity Plan Changes to capacity supported by QIAs Daily capacity meetings noting quality impact BSW Clinical Interconnect wards for NCTR -	Daily data captured on the number of temporary escalation beds used.	4	13			Escalated from CO register	System plans for reduction in NCTR including use of additional bedded capacity Inability to control demand and NEL growth Bedded bed capacity within financial control Community services to support streaming and assistance are not all currently fully optimised. No options to close to all admissions leading to use of TES/corridor	1. Implementation of Winter Plan which includes: > Reduction of length of stay and non-criteria to reside to reduce bed occupancy > Improvement of pre-mid day discharges to reduce pressure on bed capacity > Work with Primary Care and Improvement Partners to find alternative places for treatment other than A&E.	Hem, Robert	4/1/2027	Green	8	4/1/2027	Talbott, Alex	Finance and Performance Committee	9/23/2026	10/23/2026	New to the Group register this period, so no previous Group score and no direction of travel. Escalated on the SFT register from 10 to 13; the return recorded Score increased.
SFT-8759	SFT	3/2/2026	Unavailability of cash balances to support timely payments to staff and suppliers	Finance	R5 Increasing Financial Sustainability	There is a risk that insufficient cash is available during 2026/27, leading to an inability to make timely payments to staff and suppliers.	1. Although a breakeven plan was submitted for 2026/27, forecasts show insufficient cash throughout 2026/27 and particularly in H2. 2. The CIP delivery trajectory may not be delivered to full value or sufficient cash. 3. Key worker accommodation will need to be transacted. 4. Capital cashflows require active management.	1. Insufficient cash to pay staff and suppliers.	Yes	5	4	CIP/Transformation delivery cell established to ensure that the CIP delivery is on trajectory with appropriate controls in place. SCP for payment runs established by SFT financial services team to ensure that only essential payments are made, in conjunction with procurement, with alignment to BSW Hospitals group cash management arrangements. BSW Hospital group cash committee has been stood up to meet NHSE guidance, as part of the BSW Group Finance Task and Finish group. A rolling cash flow forecast and cash monitoring is	12 month rolling cash forecast included on monthly Finance report. BSW Hospital group cash committee has been established. SFT financial recovery group and internal turnaround team to ensure savings delivery.	4	13	13	Static	No change	Unable to influence cash support process with NHS England and BSW Hospitals group partners will not be in a position to support on cash support requirements.	1. Aim to transact key worker accommodation in Q2 which will provide cash coverage for circa 3 months. 2. Submission of PDC revenue support application in line with National Process.	1. Prosser, Niall 2. Wyatt, Jennie	1. 31/12/2026 2. 30/09/2026	Green	8	3/31/2027	Abbott, Lynne	Finance and Performance Committee	9/23/2026	10/23/2026	Previous score set to the September Group position (13); the return showed blank.
SFT-8791	SFT	4/1/2026	Financial position 2026/27	Finance	R5 Increasing Financial Sustainability	There is a risk that the 2026/27 break-even plan is not achieved, leading to an ongoing underlying deficit and to the agreed Deficit Support Funding being placed at risk.	1. The financial plan for 2026/27 is a break-even plan assuming 7.2% savings plus productivity improvement requirements. 2. Operational constraints limit delivery of the plan. 3. Inability to achieve financial savings. 4. Ongoing pressures related to patients with no criteria to reside. 5. Savings found non-recurrently do not address the underlying position. 6. Cash balances have depleted, with NHSE instructing that cash must be managed within the system. 7. Current forecasts identify a risk of c£17.5m.	1. Ongoing underlying deficit if savings are only found non-recurrently. 2. The agreed Deficit Support Funding of £3.4m per quarter is at risk. 3. Constraint of capital expenditure will need to be considered in the event of under-delivery of savings plans.	Yes	5	4	1 - Cash flow forecasting - monitoring reports to F&P - SFI's ensuring strong financial governance - budget signed off for April 2026/27 based on internal assumptions - Deficit support funding agreed £6.4 million - Transitional funding from ICB - Weekly agency usage monitoring - Engagement in group financial recovery structure running from group board - down to front-line - Enhanced vacancy control and temporary staffing process - Medical rate card adhered to and escalation for exceptions	Improving Together methodology being used to underpin 26/27 programme. Continued upward trajectory in Trust productivity calculation, is over the nationally required 2% Downward trend in nursing bank and agency - continued reduction in UEC length of stay. Starting to see a reduction in right to reside. Long-term trend of planned activity continues to increase.	4	13	13	Static	No change	- Delivery CIP dependent on external action - Funded growth is less than the historic trend for UEC - Uncertain unintended effects of increased vacancy control - Significant proportion of the savings plan is based on theoretical opportunity rather than fully developed plans, for example unavailability	1. Full standing up of turnaround team and financial governance in place and functioning. 2. Reporting by run-rate identifying the gaps that will result in not achieving the financial plan if they are not resolved.	1. Reccay, Holly 2. Wyatt, Jennie	1. 31/10/2026 2. 31/12/2026	Green	8	3/31/2027	Wyatt, Jennie	Finance and Performance Committee	9/23/2026	10/23/2026	

IDENTIFICATION						THE RISK				SCORING AND CONTROLS								TRAJECTORY									CONSOLIDATION
Risk Ref	Care Org	Date Opened	Risk Title	Risk Type	Linked BAF Priority	Risk Statement (one sentence)	Causes (facts, one per line, numbered)	Consequences (one per line, numbered)	Live Condition? (cause already occurring)	L (1-5)	I (1-5)	Controls in Place (numbered, mapped to causes)	Evidence of Control Effectiveness	C (1-5)	Residual Score (L×I×C)	Previous Residual Score	Direction of Travel	Status this Period	Control Gaps	Actions (numbered, with dates)	Action Owner	Action Due Date	Action RAG	Target Score	Target Date	Risk Owner	Reporting Committee	Date Last Reviewed	Next Review Due	Consolidation Note
SFT-8800	SFT	4/6/2026	Reduction of No Criteria to Reside (NCTR) to 9% as per plan	Quality and Safety	R7 Improving Value and Productivity	There is a risk of patient harm caused by patients remaining in hospital when their clinical need does not require this, leading to overcrowding in the Emergency Department and the use of escalation spaces and corridor care.	1. Hospital processes and the current operating model. 2. Patients with no criteria to reside (NCTR). 3. The hospital is not meeting 9% NCTR as per plan, nor the required reductions in length of stay.	1. Patient harm. 2. Overcrowding in the Emergency Department. 3. Use of escalation spaces. 4. Corridor care.	Yes	5	4	Site and Flow meetings 3x a day. Specific medicine ward level discharge meeting Daily reporting and monitoring. System escalation plan revised and approved. Patient flow score card monitoring delivery of KPIs. Medical Director reviews all patients with LoS over 7 days with CRH. Monthly urgent care board which the COO attends. Improved data quality Improved use of e-Whiteboards on wards. Working groups with BSW system to improve discharge process and capacity. Experienced subject matter experts - focussed on work to resolve current issues.	Monthly reporting of number of patients waiting for discharge & pathways is well understood. Length of stay decreasing - Model Hospital demonstrates SFTs emergency length of stay is now at national average. Delayed discharges have decreased from over 100 in summer 2025 to 50 in March 2026. In September 2025 this was 21.32%, which reduced to 14% in March 2026. We do not have 7-day ward rounds, as a consequence of shortage in medical staff. Ward processes are not facilitating timely discharge.	4	13	12	Deteriorating	Score increased	Reporting of timelines in patients journeys challenging with current IT systems. Complexity in pathway management is leading to delays in discharge. We are not have consistency in business as usual activity around flow and discharge. We do not have 7-day ward rounds, as a consequence of shortage in medical staff. Ward processes are not facilitating timely discharge.	1. establish and implement recommendations from external report.	Cavill, Emma	12/31/2026	Green	7	12/1/2026	Cavill, Emma	Finance and Performance Committee	9/23/2026	10/23/2026	
SFT-6229	SFT	3/4/2020	Risk of DSU - Estate Infrastructure failure	Estates and Infrastructure	R8 Reducing Avoidable Harm	There is a risk of failure of the DSU building infrastructure, leading to further delayed and cancelled procedures and to harm to patient safety, care and experience.	1. The DSU building is 'end of life' and has been identified as a priority for replacement. 2. The fabric of the building is problematic and leads to numerous roof leaks. 3. Incidents relating to the building's condition are increasing.	1. Delayed and cancelled procedures. 2. Impact on patient safety, care and experience.	Yes	3	5	None ad hoc nature of issues results in limitations around mitigations. Staff manage individual cases and issues None ad hoc nature of issues results in limitations around mitigations. Funding is agreed to create an ECC (Elective Care Centre to include Diagnostics)	Allocation of funding has now been agreed to replace DSU. Business case in development and anticipating new facility online 27/28.	4	12	12	Static	No change	Substantial capital investment is required - the whole facility needs to replacing, necessitating national capital funding. Funding for new DSU Poor environment for staff - lack of wellbeing facilities.	1. Creating new Theatre Equipment Storage Capacity to reduce fire risk. 2. DASH monies approved pending short business case - to be progressed by June 2026. If approved DASH building to commence Jan 2027 with aspiration to open the unit 2028, this will mean elective work moving from DSU to DASH 3. Seed funding allocated to SFT - requires development of the business case	1. Vandyken, Mrs Ali 2. Arnold, Laurence 3. Arnold, Laurence	31/12/2026	Green	8	1/1/2029	OKeeffe, John	Finance and Performance Committee	9/23/2026	10/23/2026	
SFT-6412	SFT	4/28/2020	Harm to women and babies through lack of dedicated 2nd obstetric theatre	Quality and Safety	R8 Reducing Avoidable Harm	There is a risk of moderate to catastrophic harm to women and babies arising from the use of a repurposed anaesthetic room as a second obstetric theatre, leading to catastrophic harm or the death of a woman or baby.	1. There is no second obstetric theatre within the maternity unit footprint. 2. A second anaesthetic room has been repurposed and is not purpose built. 3. There is a reluctance to use the repurposed room. 4. When it is used there are problems with space and equipment which make it less safe. 5. There is no guarantee from main theatres that a theatre there can be used in an emergency. 6. The caesarean section rate is rising.	1. Delays in decision making. 2. Moderate to catastrophic harm to women and babies. 3. Catastrophic harm or death of a woman or baby.	Yes	5	3	Ensuring teams are aware of options for delivery and supported in that process, including the use of main theatres Keeping elective CS to 2 per day. Making sure equipment in the anaesthetic room is updated and available and that staff are aware of where to put equipment to make most use of the space.	Current PSIRs are not showing recurrent moderate, major or catastrophic harm.	4	12	12	Static	No change	Trust remains limited in theatre capacity so ongoing risk. Complexity of Labour Ward workload demands complex and dynamic decision making for which SOP can only serve as a starting point. Clinical urgency may preclude the use of Main Theatres. The constraints of the anaesthetic room environment deters decision making clinician from using this option leading to evidenced delays in care	1. Attempt to collate data relating to: - frequency of urgent operative obstetric interventions when obstetric theatre already in use - frequency of delayed urgent interventions due to above - impact of delayed interventions 2. Broad cost information to be added to options appraisal and then re-presented at COLT.	Menston, Vicki Menston, Vicki	31/08/2026 31/08/2026	Red	3	3/31/2028	Kingston, Miss Abigail	Quality and Safety Committee	9/22/2026	10/22/2026	
SFT-7734	SFT	6/16/2023	Limited Capital Funding to support safety, building and equipment	Finance	R8 Reducing Avoidable Harm	There is a risk that capital funding is insufficient to support the capital programme, leading to a risk to the safety and availability of buildings and equipment used to deliver services	1. Shortfall in funding available, locally and nationally, for the capital programme. 2. The shortfall has been compounded by the capital demand of the EPR programme.	1. Potential risk to the safety of buildings and equipment. 2. Potential risk to the availability of buildings and equipment to deliver services.	Yes	4	4	- Capital Prioritisation and Management Group (CPMG) prioritises capital programme - Risk escalation - Datix incident reporting related to infrastructure and equipment - rolling 15 month cashflow forecast - maintain a risk assessed 5 year plan - Additional funding received through the estates safety fund.	- incident reporting highlighting areas of concern to ensure appropriate prioritisation - sub groups maintain 5 year capital plans providing visibility of programme deliverables and gaps -national funding ensuring continuation of backlog maintenance programme - DASH funding secured and business case being secured	4	12	12	Static	No change	- financial constraints on ability to address whole scale estate risk - unclear regional/national process for emergency capital bids - high cost and high priority EPR programme underway - arising pressures - may impact other programmes - slippage in the EPR programme, additional pressure likely to arise in 26/27 - cashflow uncertainty could result in a requirement to slow down cash related capital spend	1. Ongoing review of cashflow forecast to ensure maximisation of capital expenditure within affordability	Wyatt, Jennie	3/31/2027	Green	9	3/31/2027	Wyatt, Jennie	Finance and Performance Committee	9/23/2026	10/23/2026	
SFT-7917	SFT	12/1/2023	Fire risk in Main Theatres corridors	Estates and Infrastructure	R8 Reducing Avoidable Harm	As a result of the storage of equipment in corridors. Hazards to staff/patients and visitors should they need to evacuate. Restricted egress in an emergency, fire doors being restricted from closing due to racking, fire extinguishers being obscured, emergency exit signage being obscured. Potential hazards to the Fire & Rescue Service should they be required to fight a fire within the area due to equipment and cylinder storage. Risk that staff will have difficulty transferring patients into theatres.	1. Equipment is stored in the corridors. 2. Fire doors are being restricted from closing due to racking. 3. Fire extinguishers are being obscured. 4. Emergency exit signage is being obscured. 5. Equipment and cylinder storage is present within the area.	1. Hazards to staff, patients and visitors should they need to evacuate. 2. Restricted egress in an emergency. 3. Potential hazards to the Fire & Rescue Service should they be required to fight a fire within the area. 4. Staff will have difficulty transferring patients into theatres.	Yes	5	3	Areas cleared as best as possible so that a theatre trolley can be evacuated out of all the theatres using all designated routes. All fire doors and extinguishers cleared of obstructions. Fire Team to conduct a weekly walk round as a minimum. Increase in the number of trained Designated Fire Safety Offers across the theatres footprint Further embedding of the Fire Safety and Arson Policy Training for all band 6's and 7's ongoing Daily fire-walk in Theatres to assess risks. Theatre Fire Wardens monthly checklist to be completed on a weekly basis and sent through to the Fire Safety Advisor.	No incidents of fire breaking out reported. Recent Fire Service inspections completed with acknowledgement of significant improvement (although not resolution of the issues) Monthly Fire wardens checklist being completed on a weekly basis. The Team is completing weekly walk rounds. Theatre staff reminded regularly as to their responsibilities to keep corridors clear as possible	4	12	12	Static	No change	Despite the above still unable to remove all trays and equipment out of the corridors due to an lack of available alternative space.	1. Develop and complete a feasibility assessment for the preferred theatre storage solution (Corridor Infill and Payroll relocation option), including building surveying and MEP requirements, procurement route, cost plan, programme, statutory compliance and resource requirements.	OKeeffe, John	9/30/2026	Green	10	1/31/2028	Dawson, Gary	Finance and Performance Committee	9/23/2026	10/23/2026	Previous score set to the September Group position (12), the return showed 11.
SFT-7949	SFT	1/4/2024	Inadequate function of emergency bleep system	Quality and Safety	R8 Reducing Avoidable Harm	There is a risk that the emergency bleep system fails to deliver emergency messages, leading to a delayed response to a medical emergency.	1. Incidents have occurred where emergency bleeps have malfunctioned. 2. Bleep units can lose signal if the hospital bridge malfunctions and then fix on to a mobile network instead (EE, O2). 3. If coverage of that mobile network is lost then emergency messages will not go to that bleep. 4. Bleeps can fail to feed back receipt of emergency bleeps if their charge falls below 1/3		Yes	3	5	Anaesthetists encouraged to swap bleeps around so that charge remains above 1/3. 2 new charging stations purchased to allow charging of bleeps in Anaesthetic dept and Labour ward theatre. Supplier reviews the bleep system every year. Business case in development to replace the bleeps.	The current bleep system mostly works. We will use recent advice to see whether that leads to a reduction in incidents.	4	12	12	Static	No change	One way communication is inefficient and leads to failures in communication. Digital system such as Medic bleep app could be considered. Battery life is worse since moving to a 4G system. Poor hospital WiFi system, which is out of Anesthetics Dept control.	1. Will to be upgraded as part of the EPR roll out.	Gibson, Richard	1/29/2027	Green	7	7/28/2027	Hill, Jeremy	Finance and Performance Committee	9/23/2026	10/23/2026	Previous score set to the September Group position (12), the return showed 9. Status set to No change; the return recorded none.
SFT-8102	SFT	5/23/2024	Central booking workforce and process instability resulting in risk of patient harm and reduced utilisation across all areas	Performance and Access	R8 Reducing Avoidable Harm	There is a risk that referrals and appointments are not processed accurately or in a timely manner, leading to patient harm, particularly for patients on active treatment pathways.	1. Significant workforce shortages and ongoing vacancies of approximately 8.17 wte. 2. High turnover is combined with a prolonged recruitment process. 3. Inconsistency in booking processes and limited adherence to standard operating procedures. 4. Insufficient controls to prevent incorrect booking, inhibiting the ability to train new starters or cover vacancies. 5. Significant operational backlogs, including delays transferring referrals from eRS into Lorenzo, unprocessed clinic outcomes forms and delays adding patients to follow-up access plans. 6. Limited oversight and assurance regarding booking accuracy, clinic utilisation and compliance.	1. Delays to patient care. 2. Missed or incorrect appointments. 3. Patients may find to follow up. 4. Increased burden on clinical teams. 5. Poor clinic and theatre utilisation, with very high volume of slots left empty each week. 6. Patient harm, particularly for patients on active treatment pathways. 7. Potential loss of confidence from clinical teams. 8. Impact on Trust performance, operational delivery and reputation.	Yes	4	4	Recruitment into vacant posts and ongoing recruitment activity Updated processes, including using BPA (Robotic Processing Automation) for some eRS tasks Specialty admin teams providing additional support to process booking and outcome forms Closer working between Central Booking and the wider Specialty Teams - Ops and Clinical Continuing Transformation programme within Central Booking, focussing on processes and ways of working Compliance and Assurance Framework Shared Managing Organisational Change policy across the three trusts in the Group. Standardised HR FAQs to be worked up and shared with affected staff to avoid localisation and possible	Escalation of incidents and issues through Datix and governance processes Clinician feedback and outcomes providing visibility of booking failures and delays Ongoing transformation programme and recruitment activity aimed at improving service performance Development of reporting tools - OP Utilisation dashboard to improve oversight Staffing numbers collated daily and escalations where required No oversight for underutilised Outpatient clinics - awaiting	4	12	13	Improving	Score reduced	Continued staffing vacancies and reliance on ongoing recruitment and booking deputy Grades for full competency) Requirement for additional bank/agency staff to support backlog recovery Limited oversight and control mechanisms to ensure booking accuracy and compliance No oversight for underutilised Outpatient clinics - awaiting	1. Develop robust booking guides/SOPs for use within Central Booking. 2. Implement a stabilisation plan for Central Booking workforce, including accelerated recruitment, deployment of bank/agency staff, and implementation of the revised staffing structure and career framework 3. Implement robust and routine reporting and dashboard oversight for OP utilisation	Hislop, Nikki Hislop, Nikki Hislop, Nikki	1. 30/09/2026 2. 30/09/2026 3. 30/10/2026	Green	6		Hislop, Nikki	Finance and Performance Committee	9/23/2026	10/23/2026	
SFT-8780	SFT	3/20/2026	Capacity of HR and change management resource to support transformation	Workforce	R4 Transforming Models of Care	There is a risk that the Trust does not have the HR and change management capacity, experience and skills needed to complete the corporate service redesign programme effectively, leading to the financial and people outcomes of the changes not being achieved.	1. HR and change management capacity, experience and skills are not at the level needed to complete the corporate service redesign programme effectively. 2. The OD&P function is going through consultation at the same time as other CSR functions. 3. Outline proposals may require the TUPE of large numbers of staff within and from outside the group.	1. Financial outcomes from the changes are not achieved. 2. People outcomes from the changes are not achieved. 3. Delivery of the CSR programme is affected. 4. Loss of oversight and management of business as usual activity.	Yes	4	4	Allocation of HR Business Partners to cross-Group functions is enabling coverage of the CSR change agenda. CSR programme team reviewing the timelines and dependencies on a weekly basis. CSR Design Authority running bi-weekly chaired by the Group CFO, and the CSR Steering Group running on a monthly basis, chaired by the Group CEO. Templated consultation document provided.	HRBP team is in place until Jun 26 - planning to replace members leaving is ongoing current staff remain in place as of Sept 26, interviews to confirm establishment taking place week 2 Sept.	4	12	12	Static	No change	One to ones with HR and OD&P staff who are affected by the CSR Consultation with the affected teams	1. Delivery of line management training support interventions 2. Recruit and train identified roles to support line managers through change management.	Ian Crowley Crowley, Ian	1. 31/03/2027 2. 30/10/2026	Green	7	3/31/2027	Crowley, Ian	People and Culture Committee	9/23/2026	10/23/2026	Previous score set to the September Group position (12), the return showed blank.
SFT-8789	SFT	3/30/2026	Failure to meet the emergency access standards as outlined in the 26/27 planning guidance	Performance and Access	R6 Reducing Waits	There is a risk that the Trust fails to meet the emergency access standards set out in the 26/27 planning guidance, leading to patients not being seen within four hours and to ambulance response times not improving.	1. Increased demand and activity within the UEC pathway in Yorkshire. 2. Higher length of stay. 3. A higher than anticipated number of patients with No Criteria to Reside. 4. The Trust has been unable to meet the nationally agreed targets.	1. The ambition to improve to 82% of patients being admitted, transferred or discharged within four hours by March 2027 is not met. 2. Ambulance response times for Category 2 incidents do not improve.	Yes	5	3	OPEL Card and escalation plans in place Daily capacity meetings x 3 Silver bleep holders and Matron of the day in place for the Divisions Wrat 45 actions implemented to support flow when at risk of ambulance holds over 45 minutes EDIG, levels within ED Medical SDEC extension in situ Creation of CDU, Send Away Clinic, streaming to walk-in-centre Escalation plans in place to flex ED and Wards when needed to support flow UEC Board in place to support improvements in UEC pathway Medical SDEC extension in situe	Reductions in LOS for medicine Increase in D Day LOS Data that supports increased demand Shortages in professional groups Daily monitoring of all urgent care standards against constitutional standards.	4	12	13	Improving	Score reduced	Further redirection in ED to external partners ie No alternatives in working hours Out of hours- significant gaps in community pharmacy GP collective action Inability to control demand Financial staffing to meet demand in ED NCTR is still above planned level. Salisbury model for urgent care is different than other cites in BSW with the lack of urgent care centre.	1. Open new Urgent Treatment Centre.	Gondelle, Liam	10/1/2026	Green	8	3/31/2027	Prosser, Niall	Finance and Performance Committee	9/23/2026	10/23/2026	
SFT-8926	SFT	7/23/2026	Capital Shortfall for the DASH Project	Finance	R4 Transforming Models of Care	There is a risk that the £5m capital shortfall on the DASH scheme cannot be met, leading to other capital schemes not being funded.	1. The capital allocation from external sources for the DASH scheme is £77.5m. 2. Latest cost estimates for the short form business case put the cost of the building at £83.8m, giving a £6m gap. 3. It is proposed that the gap is covered by use of the Trust's annual capital allocation (CDEL) in 2028/29, which will be challenging to find. 4. Costs may increase further as the design develops.	1. Other capital schemes are not funded. 2. Further cost increases as the design develops.	Yes	5	4	Strong cost controls on the project External QS support for the Trust to estimate costs Working with the building contractor to look at opportunities for cost reduction (value engineering) Project confirmed as number 1 capital priority for the Group in 28/29 therefore funding would be available to bridge the gap	The PMB is well aware of the challenge. It has been escalated to Group level and NHSE are similarly aware of the gap in funding.	3	12	12	Static	No change	Building costs can be affected by external factors which are outside of the Trust's control. Inflationary pressures across the economy affect building costs.	1. Maintain strong cost control on DASH project throughout the remainder of design stages, through to construction and completion 2. Plan for an allocation of £5m capital to be made available for 2028/29 to fund the balance of the construction 3. Try to identify other sources of funding to supplement existing allocations for DASH	Arnold, Laurence Arnold, Laurence Arnold, Laurence	1. 29/12/2028 2. 31/01/2028 3. 29/12/2028	Green	6	11/16/2026	Arnold, Laurence	Finance and Performance Committee	9/23/2026	10/23/2026	Previous score set to the September Group position (12), the return showed blank.
RUH-1882	RUH	9/18/2017	Non-compliance with fire compartmentation	Estates and Infrastructure	R8 Reducing Avoidable Harm	There is a risk that the Trust will be in breach of its statutory duty to provide safe fire compartmentation.	1. There are numerous fire doors across the site that have been identified as requiring repair, upgrading or replacement.	1. The Fire doors requiring repair may not effectively contain fire or smoke due to their current condition leading to reduced effective horizontal compartmentation and safety risk. (1) 2. The Trust could be prosecuted for being in breach of its statutory duty to provide safe fire compartmentation. 3. The Trust could be issued with a prohibition notice when inspected by the Fire Authority which will impact on all aspects of the Trust's business.	Yes	4	5	1. The Fire Safety Improvement Project is overseeing 90-minute compartmentation for inpatient areas, prioritised on a risk-assessed basis. The project is progressing well and on target. (1) 2.Programme of upgrade accommodation fire safety has been instigated following a fire authority audit. This involved the fitting of self-closing devices to fire doors that didn't have them. Any other compartmentation works will fit into the general fire safety improvement plan on a risk based basis (2)	1. Monthly documented meetings Fire Improvement Programme with action tracker. 2. Action plan on Trust risk register in relation to accommodation.	3	12	12	Static	No change	There is insufficient capital funding to fully address all known breaches in fire compartmentation. Cases for additional funding have been made to the CPMG, which reports to TMC and Trust Board. Due to capital constraints, there is currently no on-going financial resource identified to address Trust-wide breaches in fire compartmentation and fire doors.	Fire Door Survey installation of fire doors Fire door survey condition reports 1. Fire Door Quarterly inspections 2. Commission works to fire compartmentation (doors) Prioritise list for fire door replacement prioritise fire compartmentation plan for 26-27 prioritise fire compartmentation plan for 26-27 5 year replacement programme PPM install for fire door inspection Risk assess remedial actions following fire door survey Fire door survey completed Update out-patient	Mr Anthony Green Mr Anthony Green Mr Anthony Green Mr Anthony Green Mr Martin Duggan Mr Anthony Green Mr Nigel Towy Mr Martin Duggan Mr Nigel Towy Mr Nigel Towy Mr Nigel Towy Mr Anthony Green Mr Kynan Greend Mr Anthony Green Mr Nigel Towy	30/04/2020 30/04/2020 30/04/2020 31/05/2026 31/05/2026 20/11/2024 30/09/2026 20/05/2026 30/09/2026 25/03/2027 25/03/2027 01/03/2022 03/01/2024 31/10/2024 31/10/2024	Green	6	8/9/2029	Towy, Mr Nigel	Finance & Performance Committee	10/1/2026	11/1/2026	Previous score set to the September Group position (12), the return showed 9. BAF reference carried from the September GRR mapping; the return recorded "None/Not known". To be confirmed by the Care Organisation. Risk Type carried from the September GRR mapping; the return recorded "Statutory, Legal or Reputational".
RUH-2110	RUH	1/21/2021	Business interruption from Backlog Maintenance and Infrastructure Failure	Estates and Infrastructure	R8 Reducing Avoidable Harm	The Trust could be prevented from delivering safe and effective patient care due Insufficient investment in backlog maintenance, leading to critical infrastructure failure, causing service interruptions.	1. An ageing estate requiring increasing investment to maintain 2. Limited available funds which do not meet the required demand 3. A historical lack of capital investment.	1. Clinical services experience interruption (at an increasing rate). 2. Key infrastructure - equipment, plant and building fabric deteriorates at an increasing rate that compromises safe operation of services. 3. An inability to provide safe care and environment for patients and staff. 4. A potential inability for the Trust to deliver key constitutional requirements - RTT, ED and Cancer standards.	Yes	4	5	1. There is capital allocated annually to target the highest priorities of RUH high and significant risks within the backlog maintenance plan.(1) 2. Prioritisation of capital spend to prioritise the high risk infrastructure risks (2) 3. Backlog priority decision taken by Associate Director of Estates and Associate Director of Capital Projects. (2) 4. Decisions are based on condition / environmental based reports and risk assessments provided by technical leads for each discipline. (2) 5. Planned preventative and reactive maintenance regimes implemented for the estate maintained to keep systems running life to 'broken assets and to react quickly to breakdowns to minimise operational	Previous 6-Facet survey - this is being repeated this year.Backlog maintenance prioritised by subject matter experts.	3	12	12	Static	No change	There is a significant gap between the investment given and the investment required to safely manage this risk. The backlog maintenance cost is growing at an exponential rate, previously thought to be £5m per annum, from 24/25-25/26 this rate grew by £10m. This growth is outpacing the Royal United Hospital (RUH) average annual investment of £2-2m into backlog maintenance.	Annual review/update of six facet survey 5 year investment program Annual review/update of six facet survey data Report for NCGC Annual review/update of six facet survey Back Log Maintenance Policy Backlog Maintenance Programme 21/22 Superseded - Backlog Maintenance Policy Develop backlog maintenance priorities for coming financial (25/26) - allocation of backlog maintenance capital Securing Critical infrastructure and estates safety funding for coming year - for highest risks allocate a dedicated rolling replacement fund	Mrs Andrea Sanchez Mr Matt Taylor Mrs Andrea Sanchez Mr Matt Taylor Mr Owen Margetts Mr Matt Taylor Mr Matt Taylor Mr Owen Margetts Mr Martin Duggan Mr Martin Duggan Mr Jamie Caulfield Mrs Andrea	28/05/2023 31/01/2024 31/05/2024 28/02/2023 28/02/2022 04/09/2026 01/04/2021 31/01/2025 21/01/2026 30/05/2025 01/04/2026 21/03/2026 01/03/2026	Amber	10	9/20/2028	Margetts, Mr Owen	Non-Clinical Governance Committee (Redundant)	10/1/2026	11/1/2026	Previous score set to the September Group position (12), the return showed 9. Status set to No change; the return recorded Score reduced. BAF reference carried from the September GRR mapping; the return recorded "None/Not known". To be confirmed by the Care Organisation. Risk Type carried from the September GRR mapping; the return recorded "Service Delivery & Performance".

IDENTIFICATION						THE RISK				SCORING AND CONTROLS								TRAJECTORY							CONSOLIDATION
Risk Ref	Care Org	Date Opened	Risk Title	Risk Type	Linked BAF Priority	Risk Statement (one sentence)	Causes (facts, one per line, numbered)	Consequences (one per line, numbered)	Live Condition? (cause already occurring)	L (1-5)	I (1-5)	Controls in Place (numbered, mapped to causes)	Evidence of Control Effectiveness	C (1-5)	Residual Score (L×I×C)	Previous Residual Score	Direction of Travel	Status this Period	Control Gaps	Actions (numbered, with dates)	Action Owner	Action Due Date	Action RAG	Target Score	Target Date	Risk Owner	Reporting Committee	Date Last Reviewed	Next Review Due	Consolidation Note
RUH-2124	RUH	2/24/2021	Oncology/Haematology Workforce and Service Delivery	Workforce	R2 Taking Our People With Us	There is a risk that Haematology & Oncology service cannot deliver care safely due to capacity and workforce vacancies.	1. A lack of funded establishment to meet demand. 2. A nationwide lack of available qualified staff to recruit into the vacant posts.	1. The substantive establishment working beyond their timetabled job plans leading to potential burnout. 2. A reliance on Consultant agency cover. 3. Overbooked clinics. 4. A poor patient experience 5. Staff well being and morale negatively impacted.	Yes	4	5	1. Agency Locum Consultants cover in place due to being difficulty to recruit substantively at Consultant level. (2) 2. Use of cancer pharmacists for designated outpatient clinic work (3) 3. Frequent overview of rosters to optimise patient safety and staff wellbeing (1)	Partially effective use of agency locum: 2.0WTE covering 5WTE oncology outpatient activity with an overall funding deficit of 4.19WTE against demand. 2 WTE locums covering 5WTE haematology outpatient activity with an overall funding deficit of 3.0WTE against demand. 1.0WTE non-recurrent funding in Jan 2027. Partially effective use of cancer pharmacists - Cancer pharmacists delivering follow up clinics, but resilience and short staffing in screening reduces reliability of clinic activity. Partially effective use of overbooking and WLIs: Consultant body regularly overbook clinics where clinically necessary to ensure patients maintain regimens, but has sustainability issues both financially and for staff burnout.	3	12	12	Static	No change	The substantive establishment is consistently working beyond their Job Plans to meet the clinical needs of the service. Even with Locum support, the gap in service remains. Based on the 2026/27 demand and capacity, for 4 clinics, in 26/26, there is a requirement for an additional 4.73 WTE for substantive consultants working a 10 PA job plan.	Recruit Associate Specialist Oncologist Introduce community capacity for SACT Hospital Thrombosis Committee Action Plan Investigate Hospital Acquired Thrombosis Seek approval to recruit additional MNP x 2 Recruitment to be prioritised Junior Doctor Weekend support Review implementation process for NICE/CDF treatments Increase Haematology CNS Provision Continue additional SHO clinics through to end July Consider establishment of Haematology Physician's Associate post Introduce H&O Data Manager Role	Ms Karen Rye Miss Melanie Burcombe Dr Philip Robson Dr Philip Robson Miss Carly Frape Ms Karen Rye Ms Karen Rye Ms Karen Rye Ms Karen Rye Ms Karen Rye Ms Karen Rye Miss Carly Frape	01/04/2021 15/12/2025 15/09/2023 15/09/2023 30/06/2021 30/06/2021 05/03/2021 28/05/2021 30/04/2021 05/03/2021 31/03/2022 30/06/2022 30/06/2021 30/09/2022 10/07/2023	Amber	10	9/30/2026	Rye, Ms Karen	People Committee	7/31/2026	8/31/2026	Previous score set to the September Group position (12); the return showed 9. BAF reference taken from the return (R2 Taking Our People With Us); the September GRR carried RB Reducing Avoidable Harm. Risk Type taken from the return (Workforce); the September GRR carried Quality and Safety.
RUH-2683	RUH	1/5/2024	ED overcrowding and delayed emergency treatment	Quality and Safety	RB Reducing Avoidable Harm	There is a risk of avoidable serious harm or death arising from delayed assessment and treatment of patients in an overcrowded Emergency Department.	1. The ED regularly operates beyond its physical capacity; patients are being cared for in corridors and non-standard areas. 2. The 4-hour standard is not being met. 3. RN and medical vacancies in the ED. 4. High numbers of patients with no criteria to reside in the wider bed base, reducing flow. 5. Ambulance handover delays under the WAS policy.	1. Increased mortality and morbidity associated with overcrowding. 2. Patient deterioration before first assessment. 3. Poor patient experience and dignity. 4. Regulatory action and reputational damage. 5. Deteriorating staff wellbeing, retention and morale.	Yes	4	5	1. Full capacity protocol and escalation framework (causes 1, 2). 2. Daily site safety huddles with corridor care risk assessment (causes 1, 2). 3. Streaming to UTC and SDEC pathways (causes 1, 2). 4. Block rostering and agency backfill for RN gaps (cause 3). 5. System discharge programme for NCTR patients (cause 4).	Corridor care risk assessments audited weekly, 94% completion (May 2026). SDEC streaming diverted 18% of ambulatory attendances in Q4 2025/26 (system report, June 2026). 4HR reduced from 112 to 87 beds since January 2026 (system report, June 2026). No equivalent evidence yet for the escalation framework at times of surge.	3	12	12	Static	No change	No effective control over ambulance handover delays. Escalation framework unevidenced at surge. RN vacancy rate static.	ED Action plan Ambulance Triage Nurse Exhaust funnel Ambulance HALO role Ambulance Offload SOP Monitor handover delays to influence change Coordinate Trust-wide response to SWASFT THP Revise RUH-ED protocol for supporting timely ambulance handovers Time in motion for ambulance offload and pinstop patients Ensure there is a defined Did Not Wait SOP which is shared with all staff Improved pathways for streaming to other	Miss Elise Tate Miss Tracey Thorn Mr Anthony Grant Miss Tracey Thorn Miss Charlotte Porter Ms Claire Young Mr Sufi Hussain Miss Tracey Thorn Miss Charlotte Irwin-Porter Mr James Rayner Mr James Rayner Miss Tracey Thorn	09/01/2024 30/08/2024 30/05/2025 28/02/2025 28/02/2025 03/08/2026 29/11/2025 03/08/2026 31/07/2025 30/06/2025 31/08/2026 03/08/2026	Amber	10	3/31/2027	Thorn, Miss Tracey	Quality Assurance Committee	7/30/2026	8/30/2026	Risk Type carried from the September GRR mapping; the return recorded "Patient Safety & Quality".
RUH-2973	RUH	11/14/2024	Insufficient medical palliative care provision	Quality and Safety	RB Reducing Avoidable Harm	There is risk that patients will not have timely access to specialist medical palliative care support and advice.	1. A lack of funded substantive specialist medical palliative care posts.	1. Inadequate provision of counselling of patients within the cancer services when active treatment is not felt to be beneficial 2. Increased attendance to the emergency department due to lack of advanced care planning 3. Inappropriate treatment within inpatient settings 4. Lack of EoL knowledge by medical staff across the Trust 5. Poor patient and family experience 6. Negative impact on staff well being and morale 7. Reputational damage. 8. Increased length of stay.	Yes	4	4	1. Dorothy House Hospice is currently commissioned to provide 4 sessions of medical cover a week for a total of 42 weeks. (1) 2. Medical advice can be sought via Dorothy House medical team (in hours) and general advice from the Dorothy House advice line (OOH) (1) 3. There is a highly skilled and experienced nurse-led service in place that offers a 6-day service. (3)	April 25-April 26: 49 (85% of deaths at the RUH were reviewed by SPCT (Palliative and EoL Steering Group, August 2026). MLD in place with DHH. Partially effective as currently only able to offer a 6 day nurse led service due to vacancies. NACEL shows RUH-N is in a good position in relation to peers re SW and Nationally (2025). EL 09.2026 Risk has been changed from 16 to 12 following review off all >16 risks across BSW Group	4	12	12	Static	No change	There is no provision to back fill the 10 weeks when there is no medical cover for patients within the RUH. Current medical advice can be sought via Dorothy House medical team (in hours) and general advice from the Dorothy House advice line (OOH) (1) 3. There is a highly skilled and experienced nurse-led service in place that offers a 6-day service. (3)	Collect data on referring groups Conduct data collection to provide insights to service provision and need. Risk mitigation meeting OPAL for palliative care service Operational policy & business continuity arrangements and stories Review current follow up phi referrals Lack of cover across acute service Review risk meeting	Mrs Helen Richards Mrs Helen Richards Mrs Rebecca Spicer-Thomas Mrs Carly Frape Mrs Rebecca Spicer-Thomas Dr Kylie Hart Mrs Helen Richards Dr Kylie Hart Mr Kevin Jenner	23/10/2026 09/10/2026 23/11/2026 20/12/2024 29/12/2024 12/12/2025 13/10/2026 16/12/2025 16/10/2025	Amber	10	11/30/2027	Richards, Mrs Helen	Quality Assurance Committee	10/8/2026	11/8/2026	Previous score set to the September Group position (12); the return showed 9. Risk Type carried from the September GRR mapping; the return recorded "Patient Safety & Quality".
RUH-3165	RUH	9/16/2025	Delivery of Annual Financial Plan	Finance	R5 Increasing Financial Sustainability	There is a Risk that the Trust (inclusive of Sulis) will not deliver the Annual Financial Plan which will lead to increased regulation and loss of autonomy.	1. There is a bigger underlying financial deficit compared to deficit support funding. 2. A shortfall in delivery of Savings plans, unidentified savings and other emerging cost pressures.	1. Cash shortages to fund contract payment terms 2. Increased regulatory intervention (including scoring 3 or 4 against National Oversight Framework) 3. Loss of autonomy (including system triple lock on investment and additional senior management intervention and scrutiny)	Yes	4	5	1.Trust Savings programme - overseen by Financial Improvement Programme Board, reporting Management Executive Committee. (1) 2. Group and Trust support via Turnaround team. (3) 3. BSW Hospitals group collaboration, including direct efficiency plans such as Procurement, shared resources such as SOC and shared planning and service support such as Planned Care and Urgent Care (2) 4. Enhanced Pay Controls eg. vCAWR(3) 5. Enhanced Non Pay Controls eg. No PO No Pay policy and limits on Discretionary Spend (2) 6. Enhanced Investment Controls via System Triple Lock (3)	26/27 Plan unmitigated risk score and savings maturity assessment	5	14	14	Static	No change	Call to Action Clinical Value Review Unpalatables list Turnaround team Delivery of Savings Programme	Mr Jon Lund Mr Jon Lund Mr Jon Lund Mr Jon Lund Ms Rhiannon Hills	09/10/2025 31/10/2025 29/10/2025 08/12/2025 31/03/2026	Green	10	9/14/2026	Lund, Mr Jon	Finance & Performance Committee	7/31/2026	8/31/2026	Previous score set to the September Group position (14); the return showed 9. BAF reference carried from the September GRR mapping; the return recorded "None/Not known". To be confirmed by the Care Organisation. Risk Type carried from the September GRR mapping; the return recorded "Statutory, Legal or Reputational".
RUH-3230	RUH	12/18/2025	Insufficient Patient Safety, Risk, Audit and Quality Improvement Resource	Quality and Safety	RB Reducing Avoidable Harm	There is a significant risk that Safety and Quality which includes patient safety, risk, audit, and quality improvement functions are under resourced and unable to deliver statutory, regulatory, and improvement requirements.	1. Operational pressures limit clinical engagement in improvement workstreams as protected time is not consistently available 2. Competing priorities and reduced participation from key clinical stakeholders.	1.Reduced progress of Trust wide quality improvement priorities 2.Limited embedding of PSIRF, and the ability to strengthen core governance processes.	Yes	4	4	1. Partial implementation of an expanded governance structure with defined workforce gaps (1) 2. Targeted interim capacity management and prioritisation across patient safety, audit and QI (1) 3. Role optimisation and redistribution of responsibilities to support delivery (1) 4. Strengthened investigation and organisational learning processes (1)	Additional recurrent funding identified in 2026, to enable phased implementation of priority elements of the governance model. Impact not yet released. Core safety, risk, audit and quality governance processes continue to operate with some gaps. Assurance reporting in place through key committees.	4	12	12	Static	No change	Reduce workload not commensurate with PSIRF Business Planning Revision of PSIRF Plans & Policies	Mr Chris Lafferty Mr Chris Lafferty Mr Chris Lafferty	31/07/2026 31/07/2026 30/06/2026	Green	10	8/31/2026	Lafferty, Mr Chris	Quality Assurance Committee	7/31/2026	8/31/2026	BAF reference taken from the return (RB Reducing Avoidable Harm); the September GRR carried R5 Becoming an Effective Group. Risk Type carried from the September GRR mapping; the return recorded "Patient Safety & Quality".
RUH-3235	RUH	12/22/2025	Outdated Policies and Limited Governance Resource	Regulatory & Compliance	RB Reducing Avoidable Harm	There is a risk that staff rely on outdated, incorrectly classified or inaccessible policies and procedural documents, leading to inconsistent practice, avoidable harm and failure to meet statutory and regulatory requirements.	1 - A significant number of corporate policies, guidelines and SOPs are beyond their scheduled review date. 2 - The Trust does not have an online policy and document management system providing automated review notifications, workflow, version control, escalation and management reporting. 3 - The current framework relies on the Policy Coordinator manually notifying authors three months before documents expire. 4 - Policies, guidelines and SOPs have not been consistently defined, classified or named over time	1. Staff may follow outdated, incorrectly classified or superseded policies, guidelines or SOPs. 2. Patients could experience avoidable harm where clinical or operational decisions are informed by outdated or incorrect guidance. 3. The Trust may be unable to demonstrate effective document control and compliance with statutory, regulatory and NHS governance requirements, including CQC Fundamental Standards. 4. Adverse findings, reduced assurance, enforcement action or reputational damage may arise through inspections, audits or review	Yes	4	4	1. A central policy register is maintained to record policy ownership, approval dates and review dates. (Causes 1, 3 and 12) 2. The Corporate Governance team provides central coordination and support for the policy approval and publication process. (Causes 4, 6, 7, 9 and 12) 3. Policies and procedural documents are subject to regulatory and NHS governance requirements, including CQC Fundamental Standards. 4. Committee minutes, ratification assurance statements and Executive Director approvals provide	No dedicated resource for policy management. Lack of automated tracking and alert system for policy expiry. Inconsistent ownership across departments. No escalation of overdue policies to relevant committees.	4	12			New to register	1. The Policy Review Group described within the Policy for the Development and Management of Policies is not currently operating. 2. The Policy for the Development and Management of Policies is overdue for review and no longer reflects current organisational arrangements. 3. No online document management system with automated notifications, workflow, version control and escalation.	Control of Guidelines and SOP's Policy Tracking Policy Control Progress Re-develop Policy Management Framework	Mrs Rosy Milbourne Mrs Rosy Milbourne Mrs Rosy Milbourne Mrs Rosy Milbourne	30/01/2026 31/03/2026 30/04/2026 30/01/2026	Red	10	1/30/2027	Milbourne, Mrs Rosy	Finance & Performance Committee	3/31/2026	4/30/2026	New to the Group register this period, so no previous Group score and no direction of travel. This risk was on the August Group register at 14 and left the RUH return in September without explanation; it now returns at 12. The return recorded previous score 9 and status No change. Risk Type carried to the template list by the consolidation; the return recorded "Statutory, Legal or Reputational". To be confirmed by the Care Organisation.
RUH-3243	RUH	1/13/2026	IT Asset Lifecycle Replacement of Laptops Reduced	Digital and Cyber	R3 Delivering Digital Maturity	There is a risk that laptop and desktop devices across RUH, GWH and SFT are not replaced at the end of their supported lifecycle.	This risk will be caused by: 1. Capital funding available for end-user device replacement has been reduced as a consequence of Shared ERP investment priorities. 2. All laptops and desktop devices are procured with a three-year manufacturer warranty and are designed to be replaced at the end of that period. 3. Current replacement funding is insufficient to replace all devices reaching end of life across RUH, GWH and SFT. 4. A significant number of devices are now operating beyond their intended lifecycle and warranty period.	1. Clinical and non-clinical staff, including new starters, may not receive appropriate devices in a timely manner, impacting productivity and service delivery. 2. Devices operating beyond their intended lifecycle may experience increased hardware failures, reduced reliability and degraded performance. 3. Older hardware may not support current and future operating system requirements, security features and software updates. 4. Ageing devices may be unable to support emerging technologies and AI-enabled capabilities, reducing the benefits achievable through digital transformation programmes. 5. Increased device failures and performance.	Yes	4	5	1. Device age replacement is prioritised for critical clinical areas and devices assessed as no longer fit for purpose. (1) 2. IT Rolling Replacement Programme maintains annual capital funding for device refresh activity. (2) 3. A forward replacement forecast is maintained across RUH, GWH and SFT to identify future replacement requirements and funding pressures. (3) 4. Age replacement requirements are reviewed through capital planning processes to support prioritisation decisions. (4)	1. More than 1,000 end-user devices were replaced at RUH during 2025. 2. The July 2025 IT Capital Finance Report identified an annual allocation of £547,000 for the IT Rolling Replacement Programme / PC Growth. 3. At July 2026, £258,594 had been spent or committed, demonstrating active delivery of the replacement programme. 4. Areas receiving replacement devices have reported reduced support demand and improved device reliability.	3	12	12	Static	No change	Current capital funding is insufficient to meet the full age-replacement requirements across RUH, GWH and SFT. Long-term recurring funding has not been identified to support sustainable replacement of devices at the end of their lifecycle. A significant proportion of devices remain beyond their recommended replacement date.	Financial Age Replacement Central Funding Opportunities being explored	Mr Sam Gallagher Mr Jonathan Hinchcliffe	28/01/2026 31/07/2026	Red	12	9/30/2026	Gallagher, Mr Sam	Finance & Performance Committee	7/28/2026	8/28/2026	Previous score set to the September Group position (12); the return showed 9. Risk Type carried from the September GRR mapping; the return recorded "Digital".
RUH-3273	RUH	2/25/2026	Lack of electrical infrastructure limiting site development	Estates and Infrastructure	R5 Increasing Financial Sustainability	There is a risk that the RUH has insufficient electrical capacity to support any future development on the RUH site which will limit treatment options for patients and extend waiting times. This includes the ability to deliver an Integrated Front Door	1. There is a lack of available electricity coming onto the Combe Park site. 2. The demand on current site capacity is increasing. In June 2026, it peaked at 81% 3. Increase in technologies and developments that require additional electricity are increasing - diagnostic equipment, new locations (UTC), portable air conditioning units, expansion of electrical aids for services delivery and site efficiency (charging stations)	The consequences will be: -service expansion cannot be delivered or supported. -Other services experience power failures -The Trust misses out on opportunities to develop services, such as funding bids for expansion - The Trust is not able to deliver technologically led initiatives to improve care, efficiency or productivity -Existing approved schemes could be withdrawn (such as IRD)	No	4	5	1. All new capital projects are approved at CPMG. (1) 2. Electrical SEO-Electrical demand monitored (1) 3. Any service and estate developments require assessment against available existing capacity to determine ability to support and monitor increased demand on the existing capacity. 4. A capital project has been initiated and engaged with the DNO to identify a route to increasing capacity to site.	External contractor report about state of electrical infrastructure. Commissioned a second review in discussion with National Grid. Ability to record percentage of electrical capacity used. The Trust senior engineer for electricity is monitoring consumption and demand.	4	13	13	Static	No change	The amount of electricity available coming onto the Combe Park site and the capacity of the electrical infrastructure on the site are nearing full load. The PV panels and CHP on site help to reduce costs but do not fully address capacity issues. The new air-source heat pumps are using a separate source of electricity which does not have a back-up supply from the National Grid. Essentially, the route to increasing capacity with a definitive method of delivery and timeline has not been	Routine monitoring of capacity Report to be progressed to be ready for tendering Secure funding for Electrical capacity increase and associated works Establish and Deliver electrical infrastructure project	Mr Abdisalam Mahamed Syaad Mr James Wright Mr Martin Duggan Mr James Wright	31/08/2026 29/10/2026 31/03/2027 22/12/2026	Amber	8	8/11/2027	Duggan, Mr Martin	Finance & Performance Committee	10/1/2026	11/1/2026	Previous score set to the September Group position (13); the return showed 9. BAF reference carried from the September GRR mapping; the return recorded "None/Not known". To be confirmed by the Care Organisation. Risk Type carried from the September GRR mapping; the return recorded "Estates and Facilities".
RUH-3280	RUH	3/6/2026	Absence of Retrospective Building Fire Strategies (RBFS) for Existing Healthcare and Other Buildings	Estates and Infrastructure	RB Reducing Avoidable Harm	There is a risk that current fire precautions, compartmentation arrangements, evacuation methodologies, and fire safety systems do not meet required regulatory standards. This omission could potentially harm patients, staff and visitors.	1. Several existing Trust building including clinical, patient facing areas and other buildings do not have formal Retrospective Building Fire Strategies 2. The Trust has areas without up to date fire strategies aligned to HTM 05-02 and national building and fire safety legislation. 3. Historic estate development, legacy buildings, and incremental refurbishment over time without the production of comprehensive fire strategies capturing as built design information.	1. Uncertainty regarding the effectiveness of existing fire protection measures and may lead to undetected compliance gaps or unsafe assumptions within operational practice. 2. The Trust may operate buildings with fire precautions that are not fully suitable, sufficient, or coherent, resulting in increased life safety risk and potential enforcement. 3. Inadequate or unclear fire safety design principles may compromise staff and patient safety during fire incidents, including progressive horizontal evacuation. 4. Non compliance with the Building Regulations, Regulatory Reform (Fire Safety) Order 2005 and Fire Safety Act 2021, increases the likelihood of	Yes	4	5	1 Annual Fire Risk Assessments. (1) 2 Monthly AE(Fire) audit reviews. (2) 3 Ongoing compartmentation survey programme. (3) 4 Passive and Active Fire Safety Systems - Fire alarms, detection systems, and emergency lighting maintained via PPM schedules. (3)	The absence of Retrospective Building Fire Strategies presents a significant fire safety and compliance risk, as the Trust cannot evidence that its buildings' fire precautions and evacuation strategies are adequate or aligned to relevant legislation.	3	12	12	Static	No change	1. No RBFS documents exist for several buildings. 2. No definitive confirmation of original design intent or current compliance baseline. 3. Incomplete visibility of compartmentation, evacuation strategy, and systems integration.	Commission fire strategies	Mr Nigel Tovey	30/09/2026	Green	8	12/23/2026	Tovey, Mr Nigel	Finance & Performance Committee	10/1/2026	11/1/2026	Previous score set to the September Group position (12); the return showed 9. BAF reference carried from the September GRR mapping; the return recorded "None/Not known". To be confirmed by the Care Organisation. Risk Type carried from the September GRR mapping; the return recorded "Environmental".
RUH-3289	RUH	3/12/2026	Working Capital cash shortfall	Finance	R5 Increasing Financial Sustainability	There is a Risk that there will be insufficient cash to finance day to day liabilities.	1. Income and Expenditure deficit. 2. Shortfall in commissioner funding. 3. New cost pressures arising. 4. Shortfall of cost improvement plan	1. Potential for delayed payment to pay suppliers in a timely fashion. (2) 2. Deferred capital expenditure and process demands on finance, procurement teams and budget holders.	Yes	5	4	1. Internal - Budget delivery (1) 2. Internal - Under development (1) 3. External - apply for Revenue support PDC (2) 4. External - ICB working capital cash support (2) 5. External - Group working capital cash support (2) 6. External - contract renegotiation 26/27 and 27/28 onwards (2)	Rolling daily cash flow forecast based on current run rate. Before applying control of national revenue PDC support.	4	13	12	Deteriorating	Score increased	Pace of savings delivery and commissioner funding uplift	Board and MEC briefings Principles for priority cash payments and debtors/creditors management Cash Committee Capital programme commitments Revenue PDC Support application process Daily cashflow forecast	Mr Jon Lund Mr Jon Lund Mr Jon Lund Mr Jon Lund Mr Jon Lund	27/03/2026 30/06/2026 30/06/2026 30/06/2026 27/03/2026	Green	10	9/3/2026	Lund, Mr Jon	Finance & Performance Committee	7/30/2026	8/30/2026	
RUH-3400	RUH	8/19/2026	Reduction in Activity required during Shared ERP cutover	Performance and Access	R7 Improving Value and Productivity	Trust will not meet activity and income plan as activity needs to be reduced during Shared ERP Cutover	1. Cutover required a reduction of activity to enable frontline staff to become familiar with new EPR. Our planning assumption is an average reduction of 25% of activity for 6 weeks.	1. The Trust will not meet activity and income plan for 2027/28 2. There will be deterioration in waiting times for elective care.	No	4	4	1. Modelling to understand impact (1) 2. This is now a major assumption in business planning for 2027-28 (1)	Business planning for FY 2027-28 has commenced. Reduction during cutover is built into planning assumptions (with an expectation to recover activity pre/post go-live	4	12			New to register	1. Modelling of 25% reduction planning assumption required 2. Divisional validation of modelling assumptions 3. Operational plans to mitigate lost activity pre-post go-live.	Activity Model for 25% reduction for Share EPR	Mr Charlie Gale	04/09/2026	Amber	11	10/1/2026	Husain, Mr Sufi	Finance & Performance Committee	8/19/2026	9/19/2026	Previous score set to the September Group position (12): the ret New to the Group register this period, so no previous Group sco

BSW Hospitals Group Board

Agenda item	6.2
Report title	Risk and Assurance Committee – Chair's report to the Group Board
Date of meeting	5 November 2026
Sponsor	Faried Chopdat, RAC Chair
Prepared by	Faried Chopdat, RAC Chair
Approval Process:	Risk and Assurance Committee, 21 October 2026

☒ FOR ASSURANCE	☐ FOR DECISION	☐ FOR INFORMATION

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title

BSW Hospitals Group

Risk and Assurance Committee

Chair's report to the Group Board

Committee 21 October 2026 · Group Board 5 November 2026 · Chair: Faried Chopdat · For assurance · Quorate

Summary

The Committee considered the Board Assurance Framework, the executive's report, the risk register, a fire-safety deep dive and early risk appetite returns.

Overall assurance remains LIMITED, unchanged from September.

Matters for escalation to the Group Board

1. **Fire safety.** Not compliant at any site, largely unfunded, five to ten years to remedy at RUH and SFT, and not formally accepted. The executive will take legal advice on the Board's liability for known non-compliance. For decision: the Board is asked to set an explicit tolerance for fire non-compliance as part of its risk appetite and tolerances (how much, for how long, on what conditions), and to note that critical infrastructure may need to become a principal risk.
2. **Capacity to deliver remains the overriding risk.** Turnaround, winter, EPR go-live, workforce reduction and transformation all draw on the same leaders at once. The strain shows: urgent care demand about 10% up on a year ago, finance £62m adverse with 400 WTE above plan, and people actions slipping into next year. If everything stays a priority, everything slips together. The Committee has asked for the critical path to be mapped, so the Board can see what would have to wait.

Item 1 is for decision. Item 2 is for the Board's attention now, because the choices it implies will come to the Board. Everything else in this report the Committee has taken forward itself and reports for information.

How the Committee is developing

The Committee is new: piloted earlier in 2026, live since the Group formed in July, and building in stages towards reasonable assurance.



Four things stand between limited and reasonable assurance: an agreed appetite and tolerances; Board Assurance Framework ratings that match the evidence; evidence that controls on the highest risks work; and audit and regulator findings mapped to each principal risk. The aim is that by 31 March 2027 these are in place, so the Committee gives the Board reasonable assurance and hands its next Chair a model that is proven.

The Group Risk Register at a glance

Every risk scoring 12 or above across the three Care Organisations and corporate services. Clearer than before, but its quality is still uneven.



Quality and gaps

- 39 of 46 risks unchanged; corporate-service risks not updated
- No programme or Group-level risks yet; GWH has no financial-plan risk
- Trajectories are intentions, not forecasts
- Scoring to be reflected on; the right issues are reaching the Committee by judgement

Assurance by principal risk

The Board Assurance Framework rates how much assurance the Board can take on each of its eleven principal risks. Seven are rated limited. The Committee agrees with most ratings. Only the people risk is deteriorating. The executive accepted that ‘reasonable’ is a stretch for waits and corridor care, with demand at about 335 presentations a day against 303 a year ago, and will return revised ratings. A consistent version is due in November, with the two people risks merged.

Ref	Principal risk	Residual	BAF rating	Committee’s view
R1	Becoming an effective Group	10	Limited	Agree
R2	Taking our people with us	11 / 12	Limited	Deteriorating; to merge with R9; pages disagree
R3	Delivering digital maturity	12	Limited	Agree
R4	Transforming models of care	12	Limited	Agree; no target score set
R5	Increasing sustainability	14	Limited	Agree
R6	Reducing waits	12	Reasonable	Executive accepts it is a stretch; revised rating due
R7	Improving value and productivity	14	Limited	Agree
R8	Reducing avoidable harm	12	Reasonable	Corridor care: revised rating due
R9	Improving staff satisfaction	10	Reasonable	Agree
R10	Cyber security	12 / 13	Reasonable	Summary and detail pages disagree
R11	Change and leadership capacity	12	Limited	Agree

Fire safety at a glance

Each site against the main elements of fire safety law, as at 14 October.

	RUH	SFT	GWH (PFI)
Fire strategies	None for existing buildings	About half the estate	Main building under review
Compartmentation	Cannot be evidenced	Remediated, not evidenced	Defects closed (provider view)
Fire doors	None of 1,512 passed	230+ doors in progress	73% of repairs done
Escape routes	Obstructed at times	Theatre corridors blocked	ED corridors a risk
Evacuation staffing	Not evidenced	Not evidenced	Not evidenced
Fire service findings	Notice suspended	Open since 2023	Notice possible
Estimated cost	£47.6m (£35.7m unfunded); residences £2m	£12.0m, unfunded; theatres £30m more	£0.6m, largely unfunded
Risk formally accepted	No	No	No

Alert, advise, assure

Alert	Advise	Assure
Fire safety. Not compliant, unfunded, not accepted. **Finance and workforce.** £62m adverse; 400 WTE above plan. **Urgent care.** Demand 10% up on a year ago; corridor care continues.	**EPR.** Readiness varies across sites. **Quality.** Stroke D and E; infection above average; a never event at GWH. **Appetite.** Early returns cautious; minimal for fire, open for strategy. Tolerances must be workable.	**Mortality.** Within the expected range at all three sites. **Fire deep dive.** Thorough and candid. **Financial recovery.** Design now assured.

What the Committee has required, and where assurance will come from

The Group Chief Executive asked the Committee to test questions across eight themes. It could not answer them all yet, so it agreed where each is tested (GRAC: this Committee; FSC: Financial Sustainability Committee). For information.

Theme	The question, and what is required	Where assured	When
Fire safety	Exposure carried: legal advice on Board liability; owner and date per recommendation; recovery plan	GRAC; escalated	January
Delivery capacity	Priorities sequenced against leadership capacity, lower-priority work paused; critical path mapped	GRAC	18 November
Finance and cash	Forecasts, savings and cash reconcile, and savings are recurrent	FSC, to GRAC	18 November

Theme	The question, and what is required	Where assured	When
Workforce recovery	Reduction affordable, safe and sequenced; turnaround plan reducing risk now	FSC	Assurance map
Urgent care	Corridor-care safety and escalation triggers; revised ratings; standing deep dive	GRAC	Every meeting
EPR readiness	Mitigations funded and progression safe; risks rescored on the Group method	EPR Committee, to GRAC	November
Quality and safety	Risks calibrated and evidenced; maternity and neonatal to the Board in full	GRAC and Board	With UEC
Business cases	Tested against the Group strategy, not site by site	Board	Gap to close
Highest risks	The three risks scored 14 presented by their owners, with evidence	GRAC	November
Scoring and appetite	Escalate rare, catastrophic risks on consequence; appetite statements	GRAC, then Board	December

Group Board

Agenda item	6.3
Report title	Group Board Assurance Framework
Date of meeting	5 November 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Mark Ellis, Chief Risk Officer
Approval Process:	Risk and Assurance Committee, 21 October 2026

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

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title

KEY MESSAGES

The BAF shows a predominantly high and stable strategic risk profile: seven principal risks provide limited assurance and only R2, Taking Our People With Us, is assessed as deteriorating. The Risk and Assurance Committee concluded that the framework overall provides **limited assurance**, because evidence of control design is stronger than evidence that controls are operating effectively and changing outcomes.

R2 is deteriorating because delivery of the people plan depends on the emerging Group strategy, clinical models and workforce plan, while the supporting team restructure and several material actions extend into 2027. At the same time, turnaround, winter, EPR, workforce reduction and transformation are competing for the same constrained leadership and change capacity. Short-term mitigations are not yet sufficiently developed to offset the risk while the longer-term strategy is completed.

The Board should also note that the "reasonable" assurance ratings for R6 Reducing Waits and R8 Reducing Avoidable Harm are being reviewed from non-executive challenge at the Risk and Assurance Committee. Current urgent and emergency care demand, corridor care and patient-flow pressures do not yet provide compelling evidence that controls are producing the intended improvement. More generally, several downward trajectories remain dependent on future actions and should be read as intended directions rather than evidence-based forecasts.

RECOMMENDATION

The Group Board is asked to:

1. Review the BAF and note the predominantly high and static strategic risk profile and the overall limited level of assurance.
2. Note the need to revisit the assurance ratings for R6 and R8 and to strengthen evidence of control effectiveness and credible risk-reduction trajectories across the framework.

APPENDICES

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

Purpose

To present the current Group Board Assurance Framework and draw the Board's attention to the principal changes, trends, dependencies and assurance gaps within the strategic risk profile following review by the Risk and Assurance Committee on 21 October 2026.

Overall BAF position

The BAF presents a predominantly high and stable strategic risk profile. Seven principal risks are rated as providing limited assurance, while R6 Reducing Waits, R8 Reducing Avoidable Harm, R9 Improving Staff Satisfaction and R10 Cyber Security are currently rated reasonable. The Risk and Assurance Committee's overall conclusion remains limited assurance: governance and improvement arrangements are increasingly visible, but the available evidence does not yet consistently demonstrate that controls are operating effectively, producing sustained improvement or reducing residual risk.

Principal movement: R2 Taking Our People With Us

R2 is the only principal risk assessed as deteriorating. The risk has increased because the organisation is entering a period of substantial change before the principal strategic and workforce mechanisms intended to support staff through that change are fully in place. The Group people and communications plans, common culture measures and strategic workforce planning arrangements remain under development, and the supporting team restructure is not yet complete.

Why the exposure is increasing

The longer-term people plan depends on completion of the Group strategy, clinical models and workforce plan, with several significant actions extending into 2027. In parallel, turnaround, winter delivery, EPR, workforce reduction and transformation are drawing on the same limited leadership, programme and change capacity. This increases the likelihood of slippage, weakens the organisation's capacity to engage staff consistently and risks change being experienced as a series of concurrent operational pressures rather than a coherent programme. The BAF therefore identifies a widening gap between the pace of organisational change and the maturity of the arrangements intended to take staff through it.

Required response

The response needs to distinguish immediate mitigation from longer-term transformation. Short-term workforce, engagement and change-capacity actions should be incorporated into the turnaround programme rather than deferred until the full people strategy is complete. The critical path between strategy, clinical-model development, workforce planning,

restructuring and delivery programmes should also be mapped so that dependencies, capacity pinch points and consequences of delay are visible to the Board.

Other principal risks requiring Board attention

R6 Reducing Waits and R8 Reducing Avoidable Harm. Both are currently rated as providing reasonable assurance, but the Committee considered this difficult to reconcile with continuing urgent and emergency care pressure, demand above plan, corridor care and the absence of sustained improvement in headline flow measures. The ratings are being reconsidered. The key requirement is clearer evidence connecting interventions to measurable changes in demand, flow, harm and patient experience, including evidence of what has been changed or stopped where actions have not worked.

A monthly deep dive on the UEC pathway will be undertaken by the Risk and Assurance Committee moving forward.

Risk trajectories and evidence

Most principal-risk scores are unchanged. Where the BAF shows a future reduction, this currently reflects the intended effect of planned actions more than an evidenced forecast. Greater weight should therefore be placed on whether milestones have been achieved, controls have operated over time and measures are moving in the expected direction. Assurance mapping and clearer indicators are needed to distinguish confidence in the existence of arrangements from confidence in their effectiveness.

Overall conclusion

The BAF gives the Board a clearer single view of strategic exposure, but the central message is that risk reduction has not yet been demonstrated. R2 requires particular attention because the people and change infrastructure is developing more slowly than the demands being placed on it. Across the framework, the next step is to evidence whether controls are working, make cross-risk dependencies explicit and replace intended trajectories with forecasts supported by achieved milestones and measurable outcomes.

Recommendation

The Group Board is asked to review the BAF; note the deteriorating position for R2 and the reasons set out above; consider whether the immediate and longer-term mitigations are sufficient; and note the need to revisit the assurance ratings for R6 and R8 and strengthen evidence of control effectiveness and risk-reduction trajectories across the framework.

BSW Hospitals Group

Initial Board Assurance Framework

updated October 2026

Note on this update: This version incorporates evidence from relevant meetings. Scores and assurance judgements are provisional Board-level assessments pending formal risk appetite agreement. Evidence has been distinguished from planned controls, and external events are recorded against each principal risk.

Summary: All Risks at a Glance

Assurance level: Substantial | Reasonable | Limited | Minimal. Scores, appetite, assurance levels and GRR references to be completed once Initial BAF is populated.

Ref	Strategic Priority	SRO(s)	Inherent	Residual	Target	Assurance Level	Trend	GRR Ref	Key gap / status
R1	Becoming an Effective Group	CSO	8	**10**	8	*Limited*	→	*GRP-CG-02.*	*Core Group governance is operational, but strategy and risk appetite remain unagreed; decision arrangements are not yet tested through operating experience and independent assurance is pending.*
R2	Taking Our People With Us	CPO	8	**12**	7	*Limited*	↘	*GRP-PEO-01; GRP-PEO-02; GWH-1493; RUH-2124.*	*Group people and communications plans are under development; strategic workforce planning, common culture measures and sufficient change-management capacity are not yet established.*
R3	Delivering Digital Maturity	CDIO	8	**12**	9	*Limited*	→	*GRP-DIG-01; GRP-CST-02; GRP-DIG-02; GRP-DIG-03; RUH-3243.*	*A consolidated view of digital maturity and technical debt is being developed; ageing infrastructure, EPR dependencies, constrained capacity and affordability remain material, with independent assurance pending.*
R4	Transforming Models of Care	CCTIO	8	**12**		*Limited*	→	*SFT-8780; SFT-8926.*	*Programme architecture is developing, but delivery capacity, outcomes and variation baselines remain incomplete.*
R5	Increasing Sustainability	CFO	10	**14**	9	*Limited*	→	*GRP-FIN-01; GRP-FIN-02; GWH-1401; GWH-1576; SFT-8759; SFT-8791; RUH-3165; RUH-3273; RUH-3289.*	*Cash risk, material forecast deficits, recovery-plan uncertainty and capital constraints require Board oversight.*
R6	Reducing Waits	COOs (x3)	9	**12**	9	*Reasonable*	→	*GWH-1382, GWH-1560, SFT-8789*	*Recovery plans and trajectories are in place, but reporting does not yet evidence sustained improvement; delivery remains dependent on capacity, workforce, discharge and wider system action.*

Ref	Strategic Priority	SRO(s)	Inherent	Residual	Target	Assurance Level	Trend	GRR Ref	Key gap / status
R7	Improving Value and Productivity	CFO	10	**14**	9	*Limited*	→	*GRP-CST-01, GWH-1608, SFT-8800, RUH-3400*	*Productivity opportunities are identified, but delivery is not keeping pace; validated recurrent and cash-releasing benefits, implementation capacity and evidence of run-rate improvement remain insufficient.*
R8	Reducing Avoidable Harm	CNOs	9	**12**	8	*Reasonable*	→	*GWH-570; GWH-1085; GWH-1267; GWH-1577; SFT-7573; SFT-6229; SFT-6412; SFT-7734; SFT-7917; SFT-7949; SFT-8102; RUH-1882; RUH-2110; RUH-2683; RUH-2973; RUH-3230; RUH-3235; RUH-3280.*	*A Group safety picture is being developed, setting out definitions, validation and triangulation.*
R9	Improving Staff Satisfaction	CPO	7	**10**	6	*Reasonable*	→	*None directly mapped in the October 2026 GRR.*	*Change uncertainty, workforce pressure, vacancy and turnover hotspots threaten experience and retention.*
R10	Cyber security	CDIO	9	**13**	11	*Reasonable*	→	*None directly mapped in the October 2026 GRR.*	*Cyber exposure remains material due to technical debt and legacy infrastructure with remediation constrained by capacity and capital.*
R11	Change and Leadership Capacity	CEO	9	**12**	8	*Limited*	→	None directly mapped in the October 2026 GRR.	Single governed portfolio view to demonstrate priorities, dependencies and available capacity under development

Summary: Risk Position by Level (illustrative tbc)

Risks grouped by residual score. High = 12–15 | Significant = 9–11 | Moderate = 8 or below. Scores to be populated.

HIGH Residual 12–15	**R2 -**Taking Our People With Us *Score: [12] ↘ CPO* **R3 -**Delivering Digital Maturity *Score: [12] → CDIO* **R4 -**Transforming Models of Care *Score: [12] → CCTIO* **R5 -**Increasing Sustainability *Score: [14] → CFO* **R6 -**Reducing Waits *Score: [12] → COOs (x3)* **R7 -**Improving Value and Productivity *Score: [14] → CFO* **R8 -**Reducing Avoidable Harm *Score: [12] → CNOs (x3)* **R10 -**Cyber Security *Score: [13] → CDO* **R11-** Change and leadership capacity *Score [12] → CEO*
SIGNIFICANT Residual 9–11	**R1 -**Becoming an Effective Group *Score: [10] → CSO* **R9 -**Improving Staff Satisfaction *Score: [10] → CPO*
MODERATE Residual 8 or below	

R1	Becoming an Effective Group	SRO CSO	Strategic Objective Becoming an Effective Group	GRR Reference *GRP-CG-02*	Last Reviewed *October 2026* *Next Review: November*

Risk Description There is a risk that the Group fails to establish effective governance, leadership and operating arrangements following formation, caused by the complexity of integrating three established organisations with different cultures, systems and accountability structures, resulting in unclear accountability, governance failure and an inability to realise the intended benefits of group formation.

GRR cross-reference:
GRP-CG-02

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[8]	**[10]**	**[8]**
Max 10 (Likelihood + Consequence)	*Max 15 (L + C + Control Effectiveness)*	*Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional]	***Limited***	→
To be agreed at Group risk appetite workshop	*Substantial / Reasonable / Limited / Minimal*	→ *Current assessment at August 2026*

R1 Becoming an Effective Group *- Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Operating Blueprint and Assurance Manual agreed ● Group Partnership Agreement, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation in place from go-live (July 2026) ● Group Board, Joint Committees and Group Executive Committee operating to agreed terms of reference, meeting cycle and forward plan ● Functions and Decision Map maintained by the Group Company Secretary, setting out decision authority across Group and CO levels ● CO Boards continuing to operate with their own assurance committees during the transition period ● Managing Director reports to each Board meeting include summary from each Assurance Committee ● Single approach to planning agreed	*Oversight, monitoring and challenge functions* ● Risk and Assurance Committee oversight of governance development through to go-live. Committee now fully live. ● Group Audit Committee review of internal control arrangements, first committee in common September 2026 ● Company Secretary monitoring of compliance with Standing Orders and SoRD across the three COs ● External governance review Terms of Reference agreed	*Independent assurance: audit, regulator, peer review* ● Internal Audit review of risk management process Q3 2026/27 ● NHS England oversight via the System Oversight Framework ● External Auditor Annual Report on governance and value for money

Gaps in Controls and Assurance

Core Group governance arrangements are in place, but their operating effectiveness has not yet been demonstrated consistently and evidenced through delivery of objectives. The Group Strategy and risk appetite remain to be formally agreed, limiting the basis for prioritisation and risk-informed decision-making. Committee remits, escalation routes, decision rights and the respective responsibilities of Group and Care Organisation governance require further testing and embedding in practice. Action tracking and evidence of timely closure are not yet consistently reported across the governance structure. Regulatory correspondence concerning GWH performance has also highlighted the need for clearer evidence of Board ownership, effective challenge and follow-through. Independent assurance over the design and operating effectiveness of the Group governance framework remains pending.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Complete inaugural Group Board governance actions and publish the definitive governance framework, including the Operating Blueprint, Assurance Manual and committee escalation map.	Group Chair / GCEO	July 2026	*Complete*

Group Strategy agreed	CSO	December 2026	*Under development*
Group risk appetite statement developed and agreed by the Group Board	Group CRO	December 2026	*Development session held October 2026*
Internal audit plan underway	Group Audit Committee Chair	October 2026	*Complete*
Functions and Decision Map reviewed against operating experience and updated	Group Company Secretary	December 2026	*Underway*

R2	**Taking Our People With Us – building one workforce and culture ready for change**	**SRO** CPO	**Strategic Objective** Taking Our People With Us	**GRR Reference** *GRP-PEO-01; GRP-PEO-02; GWH-1493; RUH-2124.*	**Last Reviewed** *September 2026* *Next Review: November 2026*

Risk Description: There is a risk that the Group is unable to build and sustain a workforce and culture that is ready for change and capable of delivering the Group Strategy and future operating model. This may be caused by:

- resource is focused on delivering in year quality, performance and financial recovery
- insufficient workforce planning to support future models of care;
- inconsistent leadership behaviours, culture and people practices across the Group;
- ineffective communication, engagement and consultation during periods of change;
- insufficient organisational development and change management capability and capacity;
- workforce instability arising from recruitment, retention, wellbeing or industrial relations challenges;
- competing transformation programmes creating cumulative workforce impacts; and
- inadequate alignment between workforce, cultural and strategic transformation plans.

This could result in:

- reduced staff engagement, trust and confidence;
- cultural fragmentation and variable adoption of Group ways of working;
- increased turnover, sickness absence and workforce instability;
- reduced ability to attract, retain and develop talent;
- increased resistance to change and slower implementation of transformation programmes;
- failure to realise the benefits of Group integration and service transformation;
- deterioration in productivity, quality, financial performance and patient outcomes; and
- failure to deliver the Group's strategic objectives.

GRR cross-reference:
GRP-PEO-01; GRP-PEO-02; GWH-1493; RUH-2124.

INHERENT SCORE	**RESIDUAL SCORE**	**TARGET SCORE**
[8]	**[12]**	**[7]**
Max 10 (Likelihood + Consequence)	*Max 15 (L + C + Control Effectiveness)*	*Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional]	***Limited***	↘
To be agreed at Group risk appetite workshop	*Substantial / Reasonable / Limited / Minimal*	*Deteriorating*

R2 Taking Our People With Us - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Creation of a single people function to enable the one workforce approach for Group ● Care Organisation POD and Group POD ● Development of common people policies and processes ● Partnership and staff-side engagement arrangements operating across the Group. ● Leadership development and cultural alignment programmes. ● Health and wellbeing support arrangements. ● Colleague recognition and engagement programmes.	*Oversight, monitoring and challenge functions* ● People and Culture Committee oversight of staff engagement and culture indicators ● Pulse survey and NHS Staff Survey results monitored at Group and CO level ● Group CSR Design Authority oversight of consequential workforce changes ● Group transformation and programme governance arrangements. ● Care Organisation governance arrangements	*Independent assurance: audit, regulator, peer review* ● NHS Staff Survey national benchmarking ● Internal Audit review of change management arrangements ● WRES and WDES assurance. ● Gender Pay Gap reporting. ● Internal Audit reviews of workforce transformation, organisational development and change capability. ● Independent cultural and organisational effectiveness reviews where commissioned. ●

Gaps in Controls and Assurance

HR change management capacity has been flagged at SFT (SFT-8780) and may apply across the Group.

Development and implementation of Group people delivery plan to support Group Strategy
Development and implementation of a Group communications and engagement plan to support Group Strategy
Development of an agreed strategic workforce plan for the BSW Workforce to deliver future models of care
Development of a single agreed Group culture and behavioural framework supporting one organisational culture.
Change management and organisational development capacity is not yet consistently assured across the Group.
Group-level workforce, culture and readiness indicators require further development and embedding.
Workforce impacts across multiple transformation programmes are not consistently assessed at Group level.
Variable staff experience, recognitionand wellbeing arrangements remain across Care Organisations

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group People Plan Secure Group Board approval of an integrated Group People Delivery Plan, aligned to the Group Strategy and transformation portfolio.	Group CPO	December 2026 – 2026/27 People Plan	*Under development*

		June 2027 – 5 Year People Plan	
Group People and Transformation Communications & Engagement Plan Approve and begin implementation of a Group People and Transformation Communications and Engagement Plan covering colleagues, clinical leaders, staff-side representatives and other identified audiences.	Group CPO & Director of Comms	December 2026 tbc	*Under development*
Group Strategic Workforce Plan Develop and approve a Group Strategic Workforce Plan aligned to the future clinical models, Group operating model and transformation portfolio.	Group CPO	Q1/2027	*Under development*
Group Culture Indicators Agree and implement a set of Group culture and engagement indicators which will show Group and Care Organisation level performance and reported through for People and Culture Committee	Group CPO	Q1/2027	*Under development*
Group Culture & Behaviours Framework Co-design and approve a Group Culture and Behaviours Framework that defines the leadership and colleague behaviours required to operate as one Group, together with arrangements for embedding these expectations in recruitment, induction, appraisal, development, recognition and performance management.	Group CPO	Q1/2028	*Under development*
Change Management and Organisational Development Capability and Capacity Complete a Group-wide assessment of change management and organisational development demand, capability and capacity, and secure a resourced improvement plan addressing identified gaps across the Group and major transformation programmes.	Group CPO	Q1/2027	Under development
Group Workforce and people-impact assessment Introduce a Group workforce and people-impact assessment for every major transformation programme, supported by a consolidated quarterly review of cumulative impacts, dependencies and workforce risks across the full transformation portfolio.	CCTO	tbc	Under development

R3	Delivering Digital Maturity	SRO CDIO	Strategic Objective Delivering Digital Maturity	GRR Reference *GRP-DIG-01; GRP-CST-02; GRP-DIG-02; GRP-DIG-03; RUH-3243.*	Last Reviewed *02/10/26* *Next Review: 11/26*

There is a risk that the Group fails to deliver the digital maturity required to enable safe, efficient and transformed care, caused by fragmented legacy systems, material technical debt, unsupported infrastructure, inconsistent cyber and digital controls across the three Care Organisations, constrained capital investment, Digital services capacity and the complexity of delivering major programmes such as EPR, resulting in operational inefficiency, avoidable clinical risk, reduced resilience, inability to standardise pathways and failure to realise the clinical, productivity and financial benefits of group working.

GRR cross-reference:
GRP-DIG-01; GRP-CST-02; GRP-DIG-02; GRP-DIG-03; RUH-3243.

R4 Transforming Models of Care – digital capability enables pathway transformation.
R5 Increasing Sustainability – capital constraints limit digital remediation.
R7 Improving Value and Productivity – productivity benefits depend on digital standardisation.
R10 Cyber Security – technical debt increases cyber exposure.
R6 Reducing Waits – operational performance depends on reliable digital systems and data.

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[8] *Max 10 (Likelihood + Consequence)*	**[12]** *Max 15 (L + C + Control Effectiveness)*	**[9]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***Limited*** *Substantial / Reasonable / Limited / Minimal*	→ *Stable (initial position)*

R3 Delivering Digital Maturity - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Group-wide technical debt register, consolidated from RUH, GWH and SFT digital risk registers ● Prioritised remediation plan for unsupported servers, operating systems, network infrastructure, end-user devices and high-risk clinical systems. ● Architecture review board and Digital Design Authority to prevent further divergence and manage exceptions. ● Capital prioritisation process linked to digital risk scoring, clinical impact and cyber exposure. ● Lifecycle management standards for infrastructure, applications and medical/IoT devices. ● Cyber security single operational team in place with updated tools and standardised operational risk management.	*Oversight, monitoring and challenge functions* ● Group Digital Oversight Committee review of technical debt, infrastructure resilience and programme delivery risk. ● Group Risk and Assurance Committee oversight of aggregated digital risk profile ● Finance and capital governance review of unfunded digital risk and deferred remediation. ● Clinical safety review of digital risks affecting patient pathways, diagnostics, prescribing, imaging, pathology and EPR dependencies. ● Digital risk heatmap at Group/CO, showing common risks, outliers and escalation requirements prior to standardisation of service deliver, tools and teams.	*Independent assurance: audit, regulator, peer review* ● Independent review of digital maturity and technical debt baseline across the Group. ● Internal Audit review of digital governance, digital programme controls and benefits realisation. ● External assurance of EPR readiness, interoperability and clinical safety case. ● DSPT, penetration testing and cyber assurance only where they evidence maturity dependencies. ● Benchmarking against NHS digital maturity assessment, WGLL DMA and peer acute provider groups. ●

Gaps in Controls and Assurance

Group Digital Strategic plan is to be initiated, with a single consolidated view of digital maturity, technical debt, infrastructure resilience and digital investment across RUH, GWH and SFT work in progress. Group Digital and CO risk registers identify common exposure around ageing infrastructure, unsupported systems, inconsistent tooling, system resilience, constrained capital, EPR delivery dependency and capacity to deliver remediation alongside business-as-usual operational demand. Work is in progress to score Digital risks consistently, prioritised and reported through a single Group digital risk framework. There is also limited independent assurance over the totality of technical debt and the affordability of the remediation plan. A project has been initiated and is awaiting reporting of findings.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Consolidate RUH, GWH and SFT digital risk registers into a single Group digital risk and technical debt heatmap, identifying common risks, outliers and highest clinical/service impact exposures.	Group CDIO	October 2026	In progress
Establish a Group technical debt register covering infrastructure, clinical systems, end-user devices, networks, integration, data platforms and unsupported software.	Group CDIO	September 2026	In progress
Agree a risk-based digital investment and remediation plan, prioritised by patient safety, operational resilience, cyber exposure, EPR dependency and regulatory compliance.	Group CDIO/Group CFO	November 2026	Planned
Approve the Group Digital Strategic plan and digital maturity roadmap, including target maturity level standards.	Group CDIO	December 2026	In progress
Establish a Group Digital Design Authority to manage architecture standards, technical debt exceptions and convergence decisions.	Group CDIO	September 2026	Complete
Present quarterly digital maturity and technical debt assurance report to Group Digital Oversight Committee, including risk movement, funding gaps and delivery confidence.	Group CDIO	October 2026	In Progress
Commission independent assurance review of technical debt, digital governance and maturity roadmap delivery.	Group CDIO	July 2026	Complete

R4	Transforming Models of Care	SRO CCTIO	Strategic Objective Transforming Models of Care	GRR Reference *SFT-8780; SFT-8926.*	Last Reviewed *September 2026* *Next Review: November 2026*

Risk Description There is a risk that the Group fails to transform its models of care at the pace and scale required, caused by lack of dedicated clinical and project resource, insufficient clinical engagement, competing operational pressures and system complexity during transition, resulting in failure to improve patient outcomes, reduce variation, ability to provide a sustainable service, and deliver population health impact.

GRR cross-reference:
SFT-8780; SFT-8926.

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[8] *Max 10 (Likelihood + Consequence)*	**[12]** *Max 15 (L + C + Control Effectiveness)*	**[ ]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***Limited*** *Substantial / Reasonable / Limited / Minimal*	→ *Stable (initial position)*

R4 Transforming Models of Care - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team • Clinical Transformation programme structure under the Group CCTIO including the Clinical Transformation Steering Group • Weekly working group which provides a forum for cross transformation workstream sharing (UEC and Elective) • CO-level clinical leadership engaged through Group clinical fora • Specific transformation workstreams (e.g. UEC, elective recovery, community pathways) operating with named leads • Patient and public involvement arrangements across the three COs	*Oversight, monitoring and challenge functions* • Clinical Senate or equivalent Group-wide clinical advisory function • Quality and Safety oversight of transformation impacts on outcomes • Outcomes and variation reporting to the Group Quality Committee • Engagement with the BSW ICB and population health intelligence functions	*Independent assurance: audit, regulator, peer review* • External clinical peer review of transformation programmes (where commissioned) • GIRFT and other national programme benchmarking • Internal Audit review of programme management arrangements • Royal College and specialty body assurance visits

Gaps in Controls and Assurance

Gaps in Controls and Assurance. Evidence and external events reviewed: Financial sustainability discussions supported development of a Group Acute at Home model, but required a clinical risk assessment, QIA, benefits baseline and explicit stop or disinvestment criteria. Recovery discussions also highlighted limited clinical and operational capacity for transformation. Remaining gaps: fully resourced programme architecture, agreed outcomes and variation baseline, benefits-realisation discipline, patient involvement and clear management of system dependencies.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group Clinical Transformation programme plan agreed by the Group Board	Group CCTIO	September 2026	*Under development*
Outcomes and variation baseline agreed for Quality Committee reporting	Group CCTIO / Group Quality Director	November 2026	*Not started*
Patient and public involvement framework harmonised across the three COs	Group CCTIO	December 2026	*Not started*

R5	Increasing Sustainability	SRO CFO	Strategic Objective Increasing Sustainability	GRR Reference *GRP-FIN-01; GRP-FIN-02; GWH-1401; GWH-1576; SFT-8759; SFT-8791; RUH-3165; RUH-3273; RUH-3289.*	Last Reviewed *October 2026* *Next Review: November 2026*

Risk Description There is a risk that the Group fails to achieve and maintain financial sustainability, caused by structural deficits across member organisations, rising demand, inflationary pressures and the complexity of managing finances across three sites during integration, resulting in an inability to invest in transformation and compromised service delivery. Sustained financial challenge will lead to cash shortfall, this could result in inability to meet payment obligations without revenue support, loss of financial autonomy, regulatory intervention, constrained capital and transformation investment, and adverse consequences for service quality, workforce and operational delivery.

GRR cross-reference:
GRP-FIN-01; GRP-FIN-02; GWH-1401; GWH-1576; SFT-8759; SFT-8791; RUH-3165; RUH-3273; RUH-3289.

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[10] *Max 10 (Likelihood + Consequence)*	**[14]** *Max 15 (L + C + Control Effectiveness)*	**[9]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***Limited*** *Substantial / Reasonable / Limited / Minimal*	→ *Stable (initial position)*

R5 Increasing Sustainability - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Approved 2026/27 plans, budgets and Care Organisation accountability for delivery. ● Monthly financial reporting, forecasting and risk-adjusted scenario analysis across the Group. ● Group recovery plan development integrating finance, workforce, productivity, income and operational actions. ● Financial Recovery Task and Finish arrangements and Care Organisation recovery submissions. ● Daily cash monitoring, rolling cash-flow forecasts, debtors and creditors review, and preparation of revenue-support applications. ● CIP delivery cells and local turnaround arrangements focused on schemes that are not delivering at the required rate. ● Controls over vacancies, temporary staffing, discretionary expenditure, procurement and capital commitments.	*Oversight, monitoring and challenge functions* ● Financial Sustainability Committee scrutiny of forecast, recovery trajectory, cash, recurrent delivery and accountable interventions. ● Four-tier finance oversight through Care Organisations, recovery arrangements, Group Executive Committee and Group Board. ● Common challenge of forecast assumptions, DSF and income treatment, run rate, recurrent/non-recurrent delivery and risk adjustment. ● Group Finance review of Care Organisation forecasts, cash requirements and revenue-support submissions. ● Risk and Assurance Committee oversight of principal risk, control effectiveness, assurance gaps and overdue actions. ● Quality and operational impact assessment of material recovery interventions before implementation. Group SFIs providing the financial governance framework	*Independent assurance: audit, regulator, peer review* ● External Auditor opinion on financial statements and value for money ● NHS England financial regime oversight and reporting ● Internal Audit head of audit opinion on financial controls ● Independent benchmarking and external turnaround input, with outputs and delivery impact evidenced.

Gaps in Controls and Assurance

- The forecast deficit remains material and dependent on delivery of difficult recurrent actions and external assumptions.
- Evidence is not yet sufficient that controls introduced from 2 October are reducing the underlying run-rate.
- Liquidity is severe: downside scenarios indicate all three organisations could face cash shortfalls within six months.
- Some recovery assumptions remain conditional on NCTR, coding, transactions, commissioner action and system capacity.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Provide weekly and monthly evidence that expenditure controls are reducing run-rate, with variance and corrective action	Turnaround Director	October 2026	Underway

Resolve ICB reconciliation for elective income and transitional funding using one agreed dataset	Group CFO	November 2026	Undwerway
Medium-term financial plan (3-year) presented for Group Board agreement	Group CFO	March 2027	
Present month-by-month delivery evidence to each Financial Sustainability Committee, distinguishing identified, validated, delivered, recurrent and cash-releasing savings, with corrective action for slippage.	Group CFO	Monthly	Underway

R6	Reducing Waits	SRO COOs (x3)	Strategic Objective Reducing Waits	GRR Reference *GWH-1382, GWH-1560, SFT-8789*	Last Reviewed *04/09/26* *Next Review: October 2026*

Risk Description There is a risk that the Group does not deliver sustained recovery in urgent and emergency care, elective, cancer and diagnostic access at the pace required, caused by demand exceeding funded capacity; constraints in workforce, diagnostics, theatres, outpatients, beds and discharge; non-criteria-to-reside and system dependencies; pathway inefficiency and variation; competing financial-recovery requirements; and temporary disruption associated with EPR implementation. This could result in prolonged waits, avoidable harm and deterioration, corridor care, failure of constitutional and national standards, increased inequalities, regulatory intervention, reputational damage and additional operational and financial pressure.

GRR cross-reference:
GWH-1382; GWH-1560; SFT-8789.

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[9]	**[12]**	**[9]**
Max 10 (Likelihood + Consequence)	*Max 15 (L + C + Control Effectiveness)*	*Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional]	***Reasonable***	→
To be agreed at Group risk appetite workshop	*Substantial / Reasonable / Limited / Minimal*	*Stable (initial position)*

R6 Reducing Waits - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● CO-level operational delivery against RTT, cancer, diagnostic and ED standards ● Elective recovery plans in operation at each CO with named SROs ● Tier 1 / GIRFT support arrangements where in place (e.g. RUH ED) ● Patient Tracking List management and validation processes at CO level ● Cancer pathway navigators and tracking arrangements	*Oversight, monitoring and challenge functions* ● Joint Finance and Performance Committee oversight of access standards ● BSW system-level UEC and elective coordination through ICB arrangements ● Group operational performance reporting to GEC ● Harm review processes for patients waiting beyond agreed thresholds	*Independent assurance: audit, regulator, peer review* ● GIRFT national benchmarking ● NHS England operational oversight and tier rating ● CQC inspection outcomes ● Internal Audit review of waiting list management (planned, on a rolling basis)

Gaps in Controls and Assurance

Care Organisation recovery plans and trajectories provide granular evidence of the causes, controls and intended interventions, but reporting does not yet demonstrate sustained recovery.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Maintain a Group access and recovery scorecard covering UEC, RTT, cancer, diagnostics, long waits, harm, trajectory variance, action owners and delivery confidence.	Group COO function / CO COOs	August 2026	*Complete*
EPR/operational leads: agree activity-impact and recovery plans by site and specialty through planning governance	EPR/Operational leads	December 2026	*Underway, planning baseline agreed*
Demand and capacity assumptions reviewed at Group level for 2027/28 planning	Group COO function	January 2027	*Not started*

R7	Improving Value and Productivity	SRO CFO	Strategic Objective Improving Value and Productivity	GRR Reference *GRP-CST-01, GWH-1608, SFT-8800, RUH-3400*	Last Reviewed *October 2026* *Next Review: November 2026*

Risk Description There is a risk that the Group fails to improve its productivity and deliver value for money, caused by inefficient use of resources, unwarranted variation in practice across sites and failure to realise group-level efficiencies, resulting in ongoing financial deficit and an inability to reinvest in service improvement.

GRR cross-reference:
EPR programme, CST programme tracking, fit for purpose estate

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[10]	**[14]**	**[9]**
Max 10 (Likelihood + Consequence)	*Max 15 (L + C + Control Effectiveness)*	*Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional]	***Limited***	→
To be agreed at Group risk appetite workshop	*Substantial / Reasonable / Limited / Minimal*	*Stable (initial position)*

R7 Improving Value and Productivity *- Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● CO-level CIP plans with named workstream leads and delivery trajectories ● Group efficiency programme covering corporate services and clinical productivity ● Theatre, outpatient and bed productivity metrics tracked at CO level ● Procurement collaboration where established ● Agency and bank usage controls	*Oversight, monitoring and challenge functions* ● Joint Finance and Performance Committee scrutiny of productivity and CIP delivery ● Group CFO and CO Operational Directors of Finance review of productivity reporting ● Model Hospital and GIRFT data benchmarking ● Internal Audit reviews of specific productivity workstreams	*Independent assurance: audit, regulator, peer review* ● GIRFT national benchmarking and peer comparison ● Model Hospital benchmarking ● NHS England productivity programme oversight ● Internal Audit head of audit opinion

Gaps in Controls and Assurance

- Identified opportunities are not consistently converting to ledger benefit or recurrent run-rate reduction.
- Operational pressures, NCTR, sickness, enhanced care and escalation capacity constrain workforce savings.
- Service change and business-case decisions may proceed too slowly to deliver in-year value.
- Productivity gains are not always linked to cash release or improved contribution.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Maintain one finance-validated benefits tracker separating gross/net, in-year/FYE, recurrent/non-recurrent and WTE impact	Op DoFs (x3)	November 2026	*Underway*
First annual benchmarking review across the three COs presented to the Board	Group CFO	March 2027	*Not started*

R8	Reducing Avoidable Harm	**SRO** CNOs (x3)	**Strategic Objective** Reducing Avoidable Harm	**GRR Reference** *RUH-3235; GWH-1267; RUH-3314; SFT-8102; GWH-1085; GWH-1401; GWH-1560; GWH-1577; GWH-570; RUH-2124; RUH-2683; RUH-2973; RUH-3230; SFT-6229; SFT-6412; SFT-7734; SFT-7917.*	**Last Reviewed:** September 2026 *Next Review: November 2026*

Risk Description There is a risk that the Group may fail to maintain or improve safety standards leading to avoidable patient harm exacerbated by sustained operational pressures, workforce challenges, increasing demand and which may limit the capacity to implement, monitor and assure harm reduction initiatives effectively.

GRR cross-reference:

Stroke service, capacityand escalation, fit for purpose estate and infrastructure, policies and procedures

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[9] *Max 10 (Likelihood + Consequence)*	**[12]** *Max 15 (L + C + Control Effectiveness)*	**[8]** *Planned destination*
RISK APPETITE ***[Provisional]*** *To be agreed at Group risk appetite workshop*	**ASSURANCE LEVEL** ***Reasonable*** *Substantial / Reasonable / Limited / Minimal*	**DIRECTION OF TRAVEL** → *Stable (initial position)*

R8 Reducing Avoidable Harm - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Patient Safety Incident Response Framework (PSIRF) implementation across the three COs ● Datix or equivalent incident reporting in operation at each site with thematic learning ● Mortality review processes and learning from deaths reporting ● Infection prevention and control teams and surveillance ● Safe staffing reviews and acuity tools at ward level	*Oversight, monitoring and challenge functions* ● Quality and Safety Committee in each Care Organisation with escalation via MD report ● Quality oversight at Group level ● Group Perinatal Oversight Meeting ● Patient Safety Specialists and Group-level patient safety leadership ● Chief Nursing Officers and Chief Medical Officers collaborative coordination of safety reporting and themes ● Safeguarding Committees oversight	*Independent assurance: audit, regulator, peer review* ● CQC inspection outcomes and ratings ● Healthcare Safety Investigation Branch (HSIB) reviews where applicable ● Internal Audit reviews of patient safety arrangements ● External clinical audits (NCEPOD, Royal College reviews) ● NHS Resolution claims data and learning

Gaps in Controls and Assurance

The Group is developing a consistently defined, validated and timely view of avoidable harm across all three Care Organisations. Incident, mortality, infection, safe staffing, complaints and claims intelligence is being developed into a process which will routinely be triangulated into a single Group safety picture, enabling early identification of common themes, unwarranted variation and emerging risks. PSIRF maturity, learning-response capacity, oversight competence and approaches to compassionate engagement remain variable. There is a developing Group-wide assessment against the current patient safety incident response standards. Workforce pressures and governance capacity constraints remain material dependencies, while independent assurance over the effectiveness of the developing Group safety system is not yet scheduled.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Establish a Group Perinatal Oversight Group to provide oversight and ensure that learning from perinatal care reviews, incidents, and improvement activity is identified, shared and embedded across all care organisations within the Group.	Luisa Goddard, Chief Nursing Officer (GWH)	July 2026	Completed
Develop and implement a Group Safety Scorecard, underpinned by agreed definitions and robust data quality assurance processes, to provide consistent oversight of patient safety and quality, mortality, staffing and key avoidable harm measures. The scorecard will form part of the Group Integrated Performance Report.	Angie Ansell, Interim Chief Nursing Officer (SFT)	November 2026	Under development
Complete a baseline assessment of all three Care Organisations against the Patient Safety Incident Response Framework (PSIRF) standards, agree and implement prioritised actions to address partially met standards.	Jason Lugg, Chief Nursing Officer (RUH)	November 2026	Under development

Establish a quarterly Group-wide thematic review process that brings together insights from patient safety incidents, mortality reviews, infection prevention and control, safeguarding, complaints, claims, workforce indicators and patient experience. Ensure actions are tracked through a single Group improvement plan.	Angie Ansell, Interim Chief Nursing Officer (SFT)	October 2026	Under development

R9	Improving Staff Satisfaction	SRO Op DoPs (x3)	Strategic Objective Improving Staff Satisfaction	GRR Reference *None directly mapped in the August 2026 GRR.*	Last Reviewed *04/09/26* *Next Review: Novemebr 2026*
Risk Description There is a risk that the Group fails to improve staff experience and retain a productive workforce, caused by the uncertainty of changes needed to deliver Group strategy, cultural differences across organisations and ongoing workforce pressures, resulting in high turnover in hard to recruit areas, stagnation and recruitment difficulties and a deterioration in the quality of care delivered. ***GRR cross-reference:***					

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[7] *Max 10 (Likelihood + Consequence)*	**[10]** *Max 15 (L + C + Control Effectiveness)*	**[6]** *Planned destination*
RISK APPETITE ***[Provisional]*** *To be agreed at Group risk appetite workshop*	**ASSURANCE LEVEL** ***Reasonable*** *Substantial / Reasonable / Limited / Minimal*	**DIRECTION OF TRAVEL** → *Stable (initial position)*

R9 Improving Staff Satisfaction - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team ● Development and implementation of Group People Delivery Plan ● NHS Staff Survey administration and action planning at CO level and Group level ● Pulse survey arrangements where in place ● Health and wellbeing offer for staff at each CO ● Recognition schemes and long service arrangements ● Freedom to Speak Up Guardian arrangements at each CO	*Oversight, monitoring and challenge functions* ● People and Culture Committee oversight of engagement indicators ● Group CPO and Site HRDs review of turnover, vacancy and sickness data through Care Org POD and Group POD ● Speak Up Guardian reporting to the Board	*Independent assurance: audit, regulator, peer review* ● NHS Staff Survey national benchmarking ● Workforce Race Equality Standard and Workforce Disability Equality Standard returns ● Gender Pay Gap reporting ● NETS Survey ● MEQR annual review ● External cultural reviews (where commissioned)

Gaps in Controls and Assurance

Group-level staff experience indicators not yet agreed. Health and wellbeing offer varies across the three COs. Turnover hotspots (e.g. nursing, specific specialties) are known but mitigation impact is not yet assessed at Group level.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Overlap with R2: Taking our People with us			

R10	Cyber Security	SRO CDIO	Strategic Objective Delivering Digital Maturity	GRR Reference *None directly mapped in the August 2026 GRR.*	Last Reviewed *04/09/2026* *Next Review: 02/11/2026*

Risk Description:

There is a risk that the Group experiences a significant cyber security incident, ransomware attack or data breach, caused by the evolving threat landscape, fragmented legacy infrastructure across the three Care Organisations, material technical debt, unsupported systems, inconsistent cyber controls, medical and IoT device exposure, third-party and supply chain vulnerabilities, and constrained capacity to remediate known digital risks, resulting in disruption to clinical services, compromise or loss of patient and corporate data, financial loss, regulatory action, loss of public confidence and reputational damage.

GRR cross-reference:

Linked BAF dependencies: R10 is a cross-cutting enabling risk. It has a direct dependency relationship with R3 Delivering Digital Maturity, R6 Reducing Waits and R8 Reducing Avoidable Harm, and a significant enabling relationship with R4 Transforming Models of Care and R7 Improving Value and Productivity. It also has consequential links to R5 Financial Sustainability, R1 Group Effectiveness, R2 Taking Our People With Us and R9 Staff Satisfaction through service disruption,

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[9] *Max 10 (Likelihood + Consequence)*	**[12]** *Max 15 (L + C + Control Effectiveness)*	**[11]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***Reasonable*** *Substantial / Reasonable / Limited / Minimal*	→ *Stable (initial position)*

R10 Cyber security - *Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team	*Oversight, monitoring and challenge functions*	*Independent assurance: audit, regulator, peer review*
• Group-aligned cyber security framework and operating model developed, with clear accountabilities across Group Digital services. • Group-wide technical debt and cyber exposure heatmap, drawing from CO digital risk registers. • Prioritised remediation plan for unsupported operating systems, servers, applications and high-risk clinical systems. • Identity and access management improvement plan, including MFA expansion, privileged access management and joiner/mover/leaver controls. • Medical and IoT device cyber monitoring and risk-based remediation plan. • Group cyber incident response playbooks, including ransomware, EPR outage, pathology outage, imaging outage and supplier compromise. • Cyber resilience testing aligned to EPR, LIMS, PACS, pathology, radiology, e-prescribing and shared infrastructure dependencies. • Supplier cyber assurance process for critical systems and system/regional shared services.	• Group Digital Oversight Committee or equivalent to review cyber risk, technical debt and security control convergence. • Group Risk and Assurance Committee to receive a consolidated cyber risk profile. • Group Information Governance / Security Forum to monitor policy, DSPT, IG training, data breach trends and cyber control compliance. • Finance/capital governance review of unfunded cyber remediation and deferred technical debt. • Clinical safety oversight where cyber risks affect clinical systems, medical devices or critical pathways. • Regular review of supplier cyber risk for critical clinical and corporate systems.	• Independent Group-wide cyber maturity review against NHS CAF / DSPT / NCSC-aligned controls. • Internal Audit review of cyber governance and technical debt risk management. • Independent review of privileged access, endpoint protection, backup resilience and restore capability. • Tabletop exercise or live simulation of a major cyber incident affecting one or more COs. • Post-exercise assurance report to the Group Board. • Independent assurance on supplier cyber risk management for critical third parties.

Gaps in Controls and Assurance

Cyber risk remains high because CO risk registers identify material exposure from technical debt, unsupported infrastructure, inconsistent tooling, supplier vulnerabilities and constrained specialist cyber capacity. The Group does not yet have a fully consolidated cyber risk and technical debt heatmap across RUH, GWH and SFT, this is in progress. Cyber controls exist at Group Digital services, convergence of cyber tooling, identity controls, endpoint controls, USB/device controls, medical and IoT device security, supplier assurance and cyber incident response arrangements is not yet complete. Legacy infrastructure, including unsupported servers and bespoke systems, remains an active source of risk and capital constraints may delay remediation. Business continuity plans for

extended cyber outage scenarios require further testing across shared clinical dependencies, including EPR, pathology, radiology, imaging, e-prescribing and regional services.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group business continuity plans reviewed and strengthened for extended cyber outage scenarios, starting with Pathology LIMS and Integrated EPR	Group CDIO / CO COO	February 2027	Not started
Consolidate RUH, GWH and SFT cyber and digital risk registers into a single Group cyber risk and technical debt heatmap, showing highest-risk assets, unsupported systems, supplier risks and clinical service dependencies.	Group CDIO	October 2026	*In progress*
Agree Group cyber security operating model, including accountability, escalation, incident command, cyber on-call arrangements and relationship with CO teams	Group CDIO	November 2026	*In progress*
Agree Group cyber control baseline, including MFA, privileged access management, patching, endpoint protection, logging/monitoring, USB/device controls, backup resilience and incident response standards.	Group CDIO	October 2026	*Planned*
Complete risk-based remediation plan for unsupported infrastructure, legacy applications and high-risk clinical systems, prioritised by patient safety, cyber exposure and business continuity impact.	Group CDIO	December 2026	*In progress*
Complete supplier cyber assurance review for all critical systems and high-impact third parties, including regional dependencies and clinical networks.	Group CDIO	October 2026	*In progress*
Complete Group cyber incident tabletop exercise, including ransomware and extended outage scenario affecting EPR, LIMS or imaging.	Group CDIO	November 2026	*In Progress*
Report cyber training, phishing simulation, MFA coverage, patch compliance, unsupported asset reduction and cyber incidents quarterly to Group Digital Oversight Committee and Group Risk and Assurance Committee.	Group CDIO	October 2026	*In progress*

R11	Change and leadership capacity	SRO CEO	Strategic Objective Becoming and effective Group	GRR Reference	Last Reviewed *October 2026* *Next Review: November 2026*

Risk Description:

There is a risk that the Group does not have sufficient collective leadership, programme-management, clinical, operational and workforce capacity, or sufficiently clear prioritisation and sequencing, to deliver the volume and pace of concurrent financial recovery, service transformation, digital, quality, workforce and governance change. This could result in delayed or poorly controlled delivery, unmanaged interdependencies, staff overload, failure to realise planned benefits, and deterioration in quality, performance, finance or stakeholder confidence.

GRR cross-reference:

Linked BAF dependencies: R11 is a cross-cutting enabling risk. It has a direct dependency relationship with R1 Becoming and Effective Group, and a significant enabling relationship with R4 Transforming Models of Care, R7 Improving Value and Productivity, and R3 Delivering Digital Maturity. It also has consequential links to R5 Financial Sustainability, R2 Taking Our People With Us and R9 Staff Satisfaction.

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[9] *Max 10 (Likelihood + Consequence)*	**[12]** *Max 15 (L + C + Control Effectiveness)*	**[8]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***Limited*** *Substantial / Reasonable / Limited / Minimal*	→ *Stable (initial position)*

R11 Change and leadership capacity *- Controls, Assurance and Actions*

First Line of Defence	Second Line of Defence	Third Line of Defence
Operational controls owned by the SRO and team • CEO sponsorship and executive ownership of the Group's strategic priorities and principal risks. • Group Executive Committee oversight of financial recovery, transformation, quality, workforce, digital and governance priorities. • Programme and workstream governance exists for major change portfolios, with named executive leads and routine reporting. • Board Assurance Framework and Group Risk Register provide routes to identify and escalate strategic delivery risks. • Financial recovery and transformation arrangements provide an emerging mechanism to monitor delivery, benefits and dependencies. • Care-organisation leadership structures retain local accountability for operational delivery and escalation.	*Oversight, monitoring and challenge functions* • Group Board and Risk & Assurance Committee scrutiny of principal risks, assurance judgements and gaps. • GEC review of delivery priorities, interdependencies and executive ownership. • Finance, performance, quality, workforce and digital reporting provide second-line indicators of delivery strain or slippage. • Internal governance reviews of decision rights, committee accountabilities and escalation routes. • Scheduled risk-appetite and strategy work provides the basis for explicit prioritisation and tolerance decisions.	*Independent assurance: audit, regulator, peer review* • Internal Audit programme is in progress, with relevant completed reviews to be mapped to the BAF. • External Audit and NHS England oversight provide independent challenge on financial recovery, governance and delivery confidence. • Regulatory, clinical and statutory reviews provide issue-specific assurance where relevant.

Gaps in Controls and Assurance

1. No single, governed portfolio view demonstrates the totality of change, critical dependencies, delivery capacity and cumulative impact across the Group and three care organisations.
2. Prioritisation and stop/start/defer decisions are not yet consistently documented against agreed strategy, risk appetite, quality impact, affordability and benefits.
3. Leadership and specialist capacity, succession resilience and key-person dependencies have not been assessed consistently across all major programmes.
4. Benefits baselines, delivery milestones and resource assumptions are not yet sufficiently standardised to demonstrate that planned benefits are achievable and recurrent.
5. Third-line assurance has not yet been mapped to this risk and there is no independent Group-wide opinion on portfolio governance and change capacity.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Agree a single prioritised Group change portfolio and explicitly pause, stop or defer lower-priority activity.	CSO/CDIO	15 October 2026	Engine room live
Embed the Engine Room process as part of Ward to Board / Operational Management System arrangements.	CSO/Transformation team	15 October 2026	Engine room live
Implement a monthly integrated dashboard with agreed early-warning indicators for milestone slippage, resource pressure, benefits variance, workforce impact, quality impact and unresolved interdependencies; report exceptions through GEC to RAC.	CRO/Group PMO	31 October 2026	On-track/off-track methodology agreed as part of Engine room
Commission and map independent assurance over portfolio governance, prioritisation, benefits management and change capacity; update the R11 third-line column and assurance judgement when the review reports.	CRO / Internal Audit	31 December 2026	Proposed - timing to align with audit plan

Note on this template: *Good practice (HM Treasury Orange Book; GGI BAF guidance) distinguishes between controls -the measures in place to manage a risk -and assurances -the evidence that those controls are working effectively. In this Initial BAF, controls and assurances are combined within each line of defence for simplicity during the transition period. They will be separated when the Initial BAF is superseded by a mature Group BAF in early 2027.*

BSW Hospitals Group Board

Report from	Audit Committees-in-Common Chair Assurance Report	Agenda Item	6.4
Report to	Group Board		
ACiC meeting date	10th September 2026		
Board meeting date	October 2026		
Author	Chair of the Audit Committees-in-Common		
Status	Assurance		
Reporting period	FY2026/27 Period: Months 1-5		

KEY MESSAGES

As part of the BSW Hospitals Group (BSWHG) governance arrangements, the Audit Committees of Great Western Hospitals NHS FT (GWH), Royal United Hospitals NHS FT (RUH) and Salisbury Hospital NHS FT may meet in common to support shared discussion, alignment of audit and assurance matters, and collective consideration of cross-organisational themes. The meeting in common arrangement does not constitute a joint committee. Each Audit Committee remains separately constituted by, and accountable to, its own Board of Directors, with formal decisions, approvals, recommendations and escalations taken individually by each Audit Committee in accordance with its own statutory duties, delegated authority and governance responsibilities. The Audit Committees met in common for the first time on 10 September 2026. This first assurance report summarises the key matters considered at that meeting and captures the assurance, decisions and areas for escalation relevant to the three statutory Audit Committees.

The Board should note

- Limited Assurance on the effectiveness of the BAF framework (Sept 2026) at this stage of its development and endorse the distinction between Risk Assurance Committee (RAC) scrutiny of the live principal-risk position and Audit Committee in Common (ACIC) scrutiny of framework effectiveness, internal control and independent assurance.
- Signifincant Assurance on the two Internal Audit Reports in the period (Safeguarding review @ GWH, Violence and Agression review @ SFT) but note more emphasis is needed by COLTs on implementing Internal Audit Actions in a timely manner (SFT - 20 actions overdue, RUH - 6 actions overdue and GWH - 1 action overdue).
- Two amendments to technical accounting policies for the GWH 2026/27 Trust Accounts (detail below).

RECOMMENDATION

The Group Board is asked to note the report, take assurance from the matters identified within the Assure section, and consider the actions and recommendations arising from the Alert and Advise sections.

Audit Committees-in-Common Chair Assurance Repot

Key discussion points and matters to be escalated from the committee meeting.

Alert - No matters to alert.

Advice

Risk Management and Committee Oversight
The Committee endorsed the distinction between Risk Assurance Committee (RAC) scrutiny of the live principal-risk position and Audit Committee in Common (ACIC) scrutiny of framework effectiveness, internal control and independent assurance. In practice, RAC oversees the live risk position, risk appetite, risk culture, the BAF, the corporate risk register and the adequacy of mitigations. ACIC provides independent assurance on governance, risk management and internal-control effectiveness. The intended information flow is quarterly BAF updates and assurance gaps from RAC to ACIC, with relevant internal-audit findings flowing back to RAC. ACIC will continue to monitor the design and operating effectiveness of this approach.

Internal Audit Actions
The Committee will maintain oversight of key Internal Audit Actions and will encourage the implementation of recommendations in a timely manner. As at early September, SFT had 20 actions overdue, RUH had 6 actions overdue and GWH had 1 action overdue. The overall position against action tracking is part of the annual internal audit opinion and more emphasis is needed by the COLTs to implement actions within the agreed timeframes.

Techinal Accounting Updates
The Committee approved two amendments to technical accounting policies for the GWH 2026/27 Trust Accounts:

- An amendment to the Injury Cost Recovery (RTA) Bad Debt Provision Process @ GWH to align at Group level and with Dept. of Health and Social Care (DHSC) guidance. This will represent a reduction in the required provision of £561k.
- An amendment to the VAT provision for Microsoft and Associated IT Licences @ GWH based on further legal advice and time since the claim. This will represent a reduction in the required provision of £398k.

Assure

Board Assurance Framework (Limited Assurance)

The Committee took Limited Assurance on the effectiveness of the BAF framework (Sept 2026) at this stage of its development. Further work is required before the Audit Committees-in-Common can take Reasonable Assurance that each principal-risk judgement is supported by complete, current and appropriately independent evidence. A roadmap of actions and timings has been requested by the committee to detail the further work needed.

This judgement concerns framework maturity and does not, by itself, constitute a judgement that the individual principal risks are inadequately controlled. The BAF format links strategic priorities to risk descriptions, ownership, inherent, residual and target scores, three lines of defence, gaps in controls and assurance, and actions. But does not yet provide a complete, independently triangulated assurance picture for every principal

risk. In particular, the next iteration will need to complete assurance ratings, risk-appetite alignment, separation of controls from assurance evidence, third-line mapping, review dates, Group Risk Register references and validated action status'.

Internal Audit Reports (Significant Assurance)

The Committee received a progress report from KPMG (Internal Auditors and Local Counter Fraud Service) and noted that workplans are on track with no significant findings to highlight. The Internal audit reports reviewed and noted during the meeting were:

- Safeguarding review @ GWH - Significant Assurance with minor improvements.
- Violence and Agression review @ SFT – Significant Assurance with minor improvements.

BSW Hospitals Group Board

Agenda item	7.1
Report title	EPR Programme Update
Date of meeting	5th November 2026
Sponsor	Jonathan Hinchliffe, Group Chief Digital & Information Officer, SRO EPR
Prepared by	Claire Strathern, EPR Programme Director & Ciara Moore, EPR Operations Director
Approval Process:	EPR Programme Board (22nd October 2026)

☐ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
BAF R1	Becoming an effective Group
BAF R3	Delivering Digital Maturity
BAF R4	Transforming models of Care
BAF R7	Improving Value and Productivity
BAF R10	Cyber Security

KEY MESSAGES

The October 2026 EPR Programme Board agreed that the overall programme status has moved from **AMBER to RED** (please see Appendix A – Why the EPR Programme has moved to Red).

Whilst no new material issues or risks have presented in this last reporting period, this reflects the shortening timeline to deliver mitigation plans ready for the first go-live, critical dependencies affecting the delivery path, constrained subject-matter expert capacity and risks outside the programme's direct control.

It was acknowledged that the programme would be beyond the critical path within a month if mitigations are not delivered. Key stakeholders with the delegated authority to take critical, timely decisions and support the removal of blockers, from across the system is required. An immediate action was to establish a new weekly forum ('EPR Executive Escalation Huddle') to bring such stakeholders together to act on key emerging decisions to maintain the critical path.

The revised status position was escalated to the EPR Assurance Committee with immediate effect and ahead of the next routine reporting cycle (please see Appendix B – Briefing Note).

The Board recognised the progress achieved across testing, data migration, technical design and organisational readiness over the last reporting period. However, it concluded that the actions required to protect delivery now need accelerated, short-cycle executive oversight, clear delegated authority and coordinated support from the care organisations, Group functions, system partners, suppliers and clinical networks.

The key messages are:

1. **Programme status and recovery** – the Programme Board agreed that the programme should be rated RED with immediate effect. A focused recovery response will define the actions, accountable leads and three-month mitigation measures required to protect the critical path. A new weekly decision-making EPR Exec huddle will be established to enable rapid resolution of urgent risks, dependencies and resource requirements.

2. **Critical technical dependencies** – the GWH PACS/RIS delay, access to the associated test environment, the RUH Domain upgrade, WASP, AptVision and other interface dependencies continue to constrain the available testing window. Immediate supplier and executive escalation is required to secure workable mitigations and avoid further erosion of contingency.

3. **Subject-matter expert capacity** – constrained access to RTT and other specialist operational knowledge presents a material delivery risk. Care organisations are required to prioritise and ring-fence appropriate staff to support data validation, testing, defect resolution and completion of outstanding Trial Load 1 activity, with the Christmas period identified as a hard-stop. Further, the impact of Turnaround and the current vacancy freeze is impacting SME mitigation plans.

4. **Organisational readiness** – material local pressures remain across outpatient clinic schedules, training space and backfill, devices, infrastructure, data quality, funding and specialist capacity. The new Readiness Reporting Dashboard is ready to launch and will support strengthened oversight at care-organisation, divisional and specialty level. It was noted that there is a need for future reporting to distinguish EPR-specific device requirements from the existing risk relating to the wider ageing-estate replacement needs. Care organisations are still to resolve additional costs, such as training back-fill and infrastructure to support their readiness for EPR implementation.

5. **Integration Testing 1** – the Board approved the Integration Testing 1 plan. Testing commenced on 12th October 2026 and covers ten representative patient journeys across 35 solution areas. Delivery remains dependent on interface readiness, availability of test environments, completion of outstanding workflows and access to clinical, operational and technical subject-matter experts.

6. **Trial Load 1 and Trial Load 2** – the Board approved the Trial Load 1 exit report and noted that Trial Load 2 had commenced. Trial Load 1 successfully loaded data from all three care organisations and identified source-data, transformation and build issues that must be addressed through the agreed work-off plan.

7. **Access and identity management** – the Board approved synchronised Active Directory LDAP as the default EPR authentication method, with CIS2 smartcards retained where Spine access is required. The three-year cost of the Quest synchronisation solution will be funded from the existing EPR programme envelope and then funded from Group Digital Service non-pay budget.

8. **Referral management** – the Board approved the interim RUH Cinapsis and WASP co-existence model and the proposed single-EPR approach, subject to testing. It was confirmed that WASP mitigates significant manual processes which would increase following go-live to address existing variations across the care organisations.

9. **Business continuity architecture** – the Board approved implementation of the full Oracle Cloud Infrastructure model for the 724 downtime at go-live. This avoids a further disruptive infrastructure migration and outage after EPR implementation.

10. **Programme Finance** – the Board received an update on the current position noting the risk of uncommitted capital in current financial year. This is in part a reflection of the inability to secure specialist resources. An internal programme review is taking place to explore opportunities to release capital back to care organisations and to provide additional scrutiny on budget in support of Group Turnaround principles.

RECOMMENDATION

The Group Board is asked to:

- Note that the EPR Programme Board has moved the overall programme status from AMBER to RED, reflecting the narrowing mitigation window, constrained subject-matter expert capacity and critical dependencies affecting the delivery path.
- Support immediate implementation of a focused recovery response, including short-cycle executive decision-making (EPR Executive Escalation Huddle) with clear delegated authority, named accountable leads and defined mitigation actions to maintain the critical path.
- Require care organisations and Group functions to prioritise and release the clinical, operational, digital and technical capacity needed for testing, data validation, defect resolution, organisational readiness and completion of agreed work-off plans.
- Support rapid escalation and resolution of critical external, supplier and organisational dependencies, including those affecting PACS/RIS, integration environments, referral management, interfaces and access to specialist expertise.
- Note the Programme Board's approval of the Integration Testing 1 plan, Trial Load 1 exit report, Active Directory LDAP authentication approach, Cinapsis and WASP referral model, and Oracle Cloud Infrastructure architecture for the 724-downtime viewer.

APPENDICES

A – Why the EPR Programme has moved to Red	A summary overview of the reasons articulated at the EPR Programme Board held 22nd October to support the move to a Red overall status.
B – Briefing Note to EPR Assurance Committee	A copy of the briefing note provided to EPR Assurance Committee

Why the EPR programme has moved to RED

OVERALL PROGRAMME STATUS

AMBER ▷ RED

39 weeks

to GWH go-live (July 2027); IT1 testing started 12 Oct

1 Black, 19 Red of 117 risks
3 Black, 11 Red of 35 issues

> Without executive action on people, suppliers and funding, the July 2027 go-live is at risk.

1 · Critical SME gaps

4 of 15 critical SME posts vacant at IT1 start (RTT, PAS IP, Order Comms Lab/Cardio); RUH Front Door has no local lead.

2 · Interface test systems not ready

No GWH aptVision test system (Black); RIS/PACS slipping to Jan ’27 and WinPath to Mar ’27+, putting two test cycles at risk. RUH code upgrade dependency means just 1 week of interface testing in this cycle for RUH

3 · Resources held back by the financial turnaround

Finance can’t resource IT2 testing (NHSE Stage Gate 4.5); finance post deferred; CSOs, training backfill and devices unfunded.

⚠ **Compounding:** PAS IP Non-Theatres build not fit for purpose (Black); RUH clinic templates block TL2 (Black); c.5,000 GWH appointments not outcomed.

Risks, mitigations and the gaps we can't close

DRIVER & IMPACT	MITIGATION IN PROGRESS	NO MITIGATION AVAILABLE
Critical SME gaps Testing and workflow sign-off slip; RTT and national reporting untested.	• Third-party finance testers contracted for test volume • Integration resource landed; DWH developers being recruited • RUH Front Door lead and RTT SME identification; cross-Trust sharing explored	Trust SME knowledge can't be bought in: **named staff must be released**, and backfill is unfunded.
Interface test systems Interfaces may get one test cycle, not two; GWH ADT and Order Comms testing can't start.	• aptVision PO due ~29 Oct; supplier starting early • RIS/PACS test environment sought by mid-Nov; escalated to suppliers and CDIO • GWH test LIMS in place for WinPath build and first test round	Supplier dates (ICE, RIS/PACS, Clinisys/S4) are **outside programme control**; escalation is the only lever.
Financial turnaround IT2 finance testing and NHSE Stage Gate 4.5 at risk; clinical safety case under-resourced.	• CSO business case to committee 4 Dec; Deputy Group CSO at 0.3 • IT2 options drafted: move testing from year end, or fund finance SMEs • Group capital pooling under consideration for devices	No approved route or funding for finance testers, CSOs, training backfill or devices: **needs a Group Executive decision**.

Our asks, and the path back to AMBER

DECISIONS AND SUPPORT REQUESTED

1 Release the SMEs

Direct Trusts to release named RTT, PAS IP and Order Comms SMEs, exempt from vacancy control.

2 Escalate with suppliers at CEO level

Secure test environments and firm upgrade dates from the ICE, RIS/PACS and Clinisys suppliers.

3 Protect EPR in the turnaround

Agree funding for IT2 finance testing, CSOs, training backfill and devices — or formally accept the risk. EPR must have expedited processes.

4 Decide the WASP / eRS route

Confirm the BSW decision on eRS integration via WASP so interface build and testing can proceed.

NEXT 10 WEEKS

23 Oct	aptVision test system PO raised
26 Oct	Access & identity (LDAP) funding identified and order placed
2 Nov	RUH Front Door local lead and RTT SMEs released
6 Nov	GWH aptVision test system available
Mid-Nov	RIS/PACS test access for first test cycle
4 Dec	CSO capacity business case at committee
30 Dec	IT2 finance resourcing resolved

Back to AMBER when: critical SMEs are in post, GWH interface test systems are live, and funding decisions are made.

BSW HOSPITALS GROUP

BSW EPR Programme: Status Moved to Red

Briefing for Non-Executive Directors

Date: 22 October 2026
SRO: Jonathan Hinchliffe, Group CDIO
Prepared by: Claire Strathern, EPR Programme Director, Amrinder Singh, EPR Programme Manager
Purpose: For information and assurance

1. Purpose

To inform Non-Executive Directors that the EPR Programme Board on 22 October 2026 moved the overall programme status from Amber to Red and entered programme escalation, and to set out the reasons and the recovery actions under way.

2. Key messages

- **The programme is now rated Red.** This was proposed and agreed by the Programme Board with no objections.
- No new risks have emerged. The change reflects that the time available to mitigate existing risks is closing, and several are becoming acute.
- If the planned mitigations are not delivered before the next Programme Board, the programme would be beyond its critical path.
- The main drivers are external dependencies and the availability of clinical and operational subject matter experts (SMEs) from the care organisations.
- The EPR Assurance Committee is being notified now rather than at its next scheduled meeting on 4 December 2026.

3. Progress since the last Programme Board

- Trial Load 1 (TL1) has been completed and formally exited.
- Integration Testing 1 (IT1) and Trial Load 2 (TL2) are now under way.
- Training room arrangements have been agreed across all three trusts.
- The approach to access and identity (single sign-on via Active Directory) was approved, to be funded within the programme and digital budgets for the first 3 years.

4. Reasons for the Red status

1. **RUH code upgrade.** RUH goes live with its code upgrade next week. The trust integration engine must remain pointed at RUH systems for a further period, so RUH interfaces can only be tested in the final week of IT1. Any delay at RUH would have a material impact on the programme.
2. **GWH PACS/RIS.** The PACS/RIS go-live has moved from December 2026 to January 2027. Access to test systems and supplier resource falls outside the programme's test window and is currently on a best-endeavours basis.
3. **Subject matter expert availability.** There is a gap in RTT SMEs for data migration testing, and PAS, ED and Theatres are rated Red due to SME availability. The financial turnaround, including the external vacancy freeze, makes releasing operational staff harder.
4. **Carry-over and late scope.** Items deferred from Trial Load 1 must be completed in Trial Load 2, with much of it tested for the first time. Endoscopy and cardiology workflows and the WASP/ERS referral integration are still to be finalised.

These issues compound one another: a slip in any one area adds pressure on the others, and the October to December milestones have very little contingency.

5. Recovery actions

Action	Owner	By When
Stand up a weekly exec decision huddle with delegated authority (group, care organisations, programme) to expedite the resolution of arising issues.	Jonathan Hinchliffe, Mark Ellis	**29 Oct 2026**
Notify the EPR Assurance Committee of Red status and rationale	Jonathan Hinchliffe	**22 Oct 2026**
Release subject matter experts, especially RTT, for Trial Load 2 and IT1	Care organisation leads	**Now; hard stop before Christmas**
Set out the specific asks of each stakeholder needed to return to Amber	Jonathan Hinchliffe, Claire Strathern	Before next Programme Board (19th Nov 2026)
Overlay risks on the critical path plan with impact dates and hard stops	Amrinder Singh, Chris Sullivan	To be confirmed
Agree testing of GWH PACS/RIS outside the IT1 window	Amrinder Singh, Oracle Health	Before next Programme Board (19th Nov 2026)
Continue escalation of external dependencies (PACS/RIS, RUH code upgrade)	Jonathan Hinchliffe	Ongoing
Add resource in reporting, integration and data migration	Programme	In progress

6. Support requested from Organisations

- Note the Red status and the reasons for it.
- Support executive colleagues in prioritising the release of SMEs, particularly RTT, ahead of competing operational pressures.
- Be aware of the link between the financial turnaround measures and the programme's ability to secure operational staff time.
- Support rapid decision-making through the new decision huddle, recognising that monthly governance cycles are too slow for the current position.

7. Next update

Progress against the recovery actions, and the asks needed to return the programme to Amber, will be reported at the next EPR Programme Board and to the EPR Assurance Committee.

BSW Hospitals Group Board

Report from	RUHX Charity Assurance Report	Agenda Item	8.1
Report to	Group Board		
RUHX meeting date	15th October 2026		
Board meeting date	November 2026		
Author	Joy Luxford, (Stand-in) Chair of RUHX		
Status	Assurance		
Reporting period	FY2025/2 and FY26/27 Period: Months 1-5		

KEY MESSAGES

The Board should note that the Committee approved the RUHX Charity Annual Report and Accounts FY25/26 on a going concern basis. We took assurance from the auditors' unmodified opinion and noted that no control recommendations were identified.

The reports reviewed highlight the significant impact the Charity has had over the last financial year.

The Committee also noted the progress against the annual plan FY26/27 both operationally and financially, approved five grant applications and continued to encourage the RUHX team to prioritise the drawdown of the £6.9m fund reserves into high impact projects for the benefit of patients, adding value beyond NHS funding.

RECOMMENDATION

The Group Board is asked to note the report.

APPENDICES

None

RUHX Charity Assurance Repot

Key discussion points and matters to be escalated from the committee meeting.

Alert

No matters to alert.

Advice

The Committee

- Noted the progress against the annual plan FY26/27 both operationally and financially, received a helpful benchmark of RUHX to other NHS Charities and noted the re-forecast that had been performed at the end of Q1 (bringing targets down, in line with actual performance to date).

- Noted the amendments on the risk register in the last quarter, which included moving to the new group 5 + 5 + 5 model. No significant risks need to be escalated to the Group Board.

- Approved five grant applications in line with the documented delegated authority matrix for Cardiology waiting areas, ophthalmology imaging, CUSA device, Artspark match funding and Christmas funding for patients and staff in hospital on Christmas Day.

- Continued to endorse the RUHX expenditure policy that supports trust-wide recognition and celebration of staff, with a focus on planned, organisation-wide programmes using consistent criteria and seeking broad staff reach.

- Encouraged the RUHX team to continue to focus on achieving the best returns possible for £4.2m fund balances held in investments and to prioritise the drawdown of the £6.9m fund reserves into high impact projects for the benefit of patients, adding value beyond NHS funding.

Assure

<u>Annual Report and Accounts FY25/26 (Significant Assurance)</u>

The Group Board should note that the Committee approved the RUHX Charity Annual Report and Accounts FY25/26 on a going concern basis. We took assurance from the auditors' unmodified opinion and noted that no control recommendations were identified. The Report highlights the significant impact the Charity has had over the last financial year.

BSW Hospitals Group Board

Agenda item	9.3
Report title	Questions from Members of Public
Date of meeting	5 November 2026
Sponsor	Paul von der Heyde, Group Chair
Prepared by	Caroline Coles, Company Secretary GWH
Approval Process:	Associate Director of Estates & Facilities, Head of Sustainability, GWH Chief Finance Officer

☐ FOR ASSURANCE	☐ FOR DECISION	☒ FOR INFORMATION

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
n/a	

KEY MESSAGES

This paper reports on the question(s) and response(s) asked from the members of public to the Board of Directors.

RECOMMENDATION
The Group Board is asked to receive the question raised, the response given and agree if any further action is required.

Questions from Member of the Public submitted to BSW Hospitals Group Board

Answers provided in italics

Great Western Hospitals NHS FT from Chris Shepherd, Staff Governor in respect of Sustainable Travel

The Trust's Sustainable Travel Policy commits to increasing active travel and achieving 15% of staff commuting by active travel by 2030. However, concerns have been raised that recent changes may not support these objectives.

In particular, staff have highlighted the closure of a longstanding route between the Cycle Hub and the hospital without consultation, increasing challenges for cyclists accessing the site. There are also concerns regarding vehicle speeds and limited space within car parks, together with the condition and suitability of the Cycle Hub itself, including ongoing maintenance issues, unreliable shower facilities, and a lack of drying and ventilation facilities.

Given the Trust's stated commitment to sustainable travel, is the Board satisfied that sufficient action is being taken to encourage, support and invest in active travel for staff, and if not, what further measures are planned?

The Trust remains committed to promoting sustainable and active travel in line with its Sustainable Travel Policy. While the closure of the informal route between the Cycle Hub and the hospital was undertaken on safety grounds, the concerns raised regarding cycle access, vehicle movements within the car parks, and the condition of cycling facilities are recognised. The Trust has therefore committed to reviewing cycle access arrangements and the provision of supporting facilities, including showers and drying facilities, to ensure staff are appropriately supported to choose active travel.